



# Building a Better Wisconsin: Investing in the Health and Well-being of Wisconsinites

## 2023 Governor's Health Equity Council Report

Prepared by the Wisconsin Department of Health Services Office of Health Equity



**WISCONSIN DEPARTMENT**  
*of* **HEALTH SERVICES**

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**Health Equity, as this Council defines it, means “that everyone has a fair and just opportunity to be as healthy as possible.”**

## Executive Summary

In March 2019 Governor Tony Evers established the Governor’s Health Equity Council, by issuing Executive Order 17 and charging the Council with developing a comprehensive plan designed to improve “all determinants of health including access to quality health care, economic and social factors, racial disparities, and the physical environments” and “address health disparities in populations based on race, economic status, educational level, history of incarceration and geographic location” by 2030. At the time that the Governor’s Health Equity Council was established, none of us could have predicted just how drastically the world would change in ways that would bring new attention and awareness to preexisting and emerging health disparities, along with a renewed sense of urgency to not only combat these health disparities, but also address the conditions which produce them. The newly appointed members of the Governor’s Health Equity Council, originally 34 members strong, first met as a formal body virtually on September 30, 2020, where the council, under the leadership of Chairwoman Gina Green-Harris, began to set a course to establish this body of work. In July 2021, Dr. Michelle Robinson was appointed Vice-Chairwoman of the Council, providing additional strategic and operational leadership as the Council transitioned to a subcommittee structure, better enabling discussion and development of the solutions outlined in this plan.

Health equity, as the Governor’s Health Equity Council defines it, means “that everyone has a fair and just opportunity to be as healthy as possible,” (Braveman et al., 2017). The Governor’s Health Equity Council— which is composed of a racially and ethnically, geographically, and professionally diverse set of health and health equity subject matter experts – recognized that despite the tremendous and disparate impacts that once-novel COVID-19 pandemic had on our collective well-being and longevity, these outcomes were the results of preexisting gaps in access to critically important resources such as good paying jobs, safe and quality education and housing, social and community supports, access to health care, and clean water and air. Even more, the Governor’s Health Equity Council recognized that these gaps were experienced unevenly based on where you resided, how much income and wealth you have access to, or your racial or ethnic background; therefore, improving our state’s health and well-being requires addressing the obstacles impairing our overall health, as well as those producing disparate health outcomes. For that reason, the Governor’s Health Equity Council chose to **center its recommendations on addressing upstream drivers of health, focusing on three core types of factors: economic, social and the physical environment.**

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Given these areas of focus, the ideas and recommendations generated as part of its subcommittees were similarly structured to address Representation/Decision-Making/Access (Power), Targeted Programming for Under-resourced Communities (Programs) and Structural Inequities (Policy). Over the last 20 months, the members of this body have been diligently working to identify and develop the proposals included in this plan, and we are excited to share them now.

In total, the Governor's Health Equity Council adopted twenty recommendations representing a variety of policy and implementation approaches aimed at addressing issues such as access and quality of care, reenforcing existing and creating new pathways for economic opportunity, building critical infrastructure to close gaps in accessing technology, and strengthening our ability to proactively respond to threats to our collective well-being due to climate change.





## Complete List of Governor’s Health Equity Council Recommendations

The recommendations listed should be taken as a package as not every member agreed with each specific recommendation, but members agreed that these recommendations reflected the general consensus of the Governor’s Health Equity Council, and thus should be forwarded to the Governor.

### **Health and Community Services**

#### *Community Health Workers*

This recommendation calls for the creation of a Community Health Worker certification process and establishment of standards for Community Health Worker certification. In addition, the recommendation calls for the services provided by certified Community Health Workers, within their scope of practice, to become reimbursable under a newly established community health benefit in Wisconsin’s Medicaid program.

#### *Postpartum Medicaid Eligibility*

This recommendation calls for the Wisconsin Medicaid program to further extend the postpartum eligibility period to the end of the month in which the 365th day post-partum occurs. In addition, the recommendation includes support for the Wisconsin Medicaid program’s development of a housing benefit, urges the Medicaid program to prioritize pregnant and

post-partum members for this benefit, and calls for increases to the amounts provided in food assistance programs.

#### *Family Planning and Emergency Services for Immigrant Populations*

This recommendation calls for the creation of a Wisconsin program that provides family planning service benefits to individuals presently ineligible due their immigration status. In addition, the recommendation calls for exploring ways to extend the emergency service Medicaid benefit to presently ineligible individuals.

#### *Dental Health for Kids*

This recommendation calls for the Wisconsin Medicaid program to reimburse for services provided by community dental health coordinators within their scope of practice. In addition, the recommendation calls for the Wisconsin Medicaid program to pursue effective reimbursement strategies to incentivize the provision of dental services to children.

#### *School and Employer Partnerships to Increase Health Care Workforce*

This recommendation calls for Wisconsin to fund health care navigators' work with schools and employers, to provide awareness, exposure, and experience of various health care careers to students. In addition, the recommendation calls for improvements to health care career training and pathways to training at state universities and technical colleges, and improvements to dual enrollment programs for high-school students simultaneously enrolled in health care profession training programs.

#### *Rural Broadband Internet Access*

This recommendation supports the recommendations contained within the Governor's Task Force on Broadband Access and the Public Service Commission's State Broadband Plan, namely those with a focus on improving digital equity — creating a digital equity fund, establishing an internet assistance program, and increasing broadband expansion grant funding across urban and rural communities.

### **Education and Housing**

#### *Tuition Waivers for Enrolled Members of Wisconsin Tribal Nations*

This recommendation calls for enrolled members of Tribal nations in Wisconsin to receive a waiver of tuition costs while attending a public four-year college or university as an undergraduate student or a two-year college or technical school in Wisconsin.

#### *Homeownership*

This recommendation calls for Wisconsin to increase the portion of existing federal funding to support ongoing and new community land trust initiatives around the state. In addition, the recommendation calls for new funding for local partners providing homeownership support services,

including educational services and financial supports to qualifying individuals.

## **Justice**

### *Employment of People Formerly Incarcerated*

This recommendation calls for Wisconsin to create a tax credit for employers who employ individuals who have been formerly incarcerated, make investments in worker cooperative development focused on providing opportunities to persons formerly incarcerated, and further evaluate and develop re-entry programs providing training and employment opportunities.

### *Transitional Services and Diversion Programs*

This recommendation calls for Wisconsin to increase the use of peer support services in prison pre-release and transitional service programs. In addition, this recommendation calls for implementing a peer-led, community-based deferred prosecution and diversion pilot program.

### *Health Care of People Currently Incarcerated*

This recommendation calls for Wisconsin to implement reforms for people currently incarcerated who are pregnant, including increasing deferred prosecution and diversion opportunities, aligning state statute with federal law and guidelines related to shackling, and supporting doulas to provide pre-natal, birthing, and post-natal support.

## **Governance**

### *Health Equity Council Permanence*

This recommendation calls for Wisconsin to make permanent the work and purpose of the Governor's Health Equity Council. Potential pathways include forming an advisory body to the Department of Health Service's Office of Health Equity, establishing the Council in State statute, and transitioning to a grassroots network, among others.

### *Transgender Health and Safety*

This recommendation calls for Wisconsin to establish an Interagency Council on Transgender Health and Safety, composed of members from state agencies and the community, to provide trainings, technical support, analysis, and recommendations to address the unique health and social needs of transgender persons.

### *Environmental Justice*

This recommendation supports the recommendation contained within the Governor's Task Force on Climate Change to create an Office of Environmental Justice charged with designing and advising on inclusive and equitable climate policies.

### *Health Data*

This recommendation calls for a variety of state agency actions, including for agencies to examine existing data sharing agreements and opportunities for improvements, include a wider range of race and ethnicity options in collecting data, provide guidance for health equity analyses and communications, and assess administrative burdens borne by individuals receiving health and social service public benefits.

### *Maternal Mortality Review Process*

This recommendation calls for Wisconsin to increase the staffing and other resources dedicated to reviewing incidents of maternal mortality within the state, with a special focus on incorporating family interviews into the review process.

## **Family-Sustaining Fiscal Policy**

### *Minimum Wage*

This recommendation calls for Wisconsin to implement incremental increases to minimum wage over the next three years, and for the creation of a taskforce to be charged with developing a viable pathway to implementing a \$15 per hour (or equivalent) minimum wage, with a specific focus on an implementation plan that ensures appropriate supports to small and local business owners to sustainably achieve this goal.

### *Earned Income Tax Credit*

This recommendation calls for Wisconsin to extend eligibility for the state's Earned Income Tax Credit to adults without dependent children, increase the credit for households with children, and allow survivors of domestic violence to claim the credit. In addition, the recommendation calls for state executive agencies to develop and implement a plan to increase the number of Wisconsinites who receive the federal Earned Income Tax Credit, particularly among adults without dependent children.

### *Guaranteed Income*

This recommendation calls for Wisconsin to implement a guaranteed income pilot program to reach individuals living in poverty in five marginalized communities throughout the state. In addition, this recommendation calls for a rigorous evaluation of the program's economic and health impacts to participants and communities.

### *Baby Bonds*

This recommendation calls for Wisconsin to provide an initial payment to all babies born in the state and for additional annual payments ranging from \$100 to \$2,500 based on family income into an account that will become available when the child turns 18. The funds would be eligible for



expenses such as education, purchasing a primary residence home, starting or expanding a business, obtaining a license or certification, retirement investment, and medical expenses. In addition, this recommendation calls for a taskforce to be charged with developing implementation policies for administering the program.

## The Path Forward

Achieving health equity in Wisconsin means that every Wisconsinite has access to the conditions and resources they need in order to achieve their optimal health and well-being — regardless of where they are born, the level of resources their birth family had access to, the color of their skin, or their cultural background. Therefore, advancing health equity across Wisconsin makes sense and is the right thing to do.

*The Council took on the task of developing a rationale for this work – that health equity is about creating, together, a stronger Wisconsin that truly works to have equity and inclusion for **all** of us – one which can have a singular voice of unity, serving as a counter to current prevailing narratives which perpetuate indifference, division, and false narratives, discouraging the power of collective voice for sustainable change that will impact the health of our state.*

Yet, in a period of heightened political and partisan divisiveness, particularly towards efforts to bring attention to and remedy historic and present injustices, we have sought ways to cut through the noise so that we can recenter conversations on the moral imperative that is being erased in those discussions: **There are actual lives on the line.**

Existing gaps in the opportunity to live long and healthy lives, and the quantifiable differences in people’s experiences with health and well-being across our state, mean that the lives of real people – infants, children, adults, and our elders – are being cut too short, too often, due to factors that we as a state, and as an interconnected community, have the power and the obligation to change. Nevertheless, the Governor’s Health Equity Council recognizes that actionable, common-sense recommendations alone may not be sufficient to garner support. And so, in addition to developing formal recommendations, the Governor’s Health Equity Council took on the task of developing a rationale for this work — that health equity is about creating, together, a stronger Wisconsin that truly works to have equity and inclusion for ALL of us — one which can have a singular voice of unity, serving as a counter to current prevailing narratives which perpetuate indifference, division, and false narratives, discouraging the power of collective voice for sustainable change that will impact the health of our State.

You can become actively involved with this effort by reviewing the Prelude and Principles to this report with an open mind, through the lens of real lives of real people and not as a political platform. Although we were instituted by Executive Order, our work is framed not in a political party or agenda, rather, it was developed in a framework of genuine care and desire to improve health and health equity in Wisconsin, because despite our differences, we believe everyone matters.

If implemented, the recommended actions contained within this report will improve our state's overall health and well-being, save lives, improve individual and community-level educational and economic standing, and advance health equity across Wisconsin — benefiting each of us.

At the same time, we would be remiss if we did not also acknowledge that to truly achieve our primary goal — optimizing the health and well-being of all Wisconsinites by working to eliminate health disparities and improve the health of every individual residing in our state — it will require much more. It requires that we be willing to identify and adopt transformative ideas, beyond those included within this plan, designed to remedy imbalances in influence and access and advance policies and programs that create and foster the essential conditions required if we are to achieve this goal.

This work is only the start. We encourage and invite all Wisconsinites to engage with the 20 solutions presented in this plan. It is within our power to create a Wisconsin that works for each of us. To do so will require bravery and partnership among the residents of our state and will require our leaders in power to move us FORWARD towards a more fair, just, and equitable future.

## Governor's Health Equity Council Members

<b>Members</b>	
<b>Dr. Amy DeLong</b>	Family Physician and Medical Director, Ho-Chunk Nation Department of Health
<b>Andrea Werner</b>	Senior Vice President, Bellin Health
<b>Diane Erickson</b>	Health Services Administrator, Red Cliff Band of Lake Superior Chippewa Indians
<b>Elizabeth Valitchka</b>	Strategic Advisor, Wisconsin Department of Children and Families
<b>Ellen Sexton</b>	Senior Vice President, Head of Specialty business at Humana
<b>Gale Johnson</b>	Director, Wisconsin Well Woman Program, Department of Health Services
<b>Gina Green-Harris</b>	Director, Center for Community Engagement and Health Partnerships, UW School of Medicine and Public Health, Wisconsin Alzheimer's Institute, GHEC Chair
<b>Guy (Anahkwet) Reiter</b>	Executive Director, Menikanaehkem Inc.
<b>Isaak Mohamed</b>	Somali Liaison, Community Health Worker, Barron City Council
<b>Janel Hines</b>	Vice President, Community Impact, Greater Milwaukee Foundation
<b>Dr. Jasmine Zapata</b>	Chief Medical Officer and State Epidemiologist for Community Health, Department of Health Services
<b>Jerry Waukau</b>	Tribal Health Director, Administrator of the Menominee Tribal Clinic
<b>Dr. Julie Mitchell</b>	Commercial Medical Director, Anthem Blue Cross Blue Shield of Wisconsin
<b>Lilliann Paine</b>	Director of Technical Assistance, National Birth Equity Collaborative
<b>Lisa Peyton-Caire</b>	Founder and President, Foundation for Black Women's Wellness
<b>Lt. Gov. Mandela Barnes</b>	Lt. Governor, State of Wisconsin
<b>Maria Barker</b>	Director of Latinx Programming and Initiatives, Planned Parenthood of WI
<b>Mary Thao</b>	IT Consultant, Marshfield Clinic; Owner, Thao Consulting, LLC
<b>Tamra Oman</b>	Statewide Program Director, FREE Campaign
<b>Dr. Michelle Robinson</b>	Director, Office of Health Equity the Wisconsin Department of Health Services , GHEC Vice Chair
<b>Patricia Metropulos</b>	President and CEO, Kathy's House
<b>Paula Tran</b>	State Health Officer and Division of Public Health Administrator, Wisconsin Department of Health Services
<b>Sandra Brekke</b>	Senior Consultant, Office of Population Health - Gunderson Health System
<b>Karen Timberlake</b>	Former Secretary-designee, Wisconsin Department of Health Services
<b>Shiva Bidar-Sielaff</b>	Vice President, Chief Diversity Officer-UW Health - School of Medicine and Public Health
<b>Stacy Clark</b>	Prevention Program Supervisor, Sixteenth Street Community Health Centers
<b>Tia Murray</b>	Founder and CEO, Harambee Village Douglas; PhD student at University of Wisconsin
<b>Dr. Tito Izard</b>	President and CEO, Milwaukee Health Services, Inc.
<b>Vincent P. Lyles</b>	System Vice President Community Relations, Advocate Aurora Health
<b>Wanda Montgomery</b>	Director of Community Partnerships, Children's Hospital of Wisconsin
<b>William Parke-Sutherland</b>	Health Policy Analyst, Kids Forward

## Prelude and Principles to the Report

The Wisconsin of today is a sum of the history of the land and the economies it has supported, the people, past and present, who have inhabited this place, the reasons for why and how they have come to live here, and the politics and policy, from the local to the global, that intersect with the people and communities of this state. [The Population Health Institute's State Health Report Card](#), [Department of Health Services' State Health Assessment](#) and [Minority Health Report](#) have invariably and consistently shown how measures of the burden of chronic and acute diseases, the rates of death and illness, and health-related behaviors vary by age, income, race, and so many other ways society classifies and characterizes people. Other reports and research abound, reiterating and detailing these many ways health conditions and outcomes vary at national, state, county, and neighborhood levels.

Wisconsin hovers not only in the shadow of our collective and full history, but also our present, as we continue to look for ways to navigate the shadow of the COVID-19 pandemic, the unexpected event which has consumed our lives and likely, your lives, for much of the past two and a half years. While consuming our attention and focus, the pandemic has also caused in some cases substantial and long-lasting illness, and taken the lives of far too many. The COVID-19 pandemic has helped to shine light on the state of existing gaps in health equity in Wisconsin, and further revealed the human, community, and societal costs of those gaps. In Wisconsin, as in other states, people with limited incomes and minority populations, especially Black and Brown Wisconsinites, have been the hardest hit in terms of cases, hospitalizations, and deaths. These outcomes are the direct result of the histories, present realities, and structural barriers confronting these people, their families, and their communities – low wages and poor working conditions, inadequate housing, limited transportation options, and more – to health and well-being. These shadows, our history and our present, are foundational for understanding and addressing contemporary health disparities impacting Wisconsinites and their communities across the state. This work begins with understanding that these health disparities are systemic, unjust, and largely avoidable.

While some have attributed these differences to personal and individual failings, the reality is that social, economic, and environmental conditions, and differences in the ability of some groups to shape their own future, are the underlying causes. Poorer health outcomes of all sorts are concentrated among communities and populations who have experienced some form of exclusion, whether historically or contemporary, whether economically, socially, and/or racially. That exclusion has taken many forms, including the colonization of Native Americans and removal from their land, slavery and Jim Crow, the disenfranchisement of women and people of color, restrictions on immigration of Asian, Latino, and Black people, housing segregation, inequities in criminal justice, hiring discrimination, anti-LGBTQ norms and policies, structural



poverty, and more. How exclusion plays out has morphed over our history but has remained a feature of our democracy as it benefits the self-interests of the powerful.

These forms of exclusion are what drives health outcomes: they have grave influences on peoples' ability to earn a sustaining wage, to participate in our democratic society, to have choices about the food they eat and places they live, and to feel welcome wherever they may go. **Exclusion, discrimination, inequitable policies, programs, and access to resources are not only morally wrong, but they are also economically shortsighted and contribute to less freedom, and less well-being, for all of us.** And with this, we must plot a course for a different future, one defined by fairness and inclusion, where we remove the unequal obstacles remaining in our midst so that there becomes an equal opportunity for everyone to live their life to the fullest. In service to this goal, we have identified a set of principles that will help guide our way forward.

### Guiding Principles

Wisconsin's strength comes from our ability to bring together hardworking people from different places and of different races to share our traditions and forge a better future. For this to be a place where everyone can thrive, we cannot let the self-interests of the powerful divide us based on what someone looks like, where they come from, or how much money they have. We must stand up for each other and come together to foster inclusive and welcoming communities across our state that support everyone's health and well-being, regardless of their race or ethnicity, their socioeconomic status, gender, age, educational level, experience with the criminal justice system, or their sexuality.

We can center a different set of principles from those that have recently driven our society, reexamining our programs, changing our policies, and rethink how we analyze our current situation to reflect what truly drives health and well-being for each of us and our communities: Black, white, Brown, Asian, Pacific Islander, and Indigenous. We are coming together to build a Wisconsin that is for all of us. Together, we can make Wisconsin a place where everyone can thrive. No exceptions.

To effectively pursue health equity and achieve a Wisconsin where everyone can thrive, we must embrace a shared set of standards of behavior and beliefs as a way of grounding and anchoring the work ahead, and which can serve as a framework to assess and evaluate the choices we, and those in power, make. This new set of behaviors and beliefs must, instead of supporting the status quo of exclusion, embrace and facilitate a new standard of inclusion that is both intentional and impactful. Under this tent, there is plenty of room for everyone. These shared standards, what we call principles, must stand counter to much of what we have been taught and much of what has recently driven our society: that we must all pull ourselves up by our own bootstraps, that we do not have enough to allow everyone to thrive, that our government is the

source of our problems, that economic growth is our sole aim, and that we are powerless to change our future. These ideas have led to many of the inequities in Wisconsin, and we can choose to live by a different set of principles.

As such, we offer the following principles as a way to elevate our conversations and support actions that move us beyond the reach of messages that serve to obstruct these pursuits. These principles reflect the Wisconsin we are committed to building and this council's commitment to our state.

*Everyone deserves respect and dignity*

Our worth comes from being alive — regardless of where we come from and what we look like, and what we do. Across many beliefs, dignity and autonomy continues in death, as well.

*Everyone deserves a fair shot at thriving*

The social, environmental, and economic policies and systems we make have the greatest influence on our opportunities to thrive. It is our job to transform our social fabric for health equity — so physical, mental, and social health and well-being are possible for everyone.

*In Wisconsin, we do not leave anyone behind*

Our well-being is bound to each other, and we take care of each other. It is our collective responsibility to cultivate strong, healthy communities, for we understand that we all do better when we all do better.

*We believe all Wisconsinites should have a say in decisions that affect our lives*

Everyone brings knowledge that should guide public decision making. Meaningful inclusion leads to better decisions—and people thrive when we see ourselves as valued members of our communities.

*Making Wisconsin better for all of us means changing what we do and how we do things*

Change is both a process and an outcome and is necessary for progress. We're committed, hopeful, honest, and brave about the risks, transformation, and time it will take from each of us.

*Making all our communities healthy and safe starts with us*

We have what it takes to transform Wisconsin so that everyone has what they need to provide for themselves and their families. We are facing complex issues, and we will need to address them individually, in our communities, and in our institutions. It is our nature as humans to be creative and creatively solve the problems we face. We collectively have the knowledge, resources, and the power to change our communities and our state so that we can all thrive.



## Chairs' Foreword

*“This new plan must be designed with a brighter future for all Wisconsinites. It must be built with a vision for a stronger, more robust Wisconsin that recognizes, appreciates, and values our commonalities and differences. In this plan for a better future, we must be inclusive, fair, and just. We must be willing to challenge the status quo to change policies and practices that we know continue to be obstacles to equality and justice for the most vulnerable citizens who have been historically (and continue to be) marginalized because of these known barriers. As it is through the removal of these barriers that we create an equal opportunity for everyone to live their life to the fullest.”*

*– Chairwoman Gina Green-Harris*

## Chairs' Foreword

The Governor's Health Equity Council (GHEC) began our work in September 2020, months after the COVID-19 pandemic officially reached our nation's shores. By the time we first convened, the COVID-19 virus had already stolen too many lives and devastated far more. The lives lost represent lost potential, businesses, resources, and economic growth. Lost relationships and connections. And lost love. As public health data systems were stood up, we began to learn about who these lives were. We learned that these lives disproportionately came from impoverished backgrounds, were from rural communities, were Black or Indigenous, and/or were working class. Each of these lives mattered, and every loss a devastating, world-shattering tragedy. But the fact is that we already knew who these lives would be. This is because they are the same lives that have been and continue to disproportionately experience lower quality of life and shorter life spans largely due to avoidable and preventable causes. This is the problem we aim to address when we speak about the need for health equity.

Health equity is a critical component to the Wisconsin Idea. The Wisconsin Idea is imbedded in the notion that for our state to thrive and experience health, wealth, and economic development, we must advance and enact good, smart research and evidence-informed policy that improves health, quality of life, the environment, and agriculture for all citizens of the state. It is unfortunate that at this juncture, as great of a state that we are, we find ourselves in unprecedented times of political indifference. In a time where we should be coming together in unity to heal our state, we have allowed political agendas to polarize our state to the point that we as a community of people have become disjointed and disconnected. We are currently in a state of political stalemate, with a refusal to recognize how the historical injustices of the past continue to plague us as a state (and country).

## Principles Underlying the Governor's Health Equity Council Report

- ▶ **Everyone deserves respect and dignity.**
- ▶ **Everyone deserves a fair shot at thriving.**
- ▶ **In Wisconsin, we do not leave anyone behind.**
- ▶ **We believe all Wisconsinites should have a say in decisions that affect our lives.**
- ▶ **Making Wisconsin better for all of us means changing what we do and how we do things.**
- ▶ **Making all our communities healthy and safe starts with us.**

*“All ethics so far rest upon a single premise: that the individual is a member of a community of interdependent parts.” – Aldo Leopold, UW Professor*

Health Equity, simply put, “means that everyone has a fair and just opportunity to be as healthy as possible ([Braveman et al., 2017](#)).” The key part of this definition is the phrase “a fair and just opportunity” which we interpret to state that our chances to achieve optimal health and well-being are equal to others in every possible way, and impartial, not being shaped by anything other than our own personal choices and decisions. This is the reality we hope for ourselves, our families and loved ones, and we are sure it is a reality that many others resonate with and hope for as well. Unfortunately, it is not our reality today. Achieving health equity in Wisconsin means that every Wisconsinite, regardless of where they fall on the spectrum of humanity (race, gender, age, geographic location, culture, ethnicity, religious beliefs, social and economic status), will have access to the conditions and resources they need in order to achieve their optimal health and well-being. Advancing health equity not only makes sense fundamentally, but is also critical to the prosperity and well-being of our State to thrive.

*Our individual choices and decisions alone will not protect our health when a policy decision is made that leads to increased pollutants in our water supply.*

*Our individual choices and decisions alone will not protect our health as we confront poverty and the lack of access to health care because our school districts have been underfunded, or jobs have moved away, and we are facing an unforgiving job market where even individuals with 4-year degrees struggle to make ends meet.*

*Our individual choices and decisions alone cannot protect our health against the chronic stressors of housing insecurity as rent and housing costs rise more quickly than wages, forcing tough decisions on matters like nutrition and health care for ourselves and our families.*

Our individual choices and decisions alone cannot address issues such as polluted water, housing insecurity, or lack of family-supporting jobs, as it was not our choices and decisions that created these problems in the first place. Our individual choices and decisions alone cannot address issues like these as it was not our choices and decisions that created them. It was policy that has created conditions such as these, and we will need policy that promotes the creation of the kinds of conditions that facilitate a fair and just opportunity for health and well-being to change them. While this may not be our reality today, it is possible for it to be some day. But this will require “removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care,” ([Braveman et al., 2017](#)). This is the work that members of the Governor’s Health Equity Council embraced — identifying and putting

***Our individual choices and decisions alone will not protect our health when a policy decision is made that leads to increased pollutants in our water supply.***



forth recommendations aimed at removing social, economic, and physical barriers impacting individuals' and communities' opportunity to access their greatest health and wellness potential.

As such, [Executive Order \(EO\) 17](#), signed by Governor Tony Evers in March 2019, created the Council and tasked it with an ambitious charge: to provide a plan which, if enacted, would lead to the reduction and elimination of health disparities – i.e., a pattern of worse or lowered health outcomes among excluded or marginalized groups — based on race, economic status, education level, history of incarceration, and geographic location by 2030. This charge is ambitious in part because of its timeline and the wide range of social, economic, and physical factors currently imperiling individuals' and communities' opportunity to access their optimal health and well-being. We are grateful to Governor Evers' bold leadership and visioning in making the decision to establish this Council and giving it such an important charge.

But it is also ambitious in large part due to the overall challenge we are increasingly confronting as a state and a nation simply to have constructive and civil dialogue about the role that government should and should not play in protecting and preserving the health of those of us residing within its borders. The various legal and political battles that have been occurring at an accelerated rate continue to create new threats to existing laws and rights such as Civil Rights and Equal Protections — which were created out of necessity with the intention of correcting historic injustices. By dismantling these protections, government is impairing not only our ability to name and identify inequalities, but to stand up policy and programming designed to address them. And there are powerful forces who have worked hard, and with great success, to leverage the suffering, devastation, and fear existing within and across our communities, turning it into distrust, hostility and even hatred towards one another, towards critical social institutions, and toward the idea of democracy, making it more likely that we will encounter entrenched toxic partisanship than common ground.

Despite the challenges we faced, through our work, our priority remained the people of Wisconsin, and as such we engaged in conversations that allowed for open, safe, and transparent dialogues, leading to difficult discussions about how to address and eradicate historical and current systemic barriers that impede on the health and wellness of all state residents. We affirmed that the barriers embedded in our current health care systems, policies, and procedures at the state, regional, and local levels continue to impose and expand the health disparity gaps in our state in our most vulnerable populations and communities. These gaps significantly reduce the opportunity for long, healthy lives. And quantifiable differences in people's experiences with health and well-being across our state mean that the lives of real people

***Our individual choices and decisions alone will not protect our health as we confront poverty and the lack of access to health care because our school districts have been underfunded, or jobs have moved away, and we are facing an unforgiving job market where even individuals with 4-year degrees struggle to make ends meet.***

— infants, children, adults, and our elders — are being cut too short, too often due to factors that we as a state, and as an interconnected community, have the power and the obligation to change.

Yet and still, it is within this context that we were joined by 30-plus other members of the Governor’s Health Equity Council — representing a diversity of perspective, location, background and expertise — who over twenty months gave of their time and capacity to envision a stronger, healthier state and to put forth recommendations which, if implemented, would move our state closer to being a state where everyone has a just and fair opportunity to be healthy. And it is critical that we emphasize that the twenty recommendations put forth in this plan would just be a start; to truly create a Wisconsin that supports health equity requires much more work than what can be accomplished by a single council.

As such, the recommendations laid out here are not, and nor are they intended to be, a comprehensive collection of the actions we must take to make meaningful and sizeable strides towards health equity. Such an undertaking would be gargantuan, and beyond the scope of the Executive Order charge and this report. Instead, we intend this work to be considered as a set of stepwise measures that must exist alongside the work towards health equity that has been, is being, and will be done — throughout Wisconsin, by every person, organization, and structure, to meet the urgency set forth in the executive order. The future of our state depends on it.

Gina Green-Harris, MBA, Chair

Michelle Robinson, Ph.D., Vice-Chair

***Our individual choices and decisions alone cannot protect our health against the chronic stressors of housing insecurity as rent and housing costs rise more quickly than wages, forcing tough decisions on matters like nutrition and health care for ourselves and our families.***



## About the Governor's Health Equity Council

In response to Wisconsin's consistent and persistent health disparities, as illustrated by past and current studies such as the [Population Health Institute's 2021 Wisconsin Population Health and Equity Report Card](#) and the [Wisconsin Department of Health Services State Health Assessment \(SHA\)](#), Governor Tony Evers issued [Executive Order \(EO\) 17](#) on March 19, 2019, establishing the Governor's Health Equity Council and charging it with developing a comprehensive plan to reduce and eliminate health disparities throughout the state by 2030. Specifically, the Executive Order requires the plan to address health disparities on the basis of race, economic status, education level, history of incarceration, and geographic location by improving the determinants of health "including access to quality health care, economic and social factors, racial disparities, and the physical disparities" and recognizing that "geographic disparities exist in health outcomes and the determinants that influence health in both rural and urban communities (2019 Executive Order #17)."

Executive Order 17 appointed the Lieutenant Governor, the Secretaries, or surrogate, of the Department of Health Services and the Department of Children and Families to serve as members of the Governor's Health Equity Council. In addition to these representatives from the State of Wisconsin government, the Governor appointed to the council a diverse

group of community and health equity subject-matter-experts representing business, health and health care organizations, nonprofits, and community-based-organizations from across the state. Over the life of the Governor’s Health Equity Council there have been a total of 36 members, 34 original and two added due to turnover, who have given their time and talents to the work reflected in this report. Their dedication to the enormous task laid before them is the reason we can put forth the recommendations contained within this report which, if implemented, would allow us to make significant strides in addressing inequities and disparities threatening the health, safety and prosperity of all who reside across our great state. You can find a full list of members, along with a short biography, in the Appendix.

## Council Process

The first meeting of the Governor’s Health Equity Council took place on September 30, 2020, and the final meeting on June 10, 2022. In total, the Council met as a full body twelve times over a period of 20 months. During that time, the Council undertook a variety of tasks aimed at facilitating learning, supporting big thinking, and facilitating the development of the ideas generated by Council members. The Governor’s Health Equity Council’s work has been iterative with a commitment to inclusion – relying on public discussions, elevating member voice and perspective to shape the Council’s operating model, and intentional efforts to not only garner feedback from communities and the public at-large, but to allow the public to contribute and co-develop ideas.

The Council’s work was organized in three phases:

**LEARN:** The LEARN phase spanned the period of September 30, 2020, to May 19, 2021 where the Council’s work centered on developing a shared understanding of roles, responsibilities, context and establishing shared definitions, establishing the Council’s operating model and conducting environmental scans of current and prospective local- and state-level policy, practice, programs, relationships, resources and culture.

During the GHEC’s second meeting on October 21, 2020, the Council voted on its governance structure, electing to operate under a model requiring two thirds of Council membership to be present to achieve quorum and a simple majority for a vote to pass.

**CREATE:** The CREATE phase began on May 19, 2020 and ended November 17, 2020. During this phase, subcommittees were created and members assigned to them, for the purpose of engaging with communities to support the development of recommendations and narrative content. Four subcommittees were established:

- **POWER Subcommittee:** Develop a set of recommendations aimed at addressing power imbalances, such as representation, decision-

making and access, impacting marginalized populations that facilitate health inequity in our state.

Co-Chairs: Dr. Amy DeLong and Dr. Jasmine Zapata

- POLICY Subcommittee: Develop a set of recommendations that advance policy solutions and corrections to structural funding inequities that address health equity in our state.

Co-Chairs: Maria Barker and Gale Johnson

- PROGRAMS Subcommittee: Develop a set of recommendations that advance health equity and combat health inequity in our state through intentional investments in program and programmatic solutions and strategies driven by historically and systemically oppressed communities (i.e., EO17: race and ethnicity, incarceration, economic status, and geography.)

Chair: Elizabeth Valitchka

- FRAMING Subcommittee: Develop recommendations aimed at targeting gaps in our understanding of health inequity and/or limits to accountability, and lead the development of the data narrative, framing of the work and strategy for driving plan buy-in.

Co-Chairs: Shiva Bidar and Paula Tran

**RECOMMEND:** The RECOMMEND phase is the final phase of the Council’s work and was initiated on November 17, 2020 and concludes with the publication of this plan. This phase consisted of reviewing and voting draft recommendations out of subcommittee, and the adoption of formal recommendations by the Council. On April 4, 2021, the Council convened and voted on and approved a package of twenty draft recommendations and narrative documents, consisting of revisions and amendments that are reflected in the final versions of the Council’s proposals included in this plan.

## Governor’s Health Equity Council Decision on Quorum and Voting Requirements

Members voted to use a simple majority for quorum and required an affirmative vote of two thirds of the members present to pass a motion. For example, if there were 34 total GHEC members, 18 members would need to be present to achieve a quorum and 12 members would need to vote yes for a motion to pass.





**Our health is shaped by our history. Our communities. Our economies. Our work environments. We are all intertwined. We are all healthier, safer, more well, when we are all healthy, safe, and well.**

## Who is Wisconsin?

*“The health of the 5.8 million people of Wisconsin is influenced by events, decisions, and experiences of the past, which differ depending on where people live and who they are. The geography and natural resources, the way people moved in and out of the regions, and the businesses that were started and closed, all have had long-term impacts on the people of the state”*

—Wisconsin State Health Assessment, 2022

[www.dhs.wisconsin.gov/publications/p03169.pdf](http://www.dhs.wisconsin.gov/publications/p03169.pdf)

To better understand who is Wisconsin today, we must understand our state’s collective histories that have created the current demographics of the state. Past policies and governance have, and will continue to, play a critical role in shaping each Wisconsinite’s experience, the communities they reside in, and their economic standing. For example, prior to European contact, Indigenous peoples constituted the population of what is now known as Wisconsin. Due to colonization, detrimental federal Indian policies, and European migration, Wisconsin’s Indigenous population is now a little under one percent of the total population — which includes both members of the Tribal nations in Wisconsin and other federally recognized Tribes.<sup>1</sup> Despite policies enacted with the intention to strip Tribal nations of their livelihoods and self-determination, there are still 11 federally recognized Tribal nations in Wisconsin, all which operate as sovereign nations, with their own government systems that work with the State of Wisconsin in order to maintain a government-to-government relationship.

We can find another example of how our collective histories contribute to Wisconsin’s current landscape by looking at Wisconsin’s Hmong community — a prominent population in many communities across Wisconsin. The Hmong people, who are an ethnic Chinese group that served alongside America during the Vietnam war, had to flee their homes in Laos, Thailand, and Vietnam in order to avoid political persecution. The aftermath of the Vietnam War resulted in approximately 200,000 Hmong refugees settling in the United States. Currently, Wisconsin has the third largest Hmong population in the U.S., with large populations of Hmong people residing in Wausau, Appleton, Green Bay, Manitowoc, Oshkosh, and Sheboygan.<sup>2</sup>

Another distinct characteristic of Wisconsin is the prominence of our rural communities — which comprise nearly 30% of Wisconsin’s population. While some of Wisconsin’s rural communities may rely on tourism for their local economies, many rural areas are predominately reliant on dairy and agriculture. The rise of Wisconsin’s rural farming communities began as a result of the government selling parcels of

farmlands to European immigrants in the 1830s and became more pervasive as the number of European immigrants moving to Wisconsin increased. By the 1840s, nearly 5,000 farms were created per year.<sup>3</sup> Along with the increases in the number of farms came the formation of communities.

Although Wisconsin remains a leading agricultural state, the rise of corporate farming and large-scale farms, along with other policy decisions shaping the economic context of our state's rural communities, has resulted in not only a general decline in the number of family-owned farms, but a host of other challenging economic impacts that plague our rural communities across the state. Within the context of challenging economic and opportunity constraints, rural communities face aging populations and increased migration out of their communities, resulting in rural counties across the state experiencing population declines, which has had a profound impact on the landscape of Wisconsin.<sup>4</sup>

*Understanding who is Wisconsin and the distinct and overlapping histories that led to our current demographics allows us to track how power, rights, and opportunities were historically allocated and continue to be enacted today.*

Policy decisions have and will continue to alter the populations in Wisconsin. What we have presented in this section is just a few examples of how policy decisions impact the population and composition of our state. Wisconsin, while predominantly a state composed of European immigrants, is also composed of many other population groupings — Black/African American, other East and Southeast Asian, Hispanic or Latino — whose history is not told in this section. But whose histories matter, because understanding who is Wisconsin and the distinct and overlapping histories that led to our current demographics allows us to track how power, rights, and opportunities were historically allocated and continue to be enacted today. As a result, every region in Wisconsin has unique characteristics, including employment sectors, economic status, health, access to transportation, quality health care services, community supports, and other services. Nevertheless, these populations and their histories were critical to the creation of the recommendations and findings in this report.

A more in depth examination of Wisconsin's various demographics and histories can be found at:

- [www.wiscontext.org/how-wisconsins-past-and-present-population-will-shape-its-future](http://www.wiscontext.org/how-wisconsins-past-and-present-population-will-shape-its-future).
- [www.uwosh.edu/facstaff/zaniewsk/map-gallery/ethnic-patterns-in-the-united-states/Ethnic Diversity Wisconsin.pdf](http://www.uwosh.edu/facstaff/zaniewsk/map-gallery/ethnic-patterns-in-the-united-states/Ethnic_Diversity_Wisconsin.pdf).
- [www.dhs.wisconsin.gov/publications/p01791.pdf](http://www.dhs.wisconsin.gov/publications/p01791.pdf).

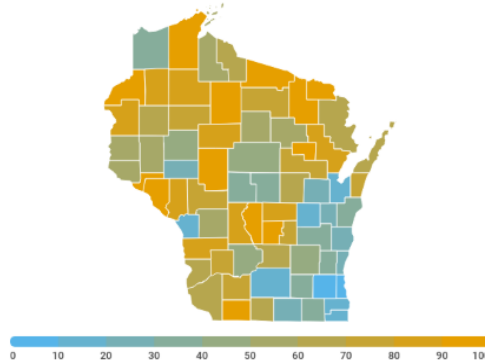
## PLACE



Nearly 3 in 10 Wisconsinites lives in a rural area.

29.8% of residents are rural

### Percent of Rural Residents by County



## RACE

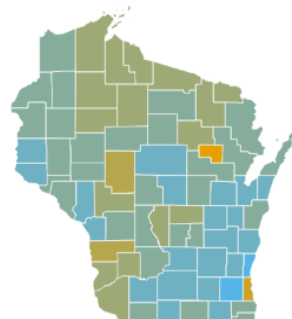


● Non-Hispanic Black ● American Indian & Alaskan Native ● Asian  
● Native Hawaiian/Other Pacific Islander ● Hispanic ● Non-Hispanic White

## INCOME

Median Household Income:  
\$64,901

### Percent of Children in Poverty by County

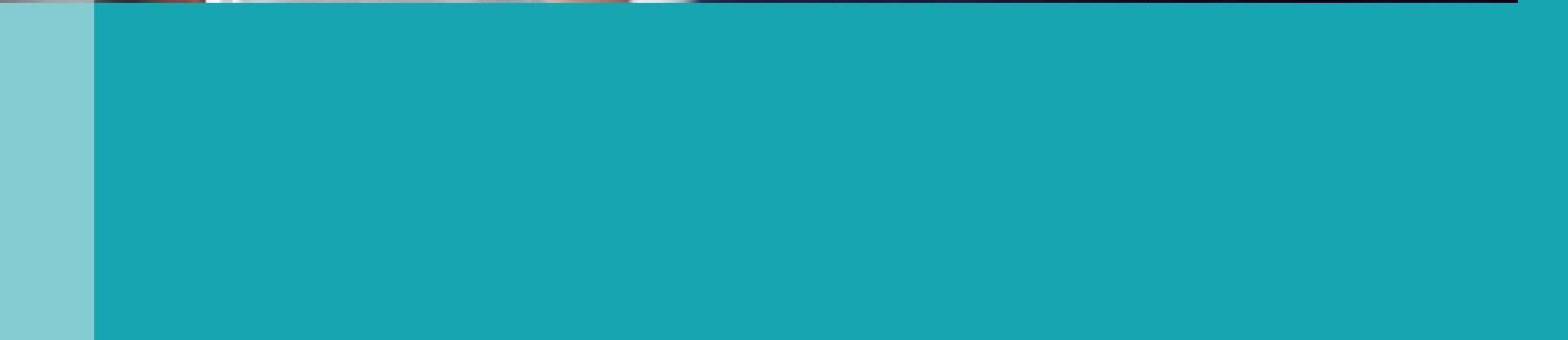


Muganda et al. 2022. *County Health Rankings & Roadmaps: Building a Culture of Health, County by County*. University of Wisconsin Population Health Institute. [www.countyhealthrankings.org/sites/default/files/media/document/CHR2022\\_WI\\_0.pdf](http://www.countyhealthrankings.org/sites/default/files/media/document/CHR2022_WI_0.pdf)

The data displayed in the infographic, along with the numbers and the recorded experiences of Wisconsinites that we have laid out, provide us with a snapshot of the population of our state. However, due to limitations in data reporting and outdated data infrastructures, we acknowledge these data do not capture the full landscape of who is Wisconsin. Current demographic categories including race, ethnicity, and gender that are widely used across federal, state, and local systems prevent researchers from recording all identities. And factors such as mistrust of government, language and cultural barriers, and lack of access also serve as barriers to assessing the full extent to which health disparities exist across Wisconsin. Nonetheless, these data serve as indicators of who and where Wisconsinites are impacted by policy decisions and inform policymakers on what interventions are needed.



# What is Health Equity?



## What is Health Equity?

In short, health equity describes the conditions where we are born, live, work, play, worship, and age that are necessary so that everyone has a fair and just opportunity to live a healthy life. In the sections that follow, we offer a brief discussion of the state of health equity in Wisconsin. But first, to facilitate shared understanding, we provide a brief overview of a few foundational concepts related to these discussions.

**Health outcomes** are a formal way to characterize our health. There are thousands of metrics to choose from, each used to describe some aspect of our health – physical, mental, emotional, psychological, etc. Generally, the ones which receive the most attention are those related to how long we live, the quality of our lives, and the incidence of major illnesses or diseases.

**Social determinants of health (SDoH)** is a phrase often used to underscore the important non-medical aspects of our lives that have measurable and significant relevance to our health. The phrase can also be understood as describing, as many others have also written, the conditions of the environments where people are born, live, work, play, worship, and age, that affect a wide range of health, functioning, and quality of life outcomes.

**Health disparities** is a phrase to reflect a comparative analysis of health outcomes by population, however defined. Often populations are defined by race, gender, educational attainment, geography, or income.

**Health inequities** is used to describe consistent and persistent health disparities which arise from avoidable and redressable social, economic, environmental, or other factors. Health inequities, by definition, are preventable.

**Health equity** is a phrase used to describe a pursuit or an envisioned future state of being, where poor health outcomes and preventable health disparities have been avoided, made rare, or otherwise mitigated. It means that everyone has “a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”<sup>5</sup>

## What is the State of Health Equity?

### Addressing Social Determinants of Health to Achieve Health Equity

Any exploration of the state of health equity must also examine the social determinants of health as they help us understand the current barriers to health existing within a community and can predict how

Health equity describes the conditions where we are born, live, work, play, worship, and age that are necessary so that everyone has a fair and just opportunity to live a healthy life.



healthy our communities may be in the future. As previously defined, social determinants of health are the conditions in which people are born, grow, live, work, worship, and age that shape health. The key determinants of health can be broken down into five domains: economic stability, education, social and community context, health and health care, and neighborhood and built environment — also known as “place.” This includes factors such as the availability of resources to meet basic needs (such as safe housing and local food markets), socioeconomic status, quality of education, job training, language, literacy, exposure to crime, and more.<sup>6</sup>

# Five Domains of the Social Determinants of Health

## **Economic Stability**

What is your income? Is your income stable or does it change? Do you have a stable enough income to meet your health needs?

*What does this mean?*

In the United States, most health care insurance is tied to your employer. But people who have steady jobs might not earn enough income to be able to afford their health care costs or may not have employer-sponsored health insurance. People without steady employment and/or stable income are more likely to be uninsured and unable to pay for the health care services they need.

*What does this have to do with your health?*

By having economic stability, you are more able to directly access quality health care and afford health care costs accrued for services such as annual exams, preventative care, and any unexpected health issues that may arise.

## **Education Access and Quality**

How much education have you received? What is the quality of the education? How much access do you have to opportunities for higher education such as vocational school, or college?

*What does this mean?*

Having access to quality K-12 education allows you to do well in school and increases your chance of attending college or trade school. In Wisconsin, public schools are funded by a combination of state funding and property taxes with about 55-60% coming from state dollars and 35-40% coming from property taxes. The way we currently fund schools does not address the needs of the student population being served by the school but cost systems that were set up in place decades ago. Unfortunately, this current structure creates funding problems for districts that have higher need, such as schools with high rates of students living in poverty. Schools that have adequate resources to meet the needs of their students are better able to provide quality education. In addition, many families cannot afford to send their children to college, and this is disproportionately true for families living in poverty or who are economically vulnerable.

*What does this have to do with your health?*

If you have a higher level of education, you are more likely to be healthy and live longer. That is because educational attainment (how much

education you have) is connected to having a higher paying job and more economic stability.

### **Health Care Access and Quality**

Do you have health insurance? Do you have a primary care provider? Do you have issues seeing a health professional because there are not any providers available in your area or you live too far away from the nearest clinic?

#### *What does this mean?*

If you do not have health insurance because you are not able to afford it, you are unable to receive important health care services like preventive screenings or treatment for illnesses or chronic conditions. If you have health insurance but are unable to access health care services because you live too far away or do not have the ability to get to a provider, you are more likely to not receive the care you need. This might mean you are not getting comprehensive health care services like cancer screenings, annual exams, and emergency services. In rural areas, there are gaps access to health services due to geographic constraints.

#### *What does this have to do with my health?*

Having access to comprehensive, high-quality health care services helps ensure you are receiving treatment for illnesses, diseases, or accidents; and screening for preventative health means that you are able to be as healthy as possible.

### **Neighborhood and Built Environment**

Where do you live? How safe is your neighborhood? Do you have access to clean drinking water and air free of environmental pollutants?

#### *What does this mean?*

Your zip code plays a large role in shaping your health. If you live in an area with high rates of violence or crime, you have a higher safety risk. If you live in an area with high poverty rates, your home may have physical hazards such as exposure to lead paint or lead pipes, poor air flow, mold, or pest-infestation — all of these have a direct impact on your physical and mental health. If you live in a farming community or near an industrial plant, your drinking water may contain harmful chemicals from run-off, or you may be exposed to air pollutants that cause lung-related illness.

#### *What does this have to do with my health?*

Living in safe, healthy neighborhoods means you are not being exposed to harmful hazards that are detrimental to your health.

## **Social and Community Context**

Do you have a strong relationship with your family and friends? How often do you interact with the people in your community? Who do you contact when you need support or someone to talk to during a crisis?

*What does this mean?*

If you don't have connections to family, friends, co-workers, or community members you might not have the social support you need. If your parent or guardian is incarcerated, you might struggle emotionally or financially. If you are bullied in school, and you have no one to speak with, your mental and physical health may take a toll.

*What does this have to do with my health?*

Having positive relationships within your community improves your mental and physical health by ensuring you have a strong support-system from your family, friends, and community leaders. Strong supports also help manage issues such as stress, depression, and anxiety.

Black and Native American youth are less likely than Latino, white, and Asian youth to graduate high school within four years.

Four in 10 Latino adults aged 25+ have less than a high school diploma, compared with one in 10 of other Wisconsin adults.

Non-Hispanic Blacks have three times the unemployment rate than Wisconsin overall.

Four of ten Black children live in poverty compared to one of 10 white children.

## Social Determinants of Health



Non-white adults are more likely than their white adult counterparts to report they didn't seek necessary health care because they couldn't afford it.

More than half of Hispanic and Black Wisconsin residents spend more than half their monthly income on housing.

More than 70% of white families own their home compared to 27% of Black families.

Black children experienced the most (lead) poisoning, at nearly three times the rate for white children.

Social Determinants of Health  
Copyright-free

Healthy People 2030

Wisconsin had the second highest Black homicide rates in the U.S. (2016). The homicide rate for Blacks was 38 per 100,000 people, nearly twice the national average.

Black people were incarcerated at 10.9 times and Native American people were incarcerated at 6.8 times the rate of White people (2017).

Wisconsin Department of Health Services. 2022. *Minority Health Report, 2018-2022: Advancing Health Equity in Wisconsin*. Wisconsin Department of Health Services. [www.dhs.wisconsin.gov/publications/p03091-2022-02.pdf](http://www.dhs.wisconsin.gov/publications/p03091-2022-02.pdf)

Because of the direct and indirect effects of the social determinants of health, health outcomes are often measured alongside the physical things that are the closest to health — things like the availability and quality of health care services; characteristics of housing, neighborhoods and nearby infrastructure; components of economic stability, income and employment; educational access, quality, and attainment; air, water, and soil cleanliness; and measures of social and community connectedness. We do this to better understand the features of our lives which shape health outcomes. For example, it is simply not enough for people to have access to medical care if they do not also live in a community that enables the opportunity to recreate, work, live, and eat in ways that facilitate good health. Nor is it enough to have access to critical resources if those resources are of subpar quality.

Most of the variation in health outcomes is explained not by differences in individuals' choices but rather differences in conditions — the social determinants of health — that people face. As such, the social determinants of health are conditions within a community that can be modified through policies and programs to improve length and quality of life. Public health has long known that where you live, your education, your income, your racial and ethnic identity, access to healthy foods, transportation, and health care shape your health outcomes more than anything else. The resources one has in their community greatly influences the outcomes of their health; the more of these attributes available in "place," the greater likelihood of positive health outcomes. Social policy and practice shapes availability and access to these resources, thus social policy indirectly impacts health outcomes.<sup>7</sup> Therefore, to create health equity in

Wisconsin, we must provide policy and programming that improve these root causes (or factors) that shape health.

### What is the State of the Social Determinants of Health in Wisconsin?

In Wisconsin, when we review measures of economic stability and education access as a determinant of health, we observe significant variation in outcomes such as educational attainment, unemployment rate, and median household income by race and ethnicity, as well as highest level of education attained. While Hispanic Wisconsinites make up the largest percentage of Wisconsinites (29.51%) with less than a high school or equivalent degree, it is Black Wisconsinites and Wisconsinites with less than a high school degree who have the highest unemployment rates (5.20% and 6.48%, respectively), and the lowest median (\$32,857 and \$28,265, respectively) household income – the point on a distribution of income where half the households in the population earns income higher than that number, and half of the households in the population earns income lower than that number. And while Wisconsinites with a high school or equivalent degree had a relatively lower unemployment rate (3.96%) their median household income was only \$33,769 compared to \$63,293 for the overall population of Wisconsin households.

<b>Overview of Social Determinants of Health for Wisconsin Residents, ACS** 5-Year Estimates, 2016-2020</b>									
	White, NH*	Black, NH	AIAN, NH	Asian, NH	Hispanic	Less than High School	High School or Equivalent	Total	Index of Disparity (ID)*
<b>% Less than High School Diploma</b>	6.0 (209,331)	15.44 (32,860)	12.32 (3,981)	14.98 (14,579)	29.51 (59,522)	--	--	7.41 (295,207)	118.81
<b>% Unemployed</b>	2.03 (82,315)	5.20 (13,939)	4.79 (1,873)	2.35 (2,926)	3.50 (9,326)	6.48 (8,076)	3.96 (24,901)	2.35 (109,854)	57.53
<b>Median Household Income</b>	66,579	32,857	45,003	72,870	48,448	28,265	33,769	63,293	24.05

\*NH: Not Hispanic.

\*\*ACS: American Community Survey.

Muganda et al. 2022. County Health Rankings & Roadmaps: Building a Culture of Health, County by County. University of Wisconsin Population Health Institute. [www.countyhealthrankings.org/sites/default/files/media/document/CHR2022\\_WI\\_0.pdf](http://www.countyhealthrankings.org/sites/default/files/media/document/CHR2022_WI_0.pdf)

While highest level of education attained, unemployment, and income do not perfectly predict each other, these measures are highly related to each other. This level of variation across these outcomes results in our state also having high levels of disparity – especially among unemployment rates and with the percentage of Wisconsinites whose highest level of education is a high school diploma or equivalent. And we see this variation in the social determinants of health translate to disparities in various health outcomes. While this information is insufficient to inform specific policy or programmatic interventions, it remains an important benchmark for effectively describing the state of health equity. As we turn to explore health outcomes, you will



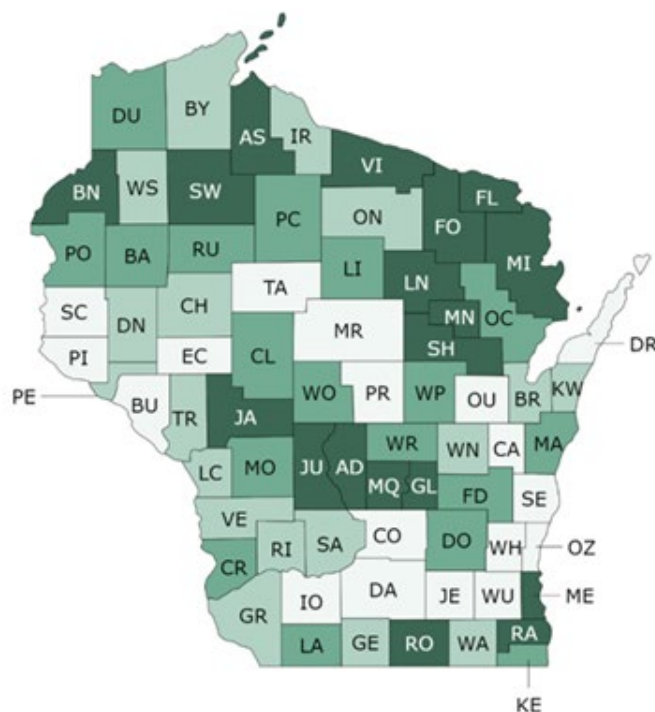
find that the patterns observed in the previous table on the social determinants of health are mirrored in health outcomes.

### **State of Health Equity – How do health outcomes look for Wisconsinites?**

The most current version of the state’s health report card, published by the [Population Health Institute in 2021](#), gave Wisconsin an overall health grade of ‘C’ and a grade of ‘C’ for health disparities on its measures relating to length of life and quality of life. In early 2022, two years into the COVID-19 pandemic, the latest state Health and Equity Report Card was released revealing that Wisconsin’s health has been further imperiled with the state’s overall declines in length and quality of life, while extreme and unacceptable disparities in these outcomes between and across racial and ethnic group, geographic locations and education levels persisted and worsened in some cases.<sup>8</sup> As such, the state of health equity in Wisconsin is one that demands improvement.

Improving our state’s health requires that we understand where residents of our state are experiencing the worse health outcomes. There are two measures commonly used by public health experts to assess health and well-being — length of life and quality of life. Health outcomes, such as premature death, self-reported health status, and low birthweight, help to represent the length and quality of life in any given community. The next map shows Wisconsin’s health outcome rankings by county displaying the relative ranking of each county on a measure of length of life (i.e., premature death — years of potential life loss before age of 75) and quality of life (i.e., self-reported health status and percentage of low birthweight newborns). Lighter counties indicate overall better health outcome scores, with scores worsening as the color gets darker.

## 2022 Health Outcomes – Wisconsin



Health Outcome Ranks  1 to 18  19 to 36  37 to 54  55 to 72

Muganda et al.

2022. *County Health Rankings & Roadmaps: Building a Culture of Health, County by County*. University of Wisconsin Population Health Institute.

[www.countyhealthrankings.org/sites/default/files/media/document/CHR2022\\_WI\\_0.pdf](http://www.countyhealthrankings.org/sites/default/files/media/document/CHR2022_WI_0.pdf)

Among the lowest quartile of counties (those with the worst health outcome scores), we find a mix of both rural and urban counties, underscoring the need for a statewide approach to improving health outcomes. Wisconsin's largest urban county, Milwaukee, ranks 70th overall, ranking lower only than Forest and Menominee Counties, both relatively rural. The variation in health outcomes in our state is evidence that we can do better.

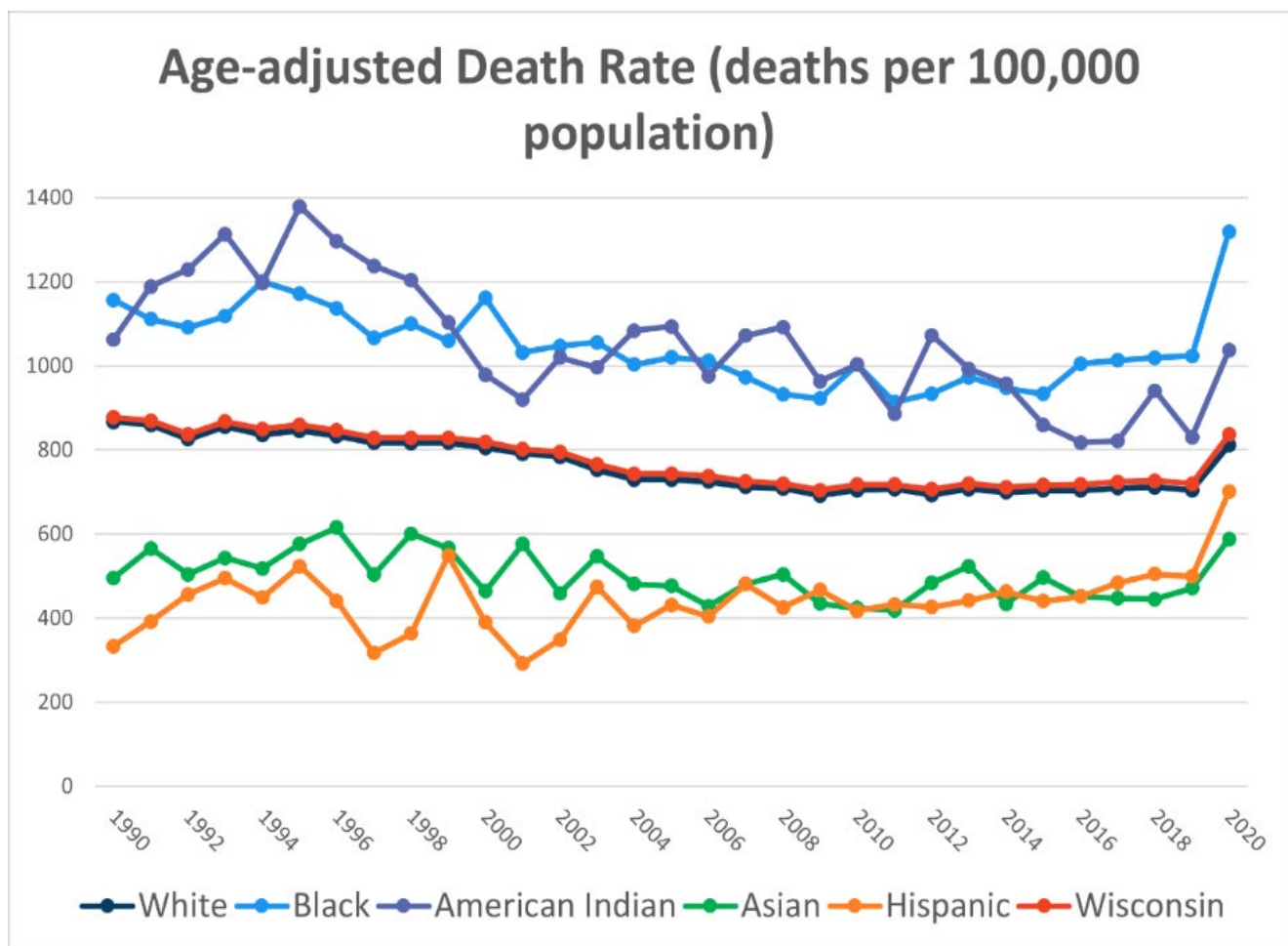
Place represents one dimension through where we see variation in health outcomes. We see similar forms of variation and disparity when we look at health outcomes based on dimensions such as race and ethnicity, income, and educational level. Examining birth outcomes and mortality is a routine activity of public health analysts around the world. Health outcomes, such as premature death, self-reported health status, and low birthweight, help to represent the length and quality of life in a given community. In the following sections, we break down the health outcomes as a metric to explore how these dimensions have shaped length and quality of life measures over time.

### State of Health Equity – What is the length of life for Wisconsinites?

Length of life is often measured using metrics such as mortality rate and/or premature death. General mortality statistics are heavily influenced by deaths of our state's elder populations, given that Wisconsin has an older population on average. Using a measure of premature death, such as Years of Potential Life Lost (YPLL), focuses attention on deaths that might have

been prevented. To gauge the degree of mortality occurring withing our population that may be otherwise avoidable, measures such as YPLL does this by giving more weight to deaths among younger.

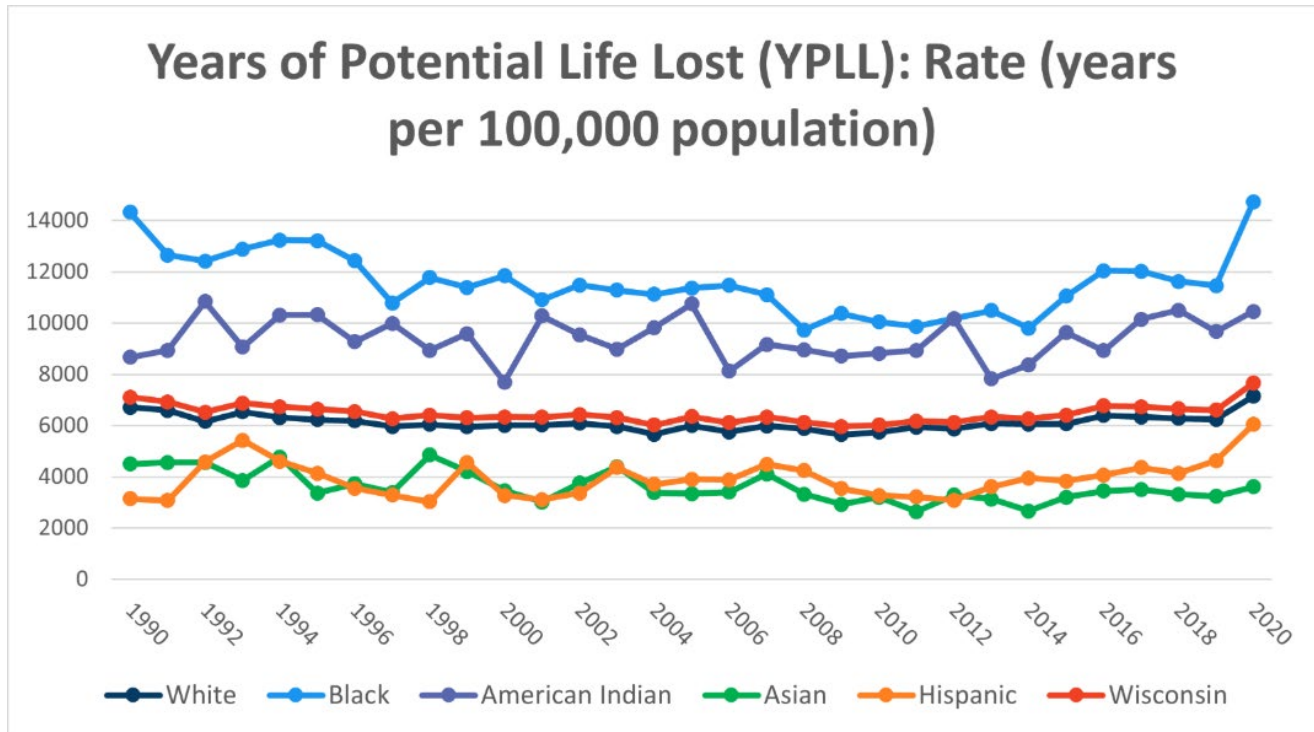
The 30-year mortality rate trends for Wisconsin’s overall population and its population broken out into the largest racial and ethnic groups are illustrated in the table titled **Age-adjusted Death Rate (deaths per 100,000 population)**. In 2020, the overall age-adjusted rate of death for Wisconsinites was 836.4 deaths per 100,000 population. This is on par with the 2020 national age-adjusted rate of death in the United States of 835.4 deaths per 100,000 population.<sup>9</sup> In 2020, the death rate in the US ranged from a low of 588.0 deaths per 100,000 in Hawaii to a high of 1,138.7 deaths per 100,000 population in Missouri. Analyses of Census data show that in 2020, 53% of Wisconsin counties experienced natural population decrease — i.e., the number of people dying was larger than the number of births — and this grew to 76% of Wisconsin counties in 2021. This represents an increase in the percentage of deaths between 2019 and 2020 of 4.98%, and 15.77% between 2020 and 2021. To be clear, this growth is driven heavily by the tragic loss of Wisconsinites due in part to COVID-19. Looking pre-pandemic, the change in the percentage of deaths between 2017 and 2019 was 2.09%, whereas we experienced a decrease in the percentage of deaths between 2018 and 2019 of 3.13%.<sup>10</sup>



Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, <https://www.dhs.wisconsin.gov/wish/index.htm>, Mortality Module, accessed 9/21/2022.

30-year period, Asian and Hispanic Wisconsinites experienced the lowest death rates in the state while Black and Indigenous Wisconsinites have historically experienced higher rates of death in comparison. The death rates for white Wisconsinites during this period has trended in the middle, lower than Black and Indigenous Wisconsinites, but higher than Asian and Hispanic Wisconsinites. When you look at rates among racial and ethnic groups in 2020, mortality ranges from 588.2 deaths per 100,000 for Asian Wisconsinites to 1,319 deaths per 100,000 for Black Wisconsinites.

General mortality statistics provide us with a measure of the number of deaths during a period of time which allows us to assess changes in the number of deaths happening within our population across time.



Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, [www.dhs.wisconsin.gov/wish/index.htm](http://www.dhs.wisconsin.gov/wish/index.htm), Mortality Module, accessed 9/21/2022.

At the same time, death rates are skewed heavily by deaths caused by aging which are deaths, that still tragic, are not typically preventable. Years of Potential Life Lost (YPLL) is a commonly used measure of premature death which allows for us to quantify deaths that might have been prevented. YPLL does this by giving more weight to deaths among younger people, which are more likely to be preventable.

YPLL is defined as the number of years of life lost among persons who die before age 75. YPLL is the sum of differences between age 75 and the age at death for everyone who died before age 75. As of 2020, the life expectancy in the United States is 77 years. When we look specifically at premature death [see chart: **Years of Potential Life Lost (YPLL): Rate (years per 100,000 population)**] a parallel pattern to the one observed for death rate appears. In 2020, the overall YPLL rate in Wisconsin was 7,658.8 years per 100,000, which falls below the national rate of 8,451.7 years per 100,000. At the same time, the YPLL rate for Black Wisconsinites in 2020 was nearly twice the overall rate, at 14,720.6 years per 100,000. In 2020, Asian Wisconsinites had the

lowest YPLL rate, with 3,606.2 years per 100,000, which is less than half of the overall rate for Wisconsin and 75% lower than the YPLL rate for Black Wisconsinites. Data from [America's Health Rankings](#), shows that in 2018, pre-Covid-19 pandemic, the state with the best YPLL rate was Minnesota, whereas Wisconsin ranked at 15 compared to other states and the District of Columbia during the same year.

The statistics we have presented show that there is significant variation in these outcomes not only over time, but by racial and ethnic identity as well as across and between U.S. states. And while we did not present this data, the [mortality metrics also vary globally](#). We must acknowledge that the information we have presented only paints part of the picture related to mortality trends in our state, as there is also significant variation in these outcomes based on characteristics such as where one lives and how much schooling and education they have acquired. For instance, in a prior chart showing how Wisconsin's counties rank relative to each other on health outcomes, we see our state's largest county sharing a similar trend of experiencing poor health outcomes alongside less-densely populated, or more rural counties, located in the northern, central and southern parts of our states highlighting the impacts the twin ills — structural poverty and structural racism — can have on communities' health, even communities that are generally characterized as in opposition to each other.

*Structural poverty refers to poverty that results from weaknesses in how our economic system is designed such as lack of access to transportation, education, child-care, health care, high quality jobs, affordable, quality housing, safe communities and critical community, social and infrastructure supports.*

*Structural racism refers to all the ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice... [and which] patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.*

Mortality metrics such as the mortality rate and premature deaths helps us assess the health of our population by looking at how our state is fairing as it relates to its health by looking at the most serious consequence of poor health — death. The presence of variation in these metrics' signals for us that the differences we are observing in outcomes are not random, or else they would look the same no matter how we organize the data. This variation in outcomes also reveals that there are actions we can take that can lead to significant improvements, as well as worsening, of these health outcomes. The mortality metrics included in this report do not allow us to speak directly to the causes or drivers of the observed patterns. In the next section, we will explore quality of life as a metric that helps shed light on some of the factors influencing the observed patterns in our state's mortality statistics.

### **State of Health Equity — What is the quality of life for Wisconsinites?**

While length of life is one important indicator of the current health of communities, we must also consider quality of life in any analysis of the state of health equity in Wisconsin. The World Health Organization (WHO) describes quality of life as ["an individual's perception of their position in life in the context of the culture and value systems in which they live and in](#)

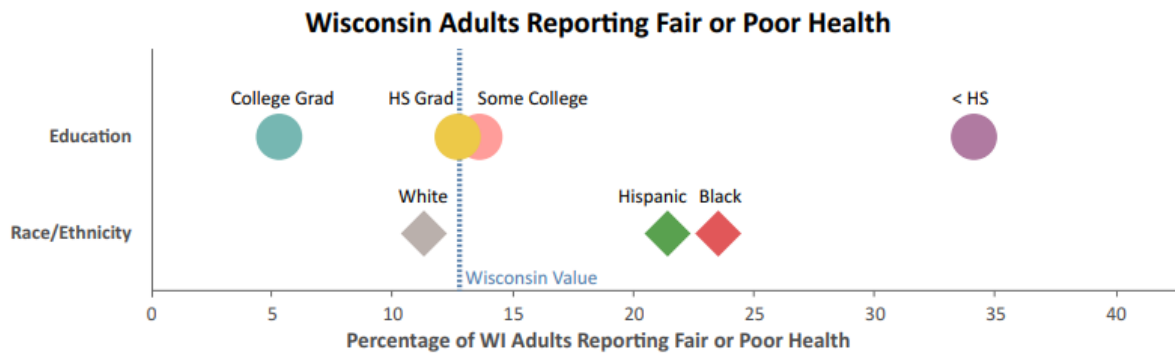
relation to their goals, expectations, standards and concerns.” Quality of life can be represented by a few metrics that reflect both objective or validated health outcomes, as well as subjective or personal perceptions of health.

For the purposes of this report, we have included self-reported health status among adults, along with measures of newborn and infant health, as our measures of quality of life.

Self-reported health status — the percentage of adults who consider themselves to be in fair or poor health — is a commonly used measure that has been found to be accurate in evaluating efforts in the prevention of chronic diseases. A benefit of using such a broad metric is that it helps us understand, at a given time, the proportion of our population who are experiencing poor, fair, good, very good, or excellent health based on the individual’s self-evaluation of how they are feeling allowing us to measure the subjective, or personal experiences with their health.

Wisconsin Population Health Institute. Wisconsin Population Health and Equity Report Card, 2021. [uwphi.pophealth.wisc.edu/wpcontent/uploads/sites/316/2022/03/2021WIPopHealthEquityReportCard\\_FINAL.pdf](http://uwphi.pophealth.wisc.edu/wpcontent/uploads/sites/316/2022/03/2021WIPopHealthEquityReportCard_FINAL.pdf).

The Population Health Institute analyzed Wisconsinites self-reported health in 2020. They found



that roughly 13% of adult Wisconsinites (599,599 adults) report fair or poor health overall. Breaking it down by race, we see that 11.3% of white, adult Wisconsinites (433,585 adults) report fair or poor health compared to 23.5% of Black, adult Wisconsinites (61,948 adults). Additionally, self-reported fair or poor health is highest among those with less than high school education (34.1%, 120,781 adults). Self-reported health status also differs by geographic location, with 12.7% of Wisconsinites in suburban counties reporting overall fair or poor health compared to 19.7% of those in the large urban county of Milwaukee.

In addition to self-reported health status, which allows us to measure health among the general adult population, examining the health outcomes of newborns in a group or community can give insights into quality life, both for the birthing parent and the infant. It can tell us about the birthing parent because we know that factors contributing to low birthweight can include:

- Barriers to proper nutrition and prenatal care
- Stress and exposure to pollution
- Substance misuse during pregnancy

Infants born with low birthweight have a greater chance of dying than those with normal birthweight, and those that survive may face adverse health outcomes such as:



- Decreased growth
- Lower IQ
- Impaired language development
- Chronic conditions

In the next table, we have three measures of quality of life for infants born in Wisconsin: 1) percentage of infants born with a low birthweight (less than 2,500 grams or 5 lbs. 8 oz.); 2) number of premature (before 37 weeks of pregnancy) births per every 1,000 births; and 3) number of infants who die before they turn 1 year-old per every 1,000 births. Looking at birthrate outcomes, among infants born in Wisconsin in 2020, roughly 7.7% weighed less than 2,500 grams. This percentage more than doubles to 16.8% when looking at only Black/African American births. In contrast, among birthing parents receiving Women, Infants, and Children Program (WIC) assistance, 10.3% gave birth to an infant under 2,500 grams, compared to 6.7% of births to parents not receiving Women, Infants, and Children Program assistance.<sup>11</sup> Overall, in 2020, Wisconsin tied for 30th ranking among the 50 states on the percentage of infants born with a low birthrate. States low birthrate percentages ranged from a low of 6.5% of births in Oregon, to a high of 11.8% in Mississippi.<sup>12</sup>

### Infant Birth and Mortality Outcomes in Wisconsin, 2020

	White (Non-Hispanic)	Black (Non-Hispanic)	AIAN (Non-Hispanic) <sup>2</sup>	Asian (Non-Hispanic)	Hispanic	WIC Recipient*	WI Total
<b>Low birthweight, %</b>	6.25%	16.82%	7.40%	6.27%	8.06%	10.30%	7.73%
<b>Premature birth, rate per 1,000 births</b>	89.6	162.6	134.3	70.8	100.5	116.4	99.2
<b>Infant mortality, rate per 1,000 births</b>	4.4	14.3	6.9	5.9	7.9	5.8	6.0

*\*Birthing parent received Women, Infants, and Children Program during pregnancy*

(Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, <http://dhs.wisconsin.gov/wish/>, Low Birthweight Module, accessed 6/28/2022.)

Moving on to premature birthrate, in 2020, Wisconsin's ranked 26th among the 50 states on the percentage of births in the state that occurred preterm. During that year, the percentage of premature births ranged from a high of approximately 14.2 premature births per 1000 in Mississippi to a low of 7.6 in Vermont.<sup>13</sup> This means that of every 1,000 births in Wisconsin during 2020, approximately 99 of those births occurred earlier than full term. As is the case with other metrics, there is significant variation in the premature birthrate in Wisconsin ranging from a high of 61% more premature births per 1,000 births among Black infants, to a low of 29% fewer premature births per 1,000 births among Asian infants.

Lastly, we turn to Wisconsin's infant mortality rates (IMR). This indicator represents the number of infants who die before they turn 1 year-old. In Wisconsin, during 2020, out of every 1,000 births, 6 infants did not survive to reach 1-year of life. This statistic represents 361 babies who are no longer with us during 2020 alone. During this same year, Vermont, California, Maine, New York, New Jersey, and Minnesota experienced infant mortality rates ranging from 0 to 3.9

infant deaths per 1,000 births on the low end while Mississippi, Louisiana, West Virginia, Arkansas, and Alaska had rates ranging from 7.2 to 8.2, respectively, on the high end.<sup>14</sup>

Of the infant related metrics, Wisconsin’s infant mortality rate is what is often discussed. This is because while the overall infant mortality rate in the state represents neither the best nor the worst in the nation, the infant mortality rate for Black infants has persistently been the starkest in the country. In 2020, the infant mortality rate for Black infants was 14.3 infant deaths out of every 1,000 births making the infant mortality rate among Black infants 2.4 times higher than the overall rate in the state. What makes the Black infant mortality rate so prolific is not only the high rate, but that the Black-white disparity persists across socioeconomic factors like educational-level which typically has a protective relationship reducing risk of negative outcomes.

### Infant Birth and Mortality Outcomes in Wisconsin, 2020

	Black (Non-Hispanic) number of deaths (IMR)	White (Non-Hispanic) number of deaths (IMR)	Risk ratio (Black vs. White)
<b>Birth parent education (years)</b>			
<b>8<sup>th</sup> grade or less</b>	X (12.8)	12 (8.6)	1.49
<b>Some high school</b>	20 (19.3)	13 (10.0)	1.93
<b>High school graduate/GED</b>	38 (12.9)	46 (5.6)	2.32
<b>Some college</b>	19 (11.2)	55 (4.5)	2.50
<b>College graduate</b>	X (8.6)	43 (3.2)	2.70
<b>Postgraduate</b>	. (.)	15 (2.5)	.
<b>Missing</b>	10 (73.5)	X (12.7)	5.81

*An "X" indicates a value that is less than 5 (but more than zero) and has been suppressed to protect confidentiality. A period (.) indicates there are zero cases in that cell.*

Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, [www.dhs.wisconsin.gov/wish/index.htm](http://www.dhs.wisconsin.gov/wish/index.htm), Infant Mortality Module, accessed 6/29/2022.

Throughout this section, we have worked to paint a picture of the state of health equity in Wisconsin relying on a set of commonly used metrics that are correlated to, and predictive of, our population’s overall health and well-being. Our intention in including this data narrative is to provide context regarding how Wisconsin is fairing on key health outcomes, as well as show that considerable variation exists across these outcomes. The existence of this variation is a sign of both hope and caution, as it reflects that we can move the needle on these outcomes in ways that can both lead to improvements in our collective health and well-being or create greater harm and further imperil for the health and well-being of Wisconsinites.

**Improvements in our collective health will require intentional, proactive, and consistent action-taking and investment in social and public policy that prioritizes Wisconsinites’ health and well-being.**

We also recognize that this analysis is a big-picture assessment, and one that likely begets more questions than it answers. We were unable to gain access to each metric consistently along dimensions such as place or socioeconomic status (e.g., education-level, income, etc.), which does not allow us to paint a complete picture of how different communities are being burdened by, albeit in different ways, negative health outcomes. It also omits critical information about age groups, causes of death, and other details that would be necessary to craft effective policies and programs to shrink these gaps.

Yet we view this approach as acceptable. This is because we are fortunate to reside in a state that is resource rich as it relates to preexisting, accessible infrastructure that allows for those who are interested to dig into the data more deeply. The existence of this infrastructure means that Wisconsin is well-suited to not only understand more deeply how health and wellness is distributed in our state, but to also track and measure our progress among the communities residing in our state as well as how we are doing compared to other states and the broader nation. As such, we recommend that the state engages with and leverages this existing infrastructure that will help us monitor our state's progress in achieving a healthier Wisconsin for all of us. In the next section we describe the key components of this infrastructure.

## Equitable Use of Data Statement

Using data that comes in the form of numbers, percentages, averages, and other statistics is one way in which we describe the world we live in. In both the public and private spheres, this kind of information can be immensely powerful in identifying problems, setting priorities, constructing stories, shaping opinions, creating policy agendas, making business decisions and evaluating programs.

Data, quantitative and qualitative, is a critical component of advancing health equity. But quantitative data does not speak for itself. If numbers, percentages, averages, and statistics are not considered within the past and present context from which they arise, people will do their own sense-making at best, and completely dismiss them at worst. Using data in a way that advances an equitable world requires an equitable approach to developing, designing, and using the systems and the information it holds. We must give context alongside data and describe what numbers alone cannot tell us.

Because data, and the conclusions drawn from data, play a key role in the Governor's Health Equity Council's recommendations, we find it important to also share some guidance on how we see data being better used to advance equity. A number of organizations have developed principles to guide equitable data use, including the Robert Wood Johnson Foundation (RWJF), the Association of State and Territorial Health Officials (ASTHO), and UW-Madison's Population Health Institute. We borrow heavily on their work in articulating the role we see for data in the pursuit of health equity. We also weave into them emergent themes from this Council's work: strengthening our ability to proactively respond to threats to our collective well-being due to climate change.

### *Capture and track data about the many social determinants of health*

This value speaks to the importance of creating and using data that can meaningfully capture the role of factors beyond the scope of visits to doctors' offices and individuals' choices in creating health. Our data systems must be set up to advance health equity. This may require data system owners to incorporate data that exists elsewhere, devise new ways to capture community-relevant and community-level determinants of health, or figure out ways to leverage data systems to nimbly adapt to emerging needs. Our data must allow us to understand and address the ways in which structural poverty and structural racism, as well as other inequities that we continue to face today, prevent us from advancing health equity and harm the health of communities bearing the brunt of these inequities.

### *Clearly articulate the purpose for collecting and analyzing data*

Data has been used in many harmful ways, including to stigmatize communities facing inequities. Data has also been used to mobilize action for policy and systems changes needed to improve community health. The use of data to advance health equity requires clearly identifies needs, gaps, and opportunities; and that the questions being pursued are rooted in equity commitment to justice. As a process, these steps create an opportunity to ensure this pursuit drives the questions that get asked and, in turn, the data can reveal the kinds of answers that can inform positive change through improved decision-making that will further the pursuit of health equity.

### *Ensure equity and community engagement in data governance*

The data and information organizations use to advance health equity themselves must be generated and governed equitably. The people and communities about which data exists must have voice in the collection and interpretation of that data, and in the case of our Tribal communities, data sovereignty must be honored and respected. This will improve the data being collected and the quality of information and interpretation, all the while building shared support for and trust in the creation, analysis, and application of information in the pursuit of health equity.

#### *Perform holistic and accessible data and policy analyses*

Collecting data on the social determinants of health is only the first step. We know many factors influence our health and so we need analyses that consider the breadth of factors and identify the most important ones in any given context. By using data that reflects the connection between the key determinants of health and specific health outcomes, analyses become more meaningful and effective. This is because the inclusion of the determinants allows for a fuller more holistic picture of the key drivers of health, thus illuminating the variety of ways to create better health. At the same time, data must be presented accessibly and clearly – the people who consume, digest, and use data need to be able to effectively wield this information to better understand, identify and disrupt the factors that affect our health.

#### *Craft narratives to advance health equity*

Data is only one possible input in stories. We need to lift up the stories about community resilience, survival, and ability to thrive despite adversity, and avoid only highlighting the struggles and challenges that marginalized communities face, as this is how we can more effectively represent the full breadth and depth of people’s lived experiences and present needs. This requires building relationships that are rooted in trust and shared understanding with marginalized communities, and to effectively work alongside these communities to create new narratives. This requires choosing words, both in our public documents and private conversations, that center communities' strengths and assets, reflect a commitment to an equitable society, and exemplify the values and principles guiding health equity work.

#### *Cultivate and deepen our ability to engage with data critically*

Taking a data-informed approach to informing our actions has limitations that we must recognize. We must all become critical thinkers and check our assumptions about the information we consume. This can start by encountering data with the following questions in mind:

- Which questions are being asked to generate the numbers and how, why, and by whom are they are being asked?
- What data are being used to answer these questions and what data do we not have?
- What decisions are being made about which data are included and highlighted and by whom?

# Advancing Health Equity for Wisconsinites – Tracking Our Progress by Leveraging our Public Health Infrastructure

Measurement, research, and evaluation are essential aspects of accountability. Through analysis, reporting, and tracking we can better understand our current context as well as observe and track the impacts of policy decisions and investments over time. Fortunately, this work is already being done by the Wisconsin Population Health Institute and the Wisconsin Department of Health Services. We encourage serious engagement with these resources to track impacts of current and future social and public policy — which we hope will include recommendations put forth by our the Governor’s Health Equity Council — on the health and well-being of the residents of our state. The Wisconsin Department of Health Services serves a regulatory function in our state as it relates to monitoring population health. Within its regulatory structure, the agency is responsible for regularly assessing population health as well as establishing an improvement plan. This is work that has and will continue to be done, providing Wisconsin with a readily available tool for establishing baselines, tracking progress, and identifying additional strategies — above and beyond what is contained in this report – to facilitate the heavy lifting that will be required to truly to improve population health, reduce disparities, and advance health equity for every Wisconsinite. Included below is an overview of the State Health Assessment (SHA) and State Health Improvement Plan (SHIP).

[State Health Assessment and State Health Improvement Plan](#) Wis. Stat. § 250.07(1) requires the Wisconsin Department of Health Services to produce a state health improvement plan and a public health agenda for the people of Wisconsin at least every 10 years. In pursuit of accreditation, and increased impact and effectiveness, the state health plan is now on a new cycle - it is a continuous process with a new state health assessment and health improvement plan once every five years.

The state health assessment (SHA) process is a systematic examination of the health status of the population, key community and social conditions and needs as well as assets to improve well-being across Wisconsin. It identifies disparities and inequities in health, social and economic conditions and access to services; and informs the prioritization process for most effective use of resources. The state health assessment incorporates both qualitative data through community conversations and listening sessions as well as hundreds of quantitative data points across many health, social, and economic well-being indicators.

The state health improvement plan (SHIP) is the roadmap to community health improvement for Wisconsin and is based on the state health assessment. It is developed in collaboration with representatives from public health, community-based organizations, health care systems and payers, employers, academia, state and local government agencies and councils, tribal communities, and the public. The state health improvement plan contains a set of priority areas, goals, objectives, measures/indicators and, most importantly, strategies for health and community well-being within the chosen priority areas. The strategies represent a list of evidence-based and community-informed interventions and policies. The implementation of the state health improvement plan



focuses on building partnerships and alliance for more equitable health outcomes and advancing the strategies outlined in the plan. The Wisconsin Department of Health Services issues annual reports to measure and demonstrate progress on work across the strategies and the latest data on the state health improvement plan's metrics.

The [Wisconsin Population Health Institute](#) contributes several integral pieces necessary for establishing and sustaining an accountability system for tracking progress on improving the overall health of Wisconsinites as well as addressing disparities in health outcomes across and between communities of residents. We provide a brief summary of these resources below:

- [Population Health and Equity Report Card](#). The press release for the 2021 report card describes it as a "...report detail[ing] how Wisconsin's health compares to the nation, by measuring the state's progress toward improving health and eliminating disparities. It is a call to action to better understand the health of our communities and implement strategies to create conditions that allow all people to have a fair and just chance to lead their healthiest life possible." This report has historically been released in five-year intervals and presents a data narrative of how the state fairs on overall population health as well as disparities along dimensions such as race and ethnicity, place (community density), and educational attainment, allowing us to better understand the distribution of health in our state, which population aggregates hide, but also allows us to assess how we are scoring according to other states. We believe it is possible for Wisconsin to become a state where the health environment and residents' health reflects an "A" grade.
- [What Works for Health](#). What Works for Health is a tool that curates evidence-informed policies, programs, and systems changes that can propel community health across our state forward. The tool is described as providing "communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors that affect health. The research underlying this site is based on a model of population health that emphasizes the many factors that can make communities healthier places to live, learn, work, and play." What Works for Health accomplishes this by assessing "strategies that could improve health through changes to health behaviors, social and economic factors, clinical care, and the physical environment. For each strategy, we assign an evidence rating, describe expected outcomes, implementation in Wisconsin and elsewhere, and link to helpful resources. We also assess likely impact on disparities for each strategy." As such, What Works for Health is a valuable resource providing evidentiary basis for many of the proposals and recommendations put forth by the Governor's Health Equity Council, as well as a trove of reports on other policies, programs and practices that were not included which, if implemented, would help steward a stronger and healthier Wisconsin.
- [County Health Rankings](#). The County Health Rankings & Roadmaps (CHR&R) is a program providing "data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support leaders in growing community power to improve health equity." The Rankings provide measures of the health of nearly every county in all 50 states and is used to support evidence-informed policy by making complex data accessible and helping deepen the public's

understanding of what makes communities healthy and facilitates improvement. This makes the County Health Rankings & Roadmaps a critical resource for not only understanding which communities are most heavily burdened by poor health outcomes, but also monitoring change in those outcomes at the county-level over time.

Our commitment and interest are in what works to advance and protect the health and well-being of Wisconsinites. As a result, monitoring population health over time is an essential aspect of accountability that must be attached to policy being enacted by a just and responsible government. Instead of proposing new infrastructure, we implore serious engagement with the quality tools that we already have at our disposal. The resources described in this section are critical tools that we must engage with to better understand population health in our state and monitor changes in population health as a result of the actions of decision-makers — whether that is taking action or choosing inaction.



## Conclusion

The pursuit of health equity reflects a commitment to and understanding of the notion that caring for those most burdened by negative health outcomes **is not a zero-sum game** — it does not have to be giving to others at the expense of oneself. Addressing the social determinants of health is about removing barriers and obstacles to health so that individual choices and decisions are the only, and most important, factors that matter regarding preventable health outcomes. The opportunities afforded to our neighbors reflect an opportunity for us. Exclusion, in all its forms, impacts each of us and is a detriment to all of us, threatening our collective safety, health, well-being, and strength as a population and a state.

One reason this is true is because poor health outcomes have the practical effect of being costly. There is a monetary cost — **the health inequity tax** — we all pay for maintaining the conditions and arrangement facilitating the current distribution of population health and health disparities in our state. Health care payers, whether they be insurers or the people and businesses who pay health insurance premiums and cost-sharing, are either immediately or ultimately saddled with the costs. And the residents of Wisconsin more broadly foot the bill for managing the various ways having a population that is not operating at optimal health and wellness create fiscal impacts.

Economists have been able estimate the cost of these health disparities, using the actual cost of care and statistical measures which provide a value for a healthy year of life. These measures can put the magnitude of this health inequity tax in perspective. [One study](#) by the Joint Center for Political and Economic Studies at George Washington University, using data

from the mid-2000s, suggests the nationwide direct, medical cost of health disparities experienced by Blacks, Asians, and Hispanics averaged \$57 billion dollars per year. The indirect costs of those disparities on health-related productivity were \$12.5 billion dollars per year. The cost of the excess deaths averaged \$239 billion dollars per year. They estimate that eliminating health disparities simply based on race and ethnicity would have reduced direct medical care expenditures by about \$230 billion and indirect costs associated with illness and premature death by more than \$1 trillion for the years 2003-2006 (in 2008 inflation-adjusted dollars).

An analysis from 2010, by the [Center for American Progress](#) found that the excess medical costs borne annually by Black/African Americans, Hispanics, and Asian Americans due to health disparities is estimated to be \$77 billion, while the total amount in health care and indirect costs that health care disparities cost the U.S. budget each year is \$413 billion.

[Another more recent study](#) by the W.K. Kellogg Foundation and Altarum looking at 2018 data found health disparities cost \$42 billion in lowered productivity and \$93 billion in excess medical costs each year.

As staggering as these numbers are it is important that we point out that they reflect the low-end of the health inequity tax we are paying. These estimates may not include the costs of premature death and health inequities for women, LGBTQ people, people with disabilities, people living in rural areas, people who don't speak English or were not born in the U.S. Additionally, most of these studies estimates are based on direct costs to the system — not the indirect costs of lost productivity ***because sick people cannot do their best work and dead people cannot pay taxes*** (adding those in puts us in the trillions). In other words, if our system is keeping people from achieving their best health, we all are suffering the financial consequences, and they are massive. We are the ultimate payer of these costs.

Yet regardless of the monetary impact, the pursuit of opportunity for everyone should also be a pursuit motivated by a moral and just imperative. Health inequities create unnecessary, preventable suffering, and provide fuel for generational distrust in systems and institutions, and they are immoral and unjust. The costs we bear due to our failure to advance policies that truly support and protect the health and well-being of Wisconsinites are not just a tax, they are also an opportunity cost. Our present situation means that we are using resources spent to manage the consequences of problems that are preventable, and which could be invested elsewhere in our state. We are also losing out on the resources that the lives impacted would contribute to the well-being of our communities and our state. It does not have to be this way.

In the following pages, we lay out specific, actionable steps that can be taken, here in Wisconsin, if we are serious about turning the tide and improving our population health. Each of the 20 recommendations, and the equitable use of data statement were voted for inclusion in this final report by the Council. We invite every Wisconsinite — who is sincerely concerned about the health and welfare of the residents of our state and is committed to seeing serious actions be taken to facilitate a healthier, more well Wisconsin that works for every person residing here — to engage with the ideas put forth by the Governor's Health Equity Council aimed at reducing some of the preventable suffering. As our state motto asserts, it is time for us to move FORWARD in advancing health equity in our state. The health and lives of Wisconsinites depends on it.





# Recommendations

## Recommendations

Over the course of twenty months, the members of the Governor's Health Equity Council worked to develop 20 recommendations. These recommendations were informed by research, data analysis, council-member expertise, as well as conversations and suggestions from Wisconsin residents. Ideas put forth for development and inclusion into the final report were required to meet a set of guiding criteria:

- ▶ Must be achievable through a policy pathway
- ▶ Reflect a commitment to equitable and just practices across all sectors of society (i.e., disparity reduction/elimination)
- ▶ Be directed at structural and systemic levers, not individual behavior
- ▶ Be respectful of groups of particular concern (i.e., groups heavily burdened by disparity)
- ▶ Be clear, intuitive, and compelling
- ▶ Be sufficiently unambiguous (focused on strategies, not outcomes alone) that it can guide policy priorities
- ▶ Be conceptually and technically sound, consistent with current understandings of best practice, or may generate new knowledges
- ▶ Be possible to operationalize for the purpose of measurement, which is essential for accountability
- ▶ Be actionable

In the following section, each of the twenty recommendations are presented. For each recommendation, we provide the following information:

- ▶ **What We Should Do:** A high-level summary of recommended actions
- ▶ **Why It Matters:** An overview of some of the reasons this recommendation was put forth
- ▶ **What We Need to Think About:** Lays out the specific details of a recommendation including design and implementation consideration
- ▶ **What Wisconsinites are Saying:** Any testimony, statements, or interview quotes gathered related to a specific recommendation
- ▶ **Where You Can Learn More:** Readings and source materials related to the specific recommendation

These recommendations were informed by research, data analysis, council-member expertise, as well as conversations and suggestions from Wisconsin residents.

# Health and Community Services

## **Community Health Workers**

### ► **What We Should Do:**

- Create a Community Health Worker (CHW) certification process
- Establish standards for Community Health Worker certification
- Reimburse certified Community Health Workers for services in their scope of practice under a newly established community health benefit in Wisconsin's Medicaid program

### ► **Why It Matters:**

Community Health Workers are a type of front-line health care professional who are trusted members of the community they serve. They provide education, navigation, and support services, including help with transportation to individuals using health and social services systems. Community Health Workers can help improve the quality and cultural appropriateness of service delivery, in turn reducing health disparities and poor health outcomes. Wisconsin currently has one of the lowest numbers of Community Health Workers in the country: there are only 350 Community Health Workers working in 47 of Wisconsin's 72 counties and in all 11 Tribal nations.

Stakeholders, including some Community Health Workers themselves, have stated a need for standardized education, certification, and professional development for Community Health Workers. In addition, these groups recognize that Community Health Worker services also need to be financially sustainable and linked with other health care systems, like medical and dental clinics, public health, and hospitals.

### ► **What We Need to Think About:**

The Governor's Health Equity Council urges Wisconsin to work alongside the Wisconsin Community Health Worker Network to create a competency-based education and certification program to develop standards for Community Health Worker training and certification. The development of a statewide Community Health Worker educational program would be based in accredited post-secondary schools and designed to align with other health profession preparation programs in nursing and allied health services like dental hygiene, physical and occupational therapy, mental health, and medical technology. This would serve as a ladder for Community Health Workers for career advancement



and as a stepping-stone to other professional degrees. There is a great need for individuals with the cultural competence skills possessed by most Community Health Workers in patient care, hospital administration, and social service positions.

Community Health Worker certification would also be a step in the process for the Community Health Worker profession to become financially sustainable through reimbursement from health care payers of the services they provide. In addition, the Governor's Health Equity Council further recommends that Community Health Worker professional organizations, health care providers, and payers review and develop the best practices for integrating Community Health Workers into mainstream health care delivery systems. This includes developing plans and recommendations for overcoming existing barriers to integration.

The second part of this recommendation, that the Wisconsin Medicaid program begin reimbursing for services provided by Community Health Workers within their scope of practice, was previously advanced by Governor Evers as part of the 2021-23 biennial budget request. The Governor's Health Equity Council lends its support for again including the necessary statutory changes and funding in the upcoming biennial budget.

► **What Wisconsinites Are Saying...**

- ❖ "Patient navigation helps to address any fears or anxieties that a patient may have." Dawn Williams, Milwaukee
- ❖ "CHWs will play a vital role in bridging the health care system and the communities that have been historically marginalized and not well-served by our health care systems." Rachel Castillo, Milwaukee
- ❖ "Just knowing that you're going to have that check-in and support is key for people to not feel alone and isolated, especially during the pandemic." Amanda Casady  
Community Health Worker, Superior

► **Where You Can Learn More...**

National Institute of Health, National Heart, Lung, and Blood Institute. "Role of Community Health Workers." U.S. Department of Health and Human Services. 2014. [Role of Community Health Workers, NHLBI, NIH](#)

Centers for Medicare and Medicaid Services. "On the Front Lines of Health Equity." U.S. Department of Health and Human Services. 2021. [On the Front Lines of Health Equity: Community Health Workers \(cms.gov\)](#)

*"Community Health Workers will play a vital role in bridging the health care system and the communities that have been historically marginalized and not well-served by our health care systems"*  
— Rachel Castillo, Milwaukee

Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention. “Integrating Community Health Workers on Clinical Care Teams in the Community.” Centers for Disease Control and Prevention. [Integrating Community Health Workers on Clinical Care Teams and in the Community | CDC | DHDSP](#)

## **Postpartum Medicaid Eligibility**

### **► What We Should Do:**

- Extend the time that the Wisconsin Medicaid program covers a person who has given birth to a full year after the birth occurs, as allowed under federal law
- Support the Wisconsin Medicaid program's development of a housing benefit and prioritize pregnant and postpartum members for this benefit
- Ensure that food assistance program benefits are consistently extended to Medicaid-eligible mothers and families and develop and implement programs to increase uptake of these benefits
- Create programs that also allow for clinically tailored meals and delivery of food boxes as well as nutritional coaching to high-risk pregnant and postpartum mothers and families
- Increase benefit amounts provided by food assistance programs

### **► Why It Matters:**

In Wisconsin, more than two out of three pregnancy-related maternal deaths occur after the baby is born, during the postpartum period. Wisconsin's Maternal Mortality Report found that Black women in Wisconsin are five times more likely than white women to die during or within one year of a pregnancy.

Achieving positive health outcomes for mothers and babies who receive health care coverage through Medicaid requires follow-up beyond the current 60-day postpartum period. A longer time period ensures postpartum individuals can receive continuous care from a familiar health care provider. This care can include recovery from childbirth, management of chronic health conditions like diabetes and high blood pressure, taking care of dental issues, and addressing mental health or substance use concerns.

In addition to physical and mental health care, access to consistent, stable housing and food during pregnancy and the first

year of a child's life is also critical. Any length of homelessness during this time has been linked to pregnancy complications, preterm birth, low birth weight, and adverse child outcomes. During pregnancy and the postpartum period, the body needs more food. In addition, making meals can become more difficult and buying food may become harder due to loss of income from not working. Making sure pregnant and postpartum mothers have enough and consistent amounts of food is critical to their and their baby's health.

► **What We Need to Think About:**

Recent state and federal legislative actions have changed the landscape of Medicaid's postpartum eligibility criteria in the last two years. In 2021, the American Rescue Plan Act modified federal law so that states could ask to extend postpartum coverage to 12 months. The enacted 2021-2023 biennial budget directed the Department of Health Services to seek federal approval to extend postpartum eligibility to 90 days. As of June 2022, the Department of Health Services has filed a request for federal approval to implement this extension to 90 days.

For Wisconsin's Medicaid program to implement a 12-month postpartum period, Wisconsin statutes would need to be revised to provide the program with the authority to seek federal approval for this eligibility change. For Medicaid postpartum eligibility of any length, at the end of the postpartum period, the household income of the parent determines whether they remain eligible for, or are disenrolled from, Medicaid. This eligibility transition creates significant disruptions in new parents' health care coverage.

Achieving positive health outcomes for mothers and babies requires not only better health care continuity, but also helping pregnant and postpartum individuals with housing and food needs. The Council therefore lends its support to the Wisconsin Medicaid program's development of a variety of housing support services to qualifying members and urges the Medicaid program to prioritize pregnant and postpartum members for this benefit.

To address food insecurity, the Council further recommends increases to the amounts provided to pregnant and postpartum women through the various food assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplementary Nutrition Program for Women, Infants and Children (WIC). This would complement the recommendations to ensure that Women, Infants, and Children Program and

*"I have health insurance now because I am pregnant but once the baby is born, I won't have it any longer."  
-Anonymous, Greendale from SHIP*

Supplemental Nutrition Assistance Program benefits are consistently extended to any Medicaid-eligible mothers and families and develop and implement programs to increase uptake of these benefits.

For the recommendations to also allow for clinically tailored meals and delivery of food boxes as well as nutritional coaching to high risk pregnant and postpartum moms and families, the Council recommends providing that benefit starting at 20 weeks into a pregnancy and continuing through the 12th month after birth.

► **What Wisconsinites are Saying:**

- ❖ “I have health insurance now because I am pregnant but once the baby is born, I won’t have it any longer.”  
Anonymous, Greendale from State Health Improvement Plan
- ❖ “It will be of great benefit for women to have access to family planning medical care because there are no resources for this service. Fear and misinformation should not be a reason why people have children they cannot support. Family planning is key to having a healthy family.” Astrid Fierro Solis, Green Bay

► **Where You Can Learn More:**

Ranji et al. “Expanding Postpartum Medicaid Coverage.” The Kaiser Family Foundation. 2021. [Expanding Postpartum Medicaid Coverage | KFF](#)

Gordon et al. “Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage.” U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. 2021. [medicaid-postpartum-coverage-ib .pdf \(hhs.gov\)](#)

Katch, Hannah. “Medicaid Expansion Improves Postpartum Coverage, Access to Care.” The Center on Budget and Policy Priorities. 2020. [Medicaid Expansion Improves Postpartum Coverage, Access to Care | Center on Budget and Policy Priorities \(cbpp.org\)](#)

## ***Family Planning and Emergency Services for Immigrant Populations***

► **What We Should Do:**

- Explore the creation of a state-funded program that provides family planning service benefits to individuals

who are not currently eligible because of their immigration status

- Explore ways to extend the emergency service Medicaid benefit to individuals who are not currently eligible

► **Why It Matters:**

Undocumented youth and adults are residents of our state, and their ability to stay healthy impacts all of us. Due to the availability and cost of employer-sponsored health insurance, as well as their legal status, these workers may have very little access, if any, to health services and supports.

Within health care, access to family planning and reproductive health services can help support individuals and families to fulfill their educational, job, and financial goals. Currently, federal restrictions on Medicaid eligibility for family planning services leave out certain immigrants from qualifying for these services. When immigrants, and more specifically immigrant women, are not able to get basic reproductive health care, their overall health, well-being, and economic security are put at risk.

The current Medicaid program also provides coverage to certain immigrant groups for emergency services, such as treatment for heart attacks, strokes, or car accidents. However, due to restrictions on the use of federal Medicaid funds, this benefit does not cover undocumented and other immigrants, leaving them without health care coverage at times when they need it most.

Ensuring health care services are available to everyone in their time of greatest need is truly a measure of a society's commitment to the preservation of health and life. Making even this limited range of emergency and family planning services available to immigrants, regardless of their status, moves Wisconsin a step forward in our shared commitment to improving health outcomes for all.

► **What We Need to Think About:**

The first part of this recommendation to make family planning services available to immigrants who are not currently eligible requires approving language in state statute and allocating state funds. The second part, related to seeking a pathway to extending emergency services to immigrants not presently eligible, requires the Department of Health Services to further investigate implementation options, including either administrative rule or statutory changes.

*“People always talk about equity and equality, well having health care is a human right, we are ALL humans and deserve equity.”*  
-Kendy Gomez, Trempealeau

The Governor’s Health Equity Council recognizes the complicated and overlapping nature of the Wisconsin Medicaid program’s eligibility determinations, benefits delivery, financial management, and legislative oversight, and urges the Department of Health Services to request the authority and resources necessary to implement this recommendation.

► **What Wisconsinites are Saying:**

- ❖ “Education is the most important. People will be more informed about how to get comprehensive medical care because family planning is usually the entry way to medical services.” Sonia Tellez, Racine
- ❖ “This is great because people will have the benefit of getting medical services they do not have access to. Preventative services are essential.” Brenda Branbila, Milwaukee
- ❖ “People always talk about equity and equality, well having health care is a human right, we are ALL humans and deserve equity.” Kendy Gomez, Trempealeau

► **Where You Can Learn More:**

- ❖ American Immigration Council. “Immigrants in Wisconsin.” American Immigration Council. 2020. [Immigrants in Wisconsin | American Immigration Council](#)
- ❖ Artiga and Diaz. “Health Coverage and Care for Undocumented Immigrants.” The Kaiser Family Foundation. 2019. [Health Coverage and Care of Undocumented Immigrants | KFF](#)
- ❖ Pew Research Center. “U.S. unauthorized immigrant population estimates by state, 2016.” Pew Research Center. 2019. [U.S. unauthorized immigrant population estimates by state, 2016 | Pew Research Center](#)
- ❖ The Commonwealth Fund. “Immigrant Women’s Access to Sexual and Reproductive Health Coverage and Care in the United States.” The Commonwealth Fund. 2018. [Immigrant Women’s Access to Sexual & Reproductive Coverage & Care | Commonwealth Fund](#)

## Dental Health for Children

### ► What We Should Do:

- Provide Wisconsin Medicaid program reimbursement for services provided by a Community Dental Health Coordinator (CDHC), within their scope of practice, to children enrolled in the Wisconsin Medicaid program
- Pursue effective reimbursement strategies to incentivize the provision of dental services to children in the Wisconsin Medicaid program

### ► Why It Matters:

Oral health is an important component of overall physical health. Cavities, or tooth decay, are one of the most common, preventable chronic illnesses of childhood and disproportionately impact children from low-income households. When children have dental pain from cavities, eating or speaking can be difficult. Dental pain that is not treated can lead to poor growth and development, difficulty learning, challenging behaviors, and negative self-esteem. Early access to consistent and routine preventive dental care and treatment is critical for ensuring good short- and long-term oral health outcomes.

Wisconsin ranks last in the country in providing preventive dental services to children enrolled in Medicaid. One of the main reasons for this is the lack of dentists across the state who accept and actively participate in Medicaid. The result is that families of young children enrolled in Medicaid have a hard time finding dentists, scheduling dental appointments, and receiving the dental care they need when they need it.

Community Dental Health Coordinators, who can work collaboratively with providers and patients, provide an opportunity to address barriers to oral health care and improve access to dental care for children by connecting them with dentists. Community Dental Health Coordinators are typically dental hygienists who receive additional training to serve as navigators, educators, and case managers for both families and dental providers.

The primary focus of Community Dental Health Coordinators centers on prevention and oral health promotion. They can work in many different settings like school-based clinics, Head Start and Early Head Start programs, medical and dental clinics, and local public health agencies. In Wisconsin, Community Dental Health Coordinators are being successfully utilized in three different sites across the state to help connect patients to dentists when they



show up at the emergency department or urgent care with non-traumatic dental pain.

In recent years, several strategies have been used to try to improve access to dental care in Wisconsin including increasing Medicaid reimbursement rates for dentists and establishing expanded function dental auxiliaries (EFDAs) as licensed oral health care providers. This recommendation builds on these approaches by adding in a critical navigation and case management component for both families and providers that is currently lacking.

► **What We Need to Think About:**

To implement coverage and reimbursement of services provided by Community Dental Health Coordinators, the Wisconsin Medicaid program will need to write policies governing the provision and payment for services provided by Community Dental Health Coordinators within their scope of practice.

Despite the recent biennial budget increase for Medicaid reimbursement for dental providers, data indicates that this alone will not improve access for children. Creating novel reimbursement strategies for dental services will require the Wisconsin Medicaid program to continue to evaluate current statewide efforts and review strategies other states' Medicaid programs have used to improve these metrics. This may include incenting referrals from school-based oral health programs, Head Start and Early Head Start programs, and appointments for children under six.

The Governor's Health Equity Council recommends that the Medicaid program seek the appropriate authority and resources necessary to implement such strategies they believe will be effective and to partner with appropriate state agencies, oral health coalitions, and oral health training programs.

The Council also acknowledges that dental health services remain a challenge for adults as well, and that the state should continue to advance solutions that address comprehensive reform in the future.

► **What Wisconsinites are Saying:**

- "My son has been on the waitlist since 2016 for services at a Community Health Worker dental clinic." Greendale, anonymous, from State Health Improvement Plan

*"There is still a hidden epidemic of oral disease in low-income and under-served populations. The solutions are there. All we need is the will and the resources to support those solutions."*  
—Terri Komay, RDH, Scenic Bluffs Health Center, Cashton

- “No child in Wisconsin should have any dental pain, much less pain so severe that it keeps them from doing their math homework or art project. School nurses and social workers are willing to do whatever we can, but we need help. If we had a Community Dental Health Coordinator, we’d have somebody who could help create the processes and relationships that make sure any kid who needs care gets it.” Janelle DeRose, RN, BSN, School Nurse, Verona
- “The school-based programs are a fantastic place to reach these children, and maybe slow or even end the education gap and improve oral health. However, school and community-based dental programs don’t just run themselves. We need Community Dental Care Coordinators to build the systems and partnerships that get families educated and find kids care. Terri Komay, RDH, Scenic Bluffs Health Center, Cashton
- “There is still a hidden epidemic of oral disease in low-income and under-served populations. The solutions are there. All we need is the will and the resources to support those solutions.” Terri Komay, RDH, Scenic Bluffs Health Center, Cashton
- “I strongly support Community Dental Care Coordinators. These workers can have a profound impact on the oral health of children.” Dr. Cliff Hartmann, President of Wisconsin Dental Association
- “Of the more than 100 Medicaid children I treated in the operating room last year for Early Childhood Caries, many of their parents saw the disease beginning a year or so before they saw me. During that time, the disease grew worse as they traveled from dentist to dentist seeking treatment. Lack of access due to Medicaid was the problem.” Dr. Cliff Hartmann, President of Wisconsin Dental Association
- “In 2021, of the 683 Emergency Room visits associated with oral health issues, 267 were specifically for tooth decay, pain or infection. This group of children averaged 5 years of age and over 10% of them required hospitalization to get the infection under control; oral antibiotics was not enough. In the same year, 761 dental cases were completed in the operating room under general anesthesia; 92% were due to tooth decay.” Pam Fraser, Director of Oral Health, Dr. Lori Barbeau, Dental Director of Community Health Worker and the pediatric dentistry residency program

► **Where You Can Learn More:**

Centers for Disease Control and Prevention. “Children’s Oral Health.” Centers for Disease Control and Prevention. 2022.

[Children's Oral Health | Basics | Children's Oral Health | Division of Oral Health | CDC](#)

- Centers for Disease Control and Prevention. “Dental Caries in Primary Teeth.” Centers for Disease Control and Prevention. 2019. [Dental Caries in Primary Teeth \(cdc.gov\)](#)
- Olson et al. “Wisconsin Healthy Smiles Survey, The Oral Health of Wisconsin’s Head Start Children: Current Status, Trends, and Disparities.” Wisconsin Department of Health Services. 2014. 2014 - [Wisconsin Healthy Smiles Survey: The Oral Health of Wisconsin's Head Start Children](#)
- Chalmers, Natalia I. “The State of Oral Health: Increasing Access and Reducing Disparities Webinar.” Centers for Medicare and Medicaid Services. [NIHCM OralHealthWebinar Chalmers.pdf](#)

## ***School and Employer Partnerships to Increase Health Care Workforce***

► **What We Should Do:**

- Fund work with schools and employers to provide students with awareness of, exposure to, and experience with various health care careers
- Address the equity gap in health care career training and pathways at state universities and technical colleges
- Reimagine dual enrollment programs for high-school students simultaneously enrolled in health care profession training programs so that they are more inclusive

► **Why It Matters:**

It is critical that the health care workforce of Wisconsin reflects its population. Evidence shows that health care organizations that center the lived experience of those they are servicing through inclusive workforces reduce health disparities particularly via better patient engagement and health outcomes.

However, health care and public health institutions have fallen short in fully including people of color, LGBTQ+, and people with disabilities. Additionally, the needs of women, in particular women in marginalized populations, are inadequately addressed

because leaders don't consider comprehensive perspectives. In Wisconsin, 9 of 10 health professions including speech therapy, occupational therapy, pharmacy, medical doctor, respiratory technology, nurse, physician assistant, and dentistry all have an inadequate pipeline diversity index, according to the Health Workforce Diversity Tracker.

Health care “navigator” positions, which connect students with employers for firsthand job experience, is one way to address this gap. Secondary students from marginalized communities often lack the access to or experience with health care careers that are in high demand/low supply in Wisconsin today. These navigator positions will work directly with school districts, technical colleges, and universities to proactively foster long-term relationships with employers in their regions to provide students with direct access to and meaningful experience with health care careers.

Several such initiatives are underway in Wisconsin. M Cubed in Milwaukee is an already successful partnership between Milwaukee Public Schools, Milwaukee Area Technical College, and University of Wisconsin-Milwaukee. Inspire Sheboygan is another successful partnership between the Sheboygan Chamber of Commerce and area school districts to connect students to future employers. This program has been so successful that they now partner with school districts outside of Sheboygan County.

A diverse workforce also requires a diverse workforce pipeline. In Wisconsin, the UW system, Wisconsin technical colleges, and K-12 public education are structurally separate entities. Collaboration across these entities and with health care employers bolsters the pipeline for diverse candidates in health care fields.

Finally, dual enrollment in high school and a technical or 4-year college makes high school studies more relevant, leads to a deeper interest in career planning, expands choices to traditionally competitive career pathways, and creates transferable credits to technical school or university. Too often, the focus of programs like dual enrollment is on students who are performing at the top of their class, and students from marginalized communities may not be aware these opportunities exist.

► **What We Need to Think About:**

To grow the role of health care navigators, the Governor's Health Equity Council advises Wisconsin to competitively award grant funding to organizations who create connections between

employers, training programs, and individuals seeking health care careers, but who have been underrepresented in those professions. For example, a navigator position could work with M Cubed to focus on Milwaukee area health care employers to foster these relationships. Similarly, a navigator position could work with Inspire Sheboygan to build on current successes and create a focus on health care employers in the broader region. It could also bring more collaboration with area education institutions like Lakeshore Technical College, Fox Valley Technical College, the University of Wisconsin-Green Bay, and the University of Wisconsin-Oshkosh.

In addition, to improve career training pathways, the Governor's Health Equity Council advises that additional funding be provided to educational and training institutions with the goal of increasing diversity in Wisconsin's health care workforce. Developing partnerships with schools, colleges, and universities, examining, and adjusting admission policies, and reaching beyond the traditional applicant pool have been shown to help increase workforce diversity.

To make dual enrollment programs more inclusive, the Governor's Health Equity Council recommends establishing a work group to look at alternate eligibility criteria with the goal of increasing diversity in the program. Additionally, this proposal recommends the creation of standardized statewide information about dual enrollment that would be made available to all Wisconsin students and families. The goal would be for all Wisconsin school districts to actively reach out each year to their student base, to educate them on their current dual enrollment programs, and to increase participation. To the extent some school districts may require extra resources to do this, the Governor's Health Equity Council urges the Department of Public Instruction, the state agency responsible for public K-12 education in Wisconsin, to determine the resources necessary and request them.

Perhaps most importantly, and related to all the parts of this recommendation, the Governor's Health Equity Council urges the leadership and staff from across state agencies and educational institutions — such as the Departments of Public Instruction, Health Services, and Workforce Development, and Wisconsin's universities, technical colleges, and school districts — to work together to carry out these activities.

► **Where You Can Learn More:**

- Coronado et al. “Understanding the Dynamics of Diversity in the Public Health Workforce.” Journal of Public Health Management and Practice. 2019. [\(PDF\) Understanding the Dynamics of Diversity in the Public Health Workforce \(researchgate.net\)](#)
- Salsberg et al. “Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce.” JAMA Network Open. 2021. [Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce | Health Care Workforce | JAMA Network Open | JAMA Network](#)
- Fitzhugh Mullan Institute for Health Workforce Equity. “Health Workforce Diversity Tracker.” The George Washington University. 2021. [Diversity Tracker — MULLAN INSTITUTE \(gwhwi.org\)](#)
- Wisconsin Public Health Association. “Diversity Matters: Key Findings Report.” Wisconsin Public Health Association. 2018. [Microsoft Word — Key Findings Report.doc \(ymaws.com\)](#)

## **Rural Broadband Internet Access**

► **What We Should Do:**

- Support the recommendations contained within the Governor’s Task Force on Broadband Access, specifically those with a focus on improving “digital equity,” or the condition in which all individuals and communities have the information technology capacity needed for full participation in our society, democracy, and economy
- Creating a digital equity fund to support digital inclusion activities that lead to all Wisconsinites being fully able to participate in society
- Starting an internet assistance program to address broadband affordability for low-income families.
- Increasing broadband expansion grant funding across urban and rural communities to improve access to high-speed internet services
- Support the Public Service Commission’s (PSC) ongoing work to reduce and get rid of barriers to affordable high-speed internet, as detailed in the annual State Broadband Plan

► **Why It Matters:**

Wisconsin's residents in both rural and urban areas of Wisconsin have health care needs that often require them to spend time traveling to appointments and navigating a complicated health care system. Technological advances now allow many services to be provided via telehealth, reducing the time burdens of seeking and receiving needed health care services. However, these technologies require access to affordable high-speed internet service. While rural areas of the state face more widespread challenges in accessing robust broadband infrastructure, residents of both urban and rural areas share common barriers to accessing affordable internet service.

In July 2020, Governor Evers signed Executive Order 80 creating the Governor's Task Force on Broadband Access to advise the Governor and Wisconsin State Legislature on broadband actions and policy, including strategies for digital inclusion. In 2021, the Task Force released its report with multiple recommendations that addressed broadband access, affordability, and adoption. By implementing the various recommendations advanced by the Governor's Task Force on Broadband Access and the Public Service commission, more households, regardless of where they live and regardless of their incomes, will be able to reap the health and economic benefits that come with having high-speed internet service.

As the Task Force on Broadband also states, functioning broadband internet service is an integral part of today's society, allowing essential commerce, educational, energy, public safety, and other functions to operate consistently and effortlessly. As it relates to the work of this Council, broadband is integral to the operation of our health care system.

► **What We Need to Think About:**

Both the Task Force's report and the Public Service Commission's Broadband Plan (which shares the same vision as the Task Force, and sets goals to make broadband more accessible, resilient, competitive, and affordable) provide detailed analysis of the variety of issues related to high-speed internet access throughout the state and opportunities for improvement.

The recommendations of the Task Force, to which the Governor's Health Equity Council lends its support, include ideas such as pursuing novel methods of infrastructure development, creating a digital equity fund, establishing an internet assistance program, and increasing broadband expansion grant funding across urban and rural communities. These recommendations aim to address



the systemic forces that purposely or accidentally limit broadband access in rural areas. They also provide specific recommendations for how to implement structural approaches to reduce broadband access disparities.

In the most recent State Broadband Plan, the Public Service Commission acknowledges that the availability of broadband alone is not enough to address larger issues of connectivity speeds, affordability, and digital literacy. Its plan articulates the need for a variety of targeted strategies to fully resolve these challenges, including working with stakeholders to craft a Digital Equity and Inclusion Plan, making intentional investments to reduce the effects of historical and institutional barriers, and providing a variety of resources for improving broadband access, affordability, and digital literacy.

► **What Wisconsinites Are Saying:**

- ❖ “The COVID pandemic was the reason for increased need for telehealth, this is especially important in rural areas.”  
John Linnell, US COPD Coalition Board Member
- ❖ “Overcoming this barrier for our patients is central to our mission to ‘Enrich lives to create healthy communities through accessible, affordable, compassionate health care’.” Chris Meyer, Rick Lake

► **Where You Can Learn More:**

- Knapp and Votava. “Broadband in Rural Wisconsin: Identifying Gaps, Highlighting Successes.” [Forward Analytics. 2020. 2020-FA-Report-Broadband-in-Rural-Wisconsin.pdf \(forward-analytics.net\)](#)
- The Office of the National Coordinator for Health Information Technology. “What is Broadband and Why is it Important.” The Office of the National Coordinator for Health Information Technology. 2020. [What is broadband and why is broadband access important? | HealthIT.gov](#)
- North Carolina Department of Information Technology, Division of Broadband and Digital Equity. “Broadband 101.” 2020. [Broadband 101 | ncbroadband.gov](#)

*“The COVID pandemic was the reason for increased need for telehealth, this is especially important in rural areas.”*  
*John Linnell, US COPD Coalition Board Member*

# Education and Housing

## *Tuition Waivers*

### ► **What We Should Do:**

- Provide enrolled members of Tribal nations in Wisconsin with a waiver of tuition costs while attending a public four-year college or university as an undergraduate student or a two-year college or technical school in Wisconsin

### ► **Why It Matters:**

Educational achievement is closely linked to long-term health and economic outcomes, occurring through a variety of pathways including those related to occupation, income, wealth-building, community conditions, and health care access. However, Native Americans have low college enrollment rates compared to all other groups. For instance, data from 2016 showed that American Indian and Alaska Native young adults between the ages of 18 to 24 had the lowest college enrollment rate of any racial or ethnic group, with less than one in five enrolled in college.

In addition, as a result of colonization, displacement, and insufficient support from federal and state governments, Native Americans in Wisconsin are overall more likely to come from low-income families which can make it harder to pay for additional education after high school. Removing one cost barrier to finishing a technical or college degree can help improve both financial and health outcomes for Native Americans in Wisconsin.

A tuition waiver would serve as a strong recruitment and retention strategy for Native Americans — many who are often the first to attend college in their families and may otherwise choose not to pursue higher education due to the cost. Offering a tuition waiver for these students also sends the active message that higher and professional education programs are places where they belong. For far too long they have been excluded from access to physical places of learning that have been built upon their land.

The tuition waiver would further diversify Wisconsin's workforce, creating opportunities for Native youth to have exposure to adult role models from their communities in professional settings, which has been shown to have an important and positive impact on long-term outcomes. Moreover, Wisconsin's non-Native American population and business community would see benefits through increased workforce diversity and perspectives in those

occupations and industries where Native Americans have been grossly underrepresented.

► **What We Need to Think About:**

The implementation of this recommendation requires Wisconsin to provide consistent and sufficient funding to meet the full cost of tuition for Native Americans in Wisconsin seeking higher education at public education institutions throughout the state.

The Governor’s Health Equity Council also recommends that this tuition waiver be evaluated for its effects on educational outcomes and that Wisconsin’s educational leaders consider, based on evaluations and engagements with communities, how a similarly constructed tuition waiver could be extended to other marginalized and underrepresented groups.

► **What Wisconsinites Are Saying:**

- ❖ “The American Indian Student waiver for tuition is needed. And the tuition waiver would help families who have been relegated to minimal resources such as reservations and the eradication of Native American ancestral education.” Anonymous, community listening session for power group
- ❖ “American Indian students make up about .224% of the total UW student population. It is important for the state to have this special relationship with public universities and colleges.” Anonymous, community listening for power group

► **Where You Can Learn More:**

- University of Wisconsin System. “UW Board of Regents approves tribal consultation policy.” University of Wisconsin System. 2021. [UW System Board of Regents approves tribal consultation policy | News \(wisconsin.edu\)](#)
- American Indian College Fund. “American Indian College Fund Publishes Report on Ways for Tribal Colleges and Education Institutions to Increase Graduates in Health Fields.” American Indian College Fund. 2020. [American Indian College Fund Publishes Report on Ways for Tribal Colleges and Education Institutions to Increase Graduates in Health Fields | American Indian College Fund](#)

*“American Indian students make up about .224% of the total UW student population. It is important for the state to have this special relationship with public universities and colleges.”*

*—Anonymous, community listening for power group*

- American Indian College Fund. “Creating Visibility and Healthy Learning Environments for Native Americans in Higher Education.” American Indian College Fund. 2019. [Creating Visibility and Healthy Learning Environments for Native Americans in Higher Education | American Indian College Fund](#)
- Wisconsin Department of Public Instruction. “American Indian Studies Program.” Wisconsin Department of Public Instruction. [American Indian Studies Program | Wisconsin Department of Public Instruction](#)

## Homeownership

### ► What We Should Do:

- Allocate state funding to develop and expand existing local homeownership support programs
- Support ongoing and new Community Land Trust (CLT) initiatives around the state by using a portion of existing federal funding from the Department of Housing and Urban Development, under the HOME Investment Partnerships Program

### ► Why It Matters:

Homeownership is associated with positive health outcomes. Homeownership is also a primary means of building generational wealth within families. Well-designed policies that encourage homeownership have the dual benefit of both helping economically disadvantaged families and addressing long-standing racial disparities in access to housing.

**Addressing Economic Disadvantage.** The capital associated with home ownership can be transferred and/or passed along generations in such a manner that an individual’s positive homeowner outcomes can have a positive effect on the health and well-being of generations of family to come. Because of the strong ties between property taxes and local services, homeownership is also a significant influence on the health of communities. Communities with stable homeownership have a stronger tax base, which positively influences the quality of schools and other social services associated with health and well-being outcomes. When policies enable homeownership to grow, communities thrive.

The inadequacy in quantity and quality of affordable rental housing is a known issue in Wisconsin. This issue leads to housing instability, which is damaging to individuals, families, and

communities. The burden of housing instability also falls inequitably on many marginalized groups. One antidote to the issue is to promote homeownership. However, due to the legacy of historic policies, such as redlining, racial covenants, and other discriminatory homebuying and mortgage practices, inequitable rates of homeownership across Wisconsin also persist and are projected to only worsen by 2040.

**Addressing Racial Disparities.** Additionally, discriminatory systems and practices endure today. Across the country, stories of racial discrimination in the homebuying and home appraisal processes are common and persistent. Black applicants are rejected for mortgage loans 2.5 times as often as white applicants. In addition to historical and contemporary factors related to lending and financing, persistent inequities by race and education-level in income and wealth have created a context where the difference in rates of homeownership between white (72.2%) and Black (26.0%) Wisconsinites remains quite wide (46.2% gap).

A variety of barriers to homeownership also exist for other marginalized groups. Systemic factors affecting educational attainment, geographic location, economic status, inequitable incarceration, and other immutable factors including gender, race and ethnicity, and more, fundamentally impact a person's employment opportunities and ability to achieve the income and wealth accumulation necessary to buy a home. The individuals and populations most negatively impacted by systemic barriers to homeownership are often those most in need of the financial and situational stability and safety conferred by homeownership.

► **What We Need to Think About:**

Wisconsin currently is home to several model programs supporting education and access for first time homebuyers and homeownership preservation for marginalized groups. The first component of the recommendation is for Wisconsin to support these existing local homeownership support programs and aid local partners in building on processes that they have already shown to be successful.

To specifically address the actual needs of populations and communities around the state with low rates of homeownership, Wisconsin would work with these providers to understand specific needs and potential expansion opportunities. Some of the types of services that could be funded include resources to develop affordable housing units, rehabilitation and sale of homes to eligible buyers, education services for pre- and post-homebuyers,

down payment and closing costs and other kinds of financial support, renovation of both homes and non-profit commercial space, and tools and counseling to prospective homeowners.

In addition to supporting existing ownership support programs, the Governor’s Health Equity Council also recommends funding ongoing and new programs to develop Community Land Trusts designed to increase opportunities for low- to moderate- income individuals and families to access home ownership. Community Land Trusts are community-driven organizations or entities that acquire and maintain permanent ownership over parcels of land and govern the terms around which owners and tenants can utilize it.

The land trusts can be used for commercial and retail purposes to center and empower communities during the development of certain areas or neighborhoods, but primarily serve to advance housing affordability. They do this by using “ground leases,” which put resale restrictions into place and set guidelines about income eligibility to ensure permanent affordability. Typically, prospective homeowners enter into a long-term renewable lease instead of a traditional sale; when the homeowner sells, the family earns only a portion of the increased property value, and the remainder is kept by the trust – this helps to preserve affordability for future families while still allowing the homeowners to build wealth. Investing in Community Land Trusts creates affordable housing opportunities for low-income households, giving them more resources to put towards other activities that improve health and well-being.

The recommendation calls for using a portion of existing federal funding from the federal Department of Housing and Urban Development, within the HOME Investment Partnerships Program. The state received \$318 million in federal funding from this program, of which 15% is required to go towards various community housing development organizations. The Council recommends that two-thirds of this requirement be specifically allocated towards supporting Community Land Trusts activities throughout the state.

► **What Wisconsinites are Saying:**

- ❖ “I’m living with my dad right now. There is a lack of affordable housing and a long wait list for rental assistance. It’s like 9 months long for a waitlist.”  
Anonymous, Chippewa/Cornell Head Start

*“Supportive housing improves housing stability; employment; mental and physical health; school attendance; and reduces active substance use. Supportive housing helps people live more stable and productive lives and supports individuals and families to thrive.”*

*—Katrina Van Valkenburgh, Central Region Managing Director at CSH*

- ❖ “Minimum wage is not livable wage... For a single parent rent for a 2 bedroom isn’t affordable.” Anonymous, Greendale
- ❖ “People don't have the money to rehab their houses. They make just above the limits to get grants that could help but not enough to be able to stay on top of major repairs and still provide for the family necessities.” Anonymous, Greendale
- ❖ “Supportive housing improves housing stability; employment; mental and physical health; school attendance; and reduces active substance use. Supportive housing helps people live more stable and productive lives and supports individuals and families to thrive.” Katrina Van Valkenburgh, Central Region Managing Director at CSH

► **Where You Can Learn More:**

- Bialek, Nan. “Addressing Milwaukee’s Eviction Crisis: The pandemic’s economic shockwaves create housing instability for many Milwaukee families.” MKE Lifestyle. 2021. [Addressing Milwaukee’s Eviction Crisis | Health & Lifestyle | mkelifestyle.com](https://mkelifestyle.com)
- Badger and Ingraham. “How violence shapes children for life: Poor kids who grow up in more violent places are less likely to escape poverty later in life.” The Washington Post. 2016. [How violence shapes children for life - The Washington Post](https://www.washingtonpost.com)
- Chun-Chung Chow and Snowden. “Racial/ethnic disparities in the use of mental health services in poverty areas.” American Journal of Public Health. 2003. [Racial/ethnic disparities in the use of mental health services in poverty areas - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov)

## Justice

### ***Employment of People Formerly Incarcerated***

► **What We Should Do:**

- Create a tax credit for employers who employ people formerly incarcerated
- Invest in worker cooperative development focused on providing opportunities to people formerly incarcerated
- Further evaluate and develop re-entry programs providing training and employment opportunities that supports productive returns to community



► **Why It Matters:**

We know employment influences many health-related outcomes. Employment for people formerly incarcerated is also linked to lower rates of re-offending. The unemployment rate for people formerly incarcerated is the highest of any demographic in Wisconsin. At the same time, people formerly incarcerated seek work at higher rates than the general population, indicating that there are systemic barriers people formerly incarcerated face when attempting to enter the workforce, given the high levels of unemployment among this population do not reflect a lack of efforts or interest in securing employment.

Furthermore, when people formerly incarcerated do finally secure employment, it is often in the lowest paying, least stable positions. The impact of this is that instead of cultivating a sense of purpose and dignity through facilitating financial independence and productivity, it contributes to the cycle of hardship and barriers they already face.

These recommendations would ensure people formerly incarcerated have a fair and just opportunity to thrive, and that people currently incarcerated can look forward to fair and just opportunities upon their release. Improving access to employment will help improve post-incarceration outcomes, strengthen Wisconsin's economy, support safer communities, and ultimately save taxpayer dollars. These are the conditions that can best create the circumstances to support rehabilitation and post-incarceration success.

► **What We Need to Think About:**

The first part of this recommendation calls for a state tax credit for employers who hire people formerly incarcerated. Examples of such ideas include the federal Work Opportunity Tax Credit (WOTC) and the State of New York's Recovery Friendly Workplace Tax Credit. The Governor's Health Equity Council supports rewarding businesses that employ and retain people formerly incarcerated, and considers the following as critical for the success of a tax credit: .

- Ensure the pool of employers eligible for the state tax credit is broader than the pool of employers who are currently eligible for the federal Work Opportunity Tax Credit, which has more stringent requirements for participation
- Provide credit opportunities for both hiring and keeping people in jobs

- Provide programmatic resources, such as training or professional development, to support both the employee and employer
- Provide incentives for employers to provide health insurance, including mental health and substance use disorder treatments

The second part of this recommendation calls for the development of worker cooperative programs for people formerly incarcerated. Worker cooperatives are values-driven businesses that put worker and community benefit at the core of their purpose. In contrast to more conventionally structured companies, worker cooperatives allow workers to participate in the profits, oversight, and management of the organization using democratic processes.

An important aspect of worker cooperatives that is especially significant for people formerly incarcerated is the opportunity to secure sustainable and dignified jobs – creating promising pathways to generate wealth, improve health outcomes, and promote community and local economic development. To the best of the Governor’s Health Equity Council’s knowledge, there are no worker cooperatives focused on people formerly incarcerated in Wisconsin, though some do exist in Chicago, Los Angeles County, and Washington, D.C.

We urge Wisconsin to support worker cooperative development programs for people formerly incarcerated, both through technical assistance and funding. Funding should include both loans and grants. We encourage Wisconsin to also charge the University of Wisconsin’s Center for Cooperatives with evaluating barriers to expansion, establishment, and survival of worker cooperatives, and developing further policy recommendations to help worker cooperatives thrive.

The third and final part of this recommendation calls for a study of the effectiveness of the current pre-reentry, reentry, and post-reentry programs. Wisconsin needs different models and programs to effectively serve the different needs, backgrounds, and post-carceral circumstances of individuals leaving incarceration and support their ability to productively re-enter and compete in our state’s workforce.

Fortunately, Wisconsin has a variety of existing programs that could be expanded to better serve those groups. The state would benefit from a global analysis of these existing programs to

*“Ninety-five percent of people in prison will be released at some point, and sooner than later for most. Incentives and pre-employment development skills are necessary factors for most effectively reintegrating these 95% back into society, if for nothing else than to get a good or even the greatest return on the billion dollars Wisconsin taxpayers invest in the prison system.”*

*—Shannon Ross, person formerly incarcerated and Executive Director of The Community*

identify gaps in services and develop recommendations to strengthen program offerings and implementation. The Council recommends an advisory body of stakeholders from government, the private sector, researchers, advocates, and individuals with lived experience to oversee this analysis and to develop recommendations for improvement.

► **What Wisconsinites are Saying:**

- ❖ “Ninety-five percent of people in prison will be released at some point, and sooner than later for most. Incentives and pre-employment development skills are necessary factors for most effectively reintegrating these 95% back into society, if for nothing else than to get a good or even the greatest return on the billion dollars Wisconsin taxpayers invest in the prison system.” Shannon Ross, person formerly incarcerated, and Executive Director/founder of The Community

► **Where You Can Learn More:**

- Couloute and Kopf. “Out of Prison and Out of Work: Unemployment Among Formerly Incarcerated People.” Prison Policy Initiative. 2018. [Out of Prison & Out of Work | Prison Policy Initiative](#)
- Dholakia, Nazish. “Wisconsin Program Helps People Find Jobs After Prison.” The Vera Institute. 2021. [Wisconsin Program Helps People Find Jobs After Prison | Vera Institute](#)
- Chechik and Sprecher. “Convictions bar Wisconsinites from many jobs, making re-entry ‘a real struggle.’” Wisconsin Watch. 2021. [Convictions bar Wisconsinites from many jobs, making re-entry ‘a real struggle’ — WisconsinWatch.org](#)

## **Transitional Services and Diversion Programs**

► **What We Should Do:**

- Increase access to peer support services pre-release in prison and transitional service programs
- Implement a peer-led, community-based deferred prosecution and diversion pilot program

► **Why It Matters:**

About 20,000 people are incarcerated in Wisconsin's prisons on any given day; on a per capita basis, this number has grown by quadruple over the last 40 years. The demographics of people

incarcerated in Wisconsin does not mirror those of the state, with a higher proportion of Black, Latino, and Native Americans being held in Wisconsin's prisons. People identifying as LGBTQ+, and those experiencing mental illness are also incarcerated at disproportionate rates. The structure of our nation's systems of justice, economics, social support, and education all play a part in these disparities.

Individuals need rehabilitative programs to prepare them for life after leaving prison. Incarceration removes people from their families and communities, damages their future housing and employment prospects, and weakens social connections. People currently incarcerated, and individuals who have been recently incarcerated, also face disproportionate rates of chronic health conditions, mental illness, and substance abuse.

These stark inequities and impacts underscore the need for programs that better position individuals to improve their lives and succeed in society after incarceration. To reduce the harms caused by incarceration, Wisconsin should support the development of peer-led services and programs that enable individuals to develop the skills and knowledge that they need to positively contribute to their communities, gain future employment, and successfully engage in society at large.

Two effective strategies include increasing the use of peer support in prison pre-release and transition services and peer-led community-based deferred prosecution and/or diversion programs. The peer-led aspect of these programs is key. Individuals with lived experience of incarceration are best positioned to empathize and positively engage with individuals at risk of incarceration. In these pre-release transition and diversion program models the peers are mentors, program leaders, and managers with meaningful decision-making power. These two programs, which focus on building life skills, furthering education, career and skill building, and community building, set individuals up to improve their lives rather than returning to the same environment facing the same challenges they did before incarceration.

► **What We Need to Think About:**

The first part of this recommendation calls for an increase in peer support services in prison pre-release and transitional service programs. A peer-led pre-release transition program could be designed through a collaboration between the Wisconsin Department of Corrections and people formally incarcerated who

could serve as peer leaders. The program could first be piloted at specific sites or with relatively small numbers of individuals across multiple sites. This peer support program would be run in complement to existing targeted re-entry programs, such as Opening Avenues for Reentry Success (OARS), run by the Department of Health Services and Department of Corrections.

The second part calls for implementing a peer-led, community-based deferred prosecution and diversion pilot program in collaboration with the Department of Justice and Department of Corrections. The program should be trauma-informed, and asset focused, and could be based on the Delancey Street Foundation model. Some case referral and administrative structures from existing treatment and diversion programs (TAD) and Treatment Court could also be used as a model for this new program. However, this program should not be treated as an expansion of existing treatment and diversion programs, but rather operate independently and be primarily shaped and run by the formerly incarcerated peers.

As with other pilot programs recommended by the Governor's Health Equity Council, these programs should be evaluated for effectiveness, as measured by preventing re-entries to prison and other health and social outcomes.

► **Where You Can Learn More:**

- Center for Prison Reform. "Diversion Programs in America's Criminal Justice System." Center for Prison Reform. 2015. [Jail-Diversion-Programs-in-America.pdf \(centerforprisonreform.org\)](#)
- Robertson et al. "Mental Health and Reoffending Outcomes of Jail Diversion Participation with a Brief Incarceration after Arraignment." Psychiatric Services Journal. 2014. [Mental Health and Reoffending Outcomes of Jail Diversion Participants With a Brief Incarceration After Arraignment | Psychiatric Services \(psychiatryonline.org\)](#)
- Bernard et al. "Health outcomes and cost-effectiveness of diversion programs for low-level drug offenders: A model-based analysis." Public Library of Science. 2020. [Health outcomes and cost-effectiveness of diversion programs for low-level drug offenders: A model-based analysis | PLOS Medicine](#)

## **Health Care of People Currently Incarcerated and Pregnant**

### **► What We Should Do:**

- Align state statute with federal law and guidelines related to shackling during labor and childbirth
- Supporting doulas to provide prenatal, birthing, and postpartum support
- Increase deferred prosecution and diversion opportunities for individuals who are pregnant

### **► Why It Matters:**

Pregnancy, labor, and childbirth can be physically and emotionally challenging. Being pregnant or delivering a baby while in jail may increase the risk for adverse physical and mental health outcomes for both the parent and baby. About 5% of people who are admitted to state prisons in the United States report being pregnant. In Wisconsin, policies exist requiring “timely and appropriate prenatal, intrapartum and postpartum care,” but more can be done to support individuals through labor, delivery, breastfeeding and pumping, and other pre- and post-pregnancy experiences.

Shackling, or physically restraining incarcerated people who are pregnant to prevent free movement, while they are giving birth can pose serious mental and physical risks to the mother and child. Federal law and United States Bureau of Justice guidelines prohibit the shackling of people who are pregnant and in federal custody with limited exceptions. Since 2018, the policy of the Wisconsin Department of Corrections for restraining people who are pregnant has been to use the least restrictive means necessary, and that restraint during labor and delivery is not used except when necessary. However, no equivalent policy for county jails in the state exists.

People currently incarcerated and pregnant also do not have full access to the people who can support them throughout their pregnancies. Doulas, a type of trained provider who offers emotional, informational, and physical support services, can help fill gaps in a person’s support systems. Prison doula programs exist in Illinois, Minnesota, and Michigan. These programs provide care, and train people who are incarcerated as doulas. Whether in or out of prisons, people who are pregnant and receive support from doulas typically have improved pregnancy experiences, which are linked to fewer medical treatments and interventions during labor and delivery.

Diversion, or providing an alternative to incarceration for certain individuals, and deferred prosecution programs, like the ARC Maternal and Infant Program in Madison, can help keep people who are pregnant out of prisons and connected to their communities and support systems, including their health care providers. This can result in better health outcomes for mothers and babies.

► **What We Need to Think About:**

Wisconsin should implement three policies for people who are pregnant and involved with Wisconsin's criminal justice systems: 1) align state statute with federal law and guidelines related to shackling, 2) allow people who are incarcerated to receive prenatal, birthing, and postpartum support from doulas, and 3) increase deferred prosecution and diversion opportunities.

To make sure restraint policies for individuals who are pregnant are the same in both state and county facilities, the Governor's Health Equity Council calls for changes to state law to require county-level shackling practices align with federal law. In 2017, a bipartisan bill banning the shackling of people who are pregnant in all correctional facilities, including jails, was proposed in the Wisconsin legislature but did not pass before the end of the session. This legislation should be re-introduced and passed in a timely manner.

The second part calls for the Department of Corrections to allow inmates to be assisted by trained doulas through their pregnancy and into the period following birth. The Governor's Health Equity Council urges the Department of Corrections, as a part of ongoing inmate job training efforts, to provide opportunities for people who are incarcerated themselves to be trained as doulas and to allow them to provide those services to fellow inmates, as desired. This would be a collaborative effort with the Department of Health Services.

The final part of the recommendation calls for creating diversion or deferred prosecution opportunities, whenever possible, for people who are pregnant and charged with non-violent offenses or technical or crimeless revocations. Policies to increase the referral of individuals who are pregnant to diversion and deferred prosecution programs would require coordination with and the cooperation of the Wisconsin Department of Justice. It may also require funding the development of additional specialized programs and policies specific to individuals who are pregnant through the state budgeting process

*"As a woman that just had a child, I cannot stress how important adequate health care is for a woman incarcerated. While I was blessed to be able to go through my pregnancy and delivery at home, I have witnessed the treatment of women while pregnant and incarcerated and it is not a fate I would wish on anyone. Pregnancy is both beautiful and traumatic, the changes a woman experiences to both her mind and body during and after require an attentiveness and care that just is not offered during incarceration. If we want to see the next generation healthier, we must take care of those tasked with bringing them into this world and raising them after. Everyone makes mistakes, but in order to make sure those mistakes aren't perpetuated by the next generation we need to also care for this one, even though, and especially when, incarcerated." Niki Schabo, Constituent Services, Office of Senator Lena Taylor*



► **What Wisconsinites Are Saying:**

“As a woman that just had a child, I cannot stress how important adequate health care is for a woman incarcerated. While I was blessed to be able to go through my pregnancy and delivery at home, I have witnessed the treatment of women while pregnant and incarcerated and it is not a fate I would wish on anyone. Pregnancy is both beautiful and traumatic, the changes a woman experiences to both her mind and body during and after require an attentiveness and care that just is not offered during incarceration. If we want to see the next generation healthier, we must take care of those tasked with bringing them into this world and raising them after. Everyone makes mistakes, but in order to make sure those mistakes aren’t perpetuated by the next generation we need to also care for this one, even though, and especially when, incarcerated.” Niki Schabo, Constituent Services, Office of Senator Lena Taylor

► **Where You Can Learn More:**

- Goshin and Colbert. “The Health of Incarcerated Pregnant Women: Some Much Needed Data and Beyond.” American Journal of Public Health. 2019. [The Health of Incarcerated Pregnant Women: Some Much Needed Data and Beyond - PMC \(nih.gov\)](#)
- Sufrin et al. “Pregnancy Outcomes in US Prisons, 2016-2017.” American Journal of Public Health. 2019. [Pregnancy Outcomes in US Prisons, 2016–2017 - PMC \(nih.gov\)](#)
- Daniel, Roxanne. “Prisons neglect pregnant women in their healthcare policies.” Prison Policy Initiative. 2019. [Prisons neglect pregnant women in their healthcare policies | Prison Policy Initiative](#)
- American College of Obstetricians and Gynecologists. “Reproductive Healthcare for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals.” American College of Obstetricians and Gynecologists. 2021. [Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals | ACOG](#)

# Governance

## *Health Equity Council Permanence*

### ► **What We Should Do:**

- Make the work and purpose of the Governor's Health Equity Council permanent. Potential ways to do this include forming an advisory body to the Office of Health Equity in the Department of Health Services, establishing the Council in state law, or transitioning to a grassroots network.

### ► **Why It Matters:**

Overcoming health inequities in our nation and state will require continued action. Making the work and purpose of this Council permanent can help continue forward momentum on issues of health equity that impact our most marginalized communities. As the Council has experienced through the course of its work, developing and researching ideas, clarifying, and describing how we can implement those ideas, and monitoring, and evaluating successes and failures are all essential functions to the pursuit of health equity.

We know a variety of academic, business, non-profit, and government entities in Wisconsin carry out these functions every day. A permanent, statewide group, such as this Health Equity Council, could help all these entities work together, facilitating continued and coordinated action towards achieving a state of health equity.

### ► **What We Need to Think About:**

This recommendation calls for Wisconsin to make permanent the work and purpose of the Governor's Health Equity Council. Several pathways exist to accomplish this goal, including forming an advisory body to the Department of Health Services' Office of Health Equity, establishing the Council in state law, or transitioning to a grassroots network.

This Council recognizes the benefits and challenges inherent to the variety of possible approaches to making this body a permanent fixture of Wisconsin's fight for health equity. It urges continued discussion among the Council's membership, advocacy organizations, and state leadership to identifying the most appropriate path forward.

► **Where You Can Learn More:**

- University of Wisconsin Population Health Institute. “2021 Wisconsin Population Health and Equity Report Card.” University of Wisconsin Madison School of Medicine and Public Health. [2021WIPopHealthEquityReportCard\\_FINAL.pdf \(wisc.edu\)](#)
- Wisconsin Collaborative for Healthcare Quality. “2020 Wisconsin Health Disparities Report: Rural and Urban Populations.” Wisconsin Collaborative for Healthcare Quality. 2020. [60d34ec43d2afb2a29b20765\\_2020\\_Rural\\_Urban\\_Disparities\\_Report\\_FINAL.pdf \(webflow.com\)](#)
- Wisconsin Department of Health Services. “Minority Health Report, 2018-2020: Advancing Health Equity in Wisconsin.” Wisconsin Department of Health Services. 2022. [Minority Health Report, Advancing Health Equity in Wisconsin](#)

## ***Transgender Health and Safety***

► **What We Should Do:**

- Establish an Interagency Council on Transgender Health and Safety, made up of members from state agencies and the community
- Charge the Council on Transgender Health and Safety with providing trainings, technical support, analysis, and recommendations to address the unique health and social needs of transgender persons.

► **Why It Matters:**

There are over 19,000 transgender individuals living in Wisconsin, many of whom face serious health and economic inequalities which interrupt basic aspects of their lives. On surveys and in other forums, transgender individuals have repeatedly and consistently identified their individual and collective needs for improved health care, legal protections, and employment free of discrimination.

Through community input on this recommendation, community members made clear the challenges transgender individuals face in securing jobs, stable and safe housing, patient-centered health care, and government services, including those necessary for updating names, birth certificates, passports, health insurance, and other forms. To help improve health outcomes of transgender

individuals, council and community members highlighted the need for more inclusive environments, more gender-neutral spaces, removing extensive gender identity documentation requirements, and increasing the visibility and representation of transgender individuals in government, business, and community-based organizations.

► **What We Need to Think About:**

The Governor’s Health Equity Council recognizes the many challenges transgender individuals face. Some of which may be practical and resolved through administrative or business process changes, while others may be systemic and rooted in our political climate and discourse. To help identify, adopt, and implement these changes, the Governor’s Health Equity Council calls for Wisconsin to establish an Interagency Council on Transgender Health and Safety, made up of representatives from state agencies, community organizations, and transgender individuals with lived experience. This new Interagency Council would also be composed of diverse membership in terms of race, ethnicity, geography, economics, and ability.

This permanent Interagency Council on Transgender Health and Safety would provide trainings, technical support, analysis, and recommendations to address the unique health and social needs of transgender persons. Goals would include:

- Increasing awareness of health disparities and unmet treatment needs of LGBTQ+ individuals
- Increasing knowledge among practitioners to decrease health disparities and stigma through the adoption of evidence-informed and evidenced-based best practices
- Accelerating adoption and implementation of best practices in health care and throughout the workforce

A dedicated body, tasked with providing various forms of support, analysis, and remedies, would best address the range of issues facing the transgender community. The Governor’s Health Equity Council envisions an Interagency Council on Transgender Health and Safety that looks like the existing Interagency Council on Homelessness and would be supported and staffed by the Department of Administration.

► **What Wisconsinites are Saying:**

- ❖ “Trans folks want the opportunity to thrive and want to exist with the support we need when we need it. Just like most humans do.” Syd Robinson, Milwaukee

*“Trans folks want the opportunity to thrive and want to exist with the support we need when we need it. Just like most humans do.”*

*—Syd Robinson, Milwaukee*

- ❖ “Empowerment of trans folks could be improved by ensuring trans people are at the table.” Anonymous, Green Bay

► **Where You Can Learn More:**

- Centers for Disease Control and Prevention. “Patient Centered Care for Transgender People: Recommended Practices for Health Care Settings.” Centers for Disease Control and Prevention. 2022. [Patient-Centered Care | For Health Care Providers | Transforming Health | Clinicians | HIV | CDC](#)
- Johns Hopkins Medicine. “Transgender Health: What You Need to Know.” [Transgender Health: What You Need to Know | Johns Hopkins Medicine](#)
- American College of Obstetricians and Gynecologists. “Health Care for Transgender and Gender Diverse Individuals.” American College of Obstetricians and Gynecologists. 2021. [Health Care for Transgender and Gender Diverse Individuals | ACOG](#)

## ***Environmental Justice***

► **What We Should Do:**

- Establish the Office of Environmental Justice (OEJ) to design climate policies that reduce emissions and pollutants and address the cumulative and deadly impacts of their concentration within disproportionately impacted communities
- Charge the Office of Environmental Justice with collaborating across state agencies and engaging with Black communities, Tribal nations, communities of color, low-income communities, and environmental justice advocates
- This supports the recommendation contained within the Governor’s Task Force on Climate Change and is consistent with the newly established Office of Environmental Justice created via Executive Order 161.

► **Why It Matters:**

Our health is closely tied to the air we breathe, the water we drink, the land upon which we farm, explore, and play, and the places where we live, learn, work, worship, and socialize. Research on environmental health and justice makes clear the connection between environmental injustices and poor health

*“Our deteriorating homes are the biggest cause of my community’s carbon footprint that cost us money and health problems with little job opportunities to fix our climate issues.” Trevonna Simms, Milwaukee*

outcomes. Environmental pollution is linked to asthma, cancer, and many other illnesses, and people living in poverty and communities of color are more likely to live in unhealthy environments.

History has repeatedly shown that people and communities who experience high levels of disadvantage are most likely to bear the brunt of environmental disasters. Current health disparities along with future extreme climate events will only make those disparities worse. By collaborating with and engaging with state agencies, advocates, and marginalized and low-income communities, the Office of Environmental Justice can design and coordinate policies to address the cumulative and deadly impacts of historical, current, and future environmental injustices.

► **What We Need to Think About:**

This recommendation supports the recommendation of the Governor's Task Force on Climate Change to establish an Office of Environmental Justice, and mirrors efforts in other Great Lakes states which have created administrative bodies overseeing work on environmental justice. On April 22, 2022, in celebration of the 52nd Earth Day, [Governor Evers created an Office of Environmental Justice through an Executive Order](#). This action by the Governor represents a powerful first step towards environmental justice, and the Council encourages the establishment of the Office of Environmental Justice in state statute to entrench its mission and purpose within the operation of state government.

► **What Wisconsinites are Saying:**

- ❖ “Our deteriorating homes are the biggest cause of my community’s carbon footprint that cost us money and health problems with little job opportunities to fix our climate issues.” Trevonna Simms, Milwaukee

► **Where You Can Learn More:**

The State of Wisconsin Office of the Governor. “Executive Order #161: Relating to the Creation of the Office of Environmental Justice.” 2022. [EO161-OEJ.pdf \(wi.gov\)](#)

United States Environmental Protection Agency. “Environmental Justice.” United States Environmental Protection Agency. 2022. [Environmental Justice | US EPA](#)

Wisconsin Department of Natural Resources. “Climate Change Impacts in Wisconsin.” Wisconsin Department of Natural

Resources. [Climate Change Impacts in Wisconsin | Wisconsin DNR](#)

Wisconsin State Health Department. “The Wisconsin Environmental Equity Tool.” Wisconsin State Health Department. 2022. [The Wisconsin Environmental Equity Tool | Wisconsin Department of Health Services](#)

## Health Data

### ► What We Should Do:

Cabinet-level agencies should undertake a variety of actions to advance a more just approach to the collection, analysis, use, and sharing of data, including:

- Examining existing data sharing agreements and opportunities for improvements
- Including a wider range of race and ethnicity options in collected data
- Providing guidance for health equity analyses and communications
- Assessing administrative burdens borne by individuals receiving health and social service public benefits

### ► Why It Matters:

Data can illuminate the existence of health disparities and health inequities, and it can shape our understanding of the social challenges we face both positively and negatively. As described in the Equitable Use of Data section, the ways in which data is collected, analyzed, used, and shared are all relevant to the pursuit of health equity. And though this set of recommendations focuses on state agencies, we know that advancing equity through responsible data collection and analysis spans business, government, academic, and other entities in the state.

### ► What We Need to Think About:

These recommendations build off the priorities and values laid out in the Equitable Use of Data section of this report. Our data must allow us to address the ways in which structural poverty and structural racism prevent us from advancing health equity and creates harm to the health of communities. Broadly, these recommendations fall within agencies' data sharing and collection, program administration, and communications functions, and seek to advance the underlying data goals of the Council.

Specifically, the Council recommends the following actions. Related to the data sharing and collection, the Council recommends Cabinet-level agencies of Wisconsin to:



- Review existing data sharing agreements to promote cross-agency collaboration and more universal analysis of all the factors influencing health outcomes
- Identify useful data held by other state agencies
- Identify gaps in useful inter-agency data
- Create data sharing agreements where appropriate
- Provide a report to the governor on regulatory, statutory, and other burdens needed to achieve effective and comprehensive data sharing

For example, several actions which would fall under this recommendation include:

- The Department of Health Services should create and maintain a dataset of non-health care determinants of health, using federal data, data held across state agencies, and other available data.
- Ensure agencies collect data with accurate age information and produce age-adjusted, race-disaggregated outcome estimates, where appropriate.
- Address opportunities or barriers to requiring birthing hospitals to collect and report standardized, granular, and nuanced data on race and ethnicity (and any other relevant demographic data such as socioeconomic status) on infant feeding practices.
- Address opportunities and barriers to implementing more granular and nuanced race and ethnicity data collection standards across state government to improve agencies' ability to disaggregate administrative and program data according to racial and ethnic groupings.
- Provide access to data held within the Homeless Management Information System to contracted Medicaid health management and managed care organizations.
- Identify and address barriers to improving the Wisconsin Immunization Registry, so health care payers and other groups working toward health equity can access the Registry.
- Related to the program administration and operations, the Governor's Health Equity Council recommends:
  - Require state agencies that run cash assistance, health and social services, and other health-adjacent service programs, to provide a report to the governor of their analyses of the costs imposed on people to apply for and maintain eligibility for these programs ("administrative burdens") and identify actions to reduce these burdens.

- Require health care data-aggregation entities working with the Department of Health Services to publicly report disparities in health care access and outcomes that as can be identified from health care claims data, which could also include state law modifications.
  - Require the Wisconsin Medicaid program and other health and human service programs to significantly increase pay-for-performance payments linked on meeting equity related performance standards.
  - Require state agencies to make policies and decisions with consideration of the racialized differences in both age and life-course stage of those people and groups for whom those policies and decisions affect.
- Related to how data and the analyses they support are communicated:
    - Direct the Department of Health Services, with the state public health association and the association of local public health agencies (WPHA and WAHL DAB), to establish training opportunities and resources for practitioners and communities related to community engagement in health equity analysis, health equity promotion, and equitable health care and community services.
    - Direct the Department of Health Services to create a "Health Equity Data Analysis Guide" for the Department, other state agencies, public health practitioners, health care organizations, community groups, and other interested parties. This should be a comprehensive guide to developing, performing, reporting, and communicating health equity analyses.
    - Direct the Department of Health Services, in collaboration with health care data organizations, communities, and other state agencies to develop a health communications guide that reflects a focus on health equity and reducing health disparities.

► **Where You Can Learn More:**

Wisconsin Department of Health Services. "Data and Statistics."

Wisconsin Department of Health Services. 2020. [Data and Statistics | Wisconsin Department of Health Services](#)

Minnesota Department of Health. “HEDA: Conducting a Health Equity Data Analysis. A Guide for Local Health Departments in Minnesota.” Minnesota Department of Health. 2022. [HEDA: Conducting a Health Equity Data Analysis | A guide for local health departments in Minnesota \[version 2.1\] \(state.mn.us\)](#)

Abraham et al. “Health Equity Data Analytics, Policy Recommendations Report: September 2020.” Health Equity Solutions, DataHaven, and the Equity Research and Innovation Center at the Yale School of Medicine. 2020. [Microsoft Word — HEDA recommendations Policy Recommendations Final.docx \(ct.gov\)](#)

Ulmer et al. “Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement.” Institute of Medicine, Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement. 2009. [Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement — PubMed \(nih.gov\)](#)

## **Maternal Mortality Review Process**

### **► What We Should Do:**

- Add family interviews to the Wisconsin Maternal Mortality Review (MMR) process
- Increase staffing and other resources to develop a process, conduct family interviews, foster partnerships, and develop outreach materials to ensure success

### **► Why It Matters:**

The Department of Health Services closely reviews every pregnancy-related death to identify contributing factors and provide recommendations to prevent future deaths. However, this Maternal Mortality Review process does not currently include gathering information from families and friends who may add understanding to the circumstances that contributed to the death. Conducting family interviews as a part of Wisconsin’s Maternal Mortality Review process would provide much needed social and environmental context as well as details around experience of care and interactions with providers.

The current Maternal Mortality Review process focuses on how the deaths could have been prevented. This includes looking at whether a change to patient, family, provider, facility, system, or community factors could have prevented it. The program also considers how the death was related to the pregnancy. This means looking at factors such as whether the death arose from a

complication of the pregnancy, resulted from a chain of events initiated by pregnancy, or came from the aggravation of an unrelated condition.

The program does not have data or information about the perceptions, experiences, and accounts of families and friends of the deceased person. This information can add to the understanding of the social and environmental contexts of a maternal death, and details around experiences of care and interactions with providers and systems. Using family interviews as part of the review would help identify factors such as stigma and discrimination that may have contributed to a maternal death but are not contained in providers' records. Using family interviews to elevate community voices in the process of identifying those factors contributing to a mother's death is a vital step in implementing policies to avert future maternal deaths.

► **What We Need to Think About:**

This recommendation calls for Wisconsin to increase staffing and other resources for reviewing incidents of maternal mortality. Presently, staff at the Department of Health Services review every death among mothers during, or in the year following pregnancy, to identify factors contributing to their deaths. At current levels of staffing, only provider records are reviewed to identify these factors, so the family perspective is missing from the review and recommendations. The Governor's Health Equity Council urges the Department of Health Services to seek the additional staff and resources it deems necessary for maternal mortality reviews to implement this recommendation.

Using family interviews would be consistent with the approach taken in investigations of other deaths, including fetal and infant deaths, overdose fatalities, and suicide. There is a growing national consensus that family interviews are a best practice in maternal mortality reviews, and an increasing number of states have begun conducting them. The Governor's Health Equity Council understands that family members of a deceased mother may not want to participate in an interview, and as such urges that these interviews be conducted voluntarily.

► **Where You Can Learn More:**

Wisconsin Department of Health Services. "Wisconsin Maternal Mortality Review: Recommendations Report." Wisconsin Department of Health Services. 2018. [Maternal Mortality Review Team Recommendations Report \(wisconsin.gov\)](https://www.wisconsin.gov/health-services/maternal-mortality-review)

Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. “Annual Wisconsin Birth and Infant Mortality Report, 2017.” [Wisconsin Department of Health Services. 2019. 2017 Annual Birth Report \(P-01161-19\) \(wisconsin.gov\)](#)

Centers for Disease Control and Prevention. “Informant Interview Guide for Maternal Mortality Review Committees.” Centers for Disease Control and Prevention. 2019. [Informant Interview Guide for Maternal Mortality Review Committees \(cdc.gov\)](#)

Wisconsin Department of Health Services. “Severe Maternal Morbidity among Wisconsin Residents, 2010-2014.” Wisconsin Department of Health Services. 2015. [Severe Maternal Morbidity among Wisconsin Residents, 2010-2014](#)

## Family-Sustaining Fiscal Policy

### *Minimum Wage*

#### ► **What We Should Do:**

- Incrementally increase the minimum wage over the next three years from the current \$7.25 per hour to \$8.60, \$9.40, and \$10.15, indexed to inflation, with the goal of eventually achieving a \$15 an hour minimum wage
- Create a taskforce (made of diverse stakeholders representing the interests of government, small businesses, large businesses, and community advocates) to develop a plan for achieving and implementing a statewide \$15 per hour minimum wage, or an inflation-adjusted equivalent
- Require that an interim report be completed and a final report within two years by the taskforce
- Charge the taskforce with establishing appropriate supports to small and local business owners to achieve this goal

#### ► **Why It Matters:**

We know that income can be a key driver of what makes individuals and communities healthy. Implementing policies that address poverty also can improve health. For people who earn the minimum wage, raising it to \$15 an hour would immediately increase their earnings and, depending on their family size, would raise them above the poverty rate. A two-person household with one wage earner at the current minimum makes \$15,080 working full time (2,080 hours) in a year. That same household, under a \$15 per hour minimum wage would make \$31,000.

About 8% (377,833) of people who identify as Non-Hispanic white in Wisconsin live in poverty, compared to 30% (105,895) of people who identify as Black, 25% (11,399) of people who identify as Native American, 20% (77,861) those who identify as Hispanic, and 15% (24,001) of those who identify as Asian. This disparity means that a Black person in Wisconsin is more than three times as likely to live in poverty as a white person. Similarly, about 10.6% of rural Wisconsin residents live in poverty. And across all racial and ethnic groups, poverty rates are higher in rural areas than in urban areas. The minimum wage increase would lift the wages of half of Black workers, over half of Hispanic workers, one-third of Asian workers, and one-quarter of white workers.

► **What We Need to Think About:**

States can set their minimum wages higher than the federal minimum wage, and most states have done so. Wisconsin has not, and so our minimum wage remains at \$7.25. Over the last few years, the de-facto minimum wage has increased for many people in the state; however, the most vulnerable people in society are still earning \$7.25 an hour, and over 20% of Wisconsin workers make less than \$15 an hour.

Wisconsin Statutes establish the minimum wage for a variety of types of employees, including general employees, minors, tipped workers, and agricultural laborers. Although our formal recommendation specifically applies to general, minor, and agricultural employees, the Governor’s Health Equity Council supports increasing wages for all employees, including tipped employees.

If this recommendation is pursued, the Governor’s Health Equity Council recommends appointing a taskforce within six months after the adoption of this recommendation to develop a pathway to a \$15 per hour minimum wage. An interim report should be completed within 18 months detailing the progress the task force has made up to that point, and a final report within two years. Membership should be composed of government, business, including small business owners, and community stakeholders. The primary charge of the taskforce would be to develop an implementation plan within two years, and to ensure appropriate supports for small and local businesses. Most likely, additional staff would be needed to effectively administer these changes.

► **What Wisconsinites Are Saying:**

*“Minimum wage is not livable wage... For a single parent rent for a 2 bedroom isn’t affordable.”  
–Anonymous, Glendale WI*

- ❖ “Minimum wage is not livable wage... For a single parent rent for a two bedroom isn’t affordable.” Anonymous, Glendale WI
- ❖ “Not enough resources for middle class workers. Health care costs and living expenses have increased significantly in the past few years and both adults in the house have two jobs and cannot make all the bills.” Anonymous, Glendale WI

► **Where You Can Learn More:**

Economic Policy Institute. “Why the U.S. needs a \$15 minimum wage: How the Raise the Wage Act would benefit U.S. workers and their families.” Economic Policy Institute. 2021. [Why the U.S. needs a \\$15 minimum wage: How the Raise the Wage Act would benefit U.S. workers and their families | Economic Policy Institute \(epi.org\)](#)

Parilla and Liu. “A \$15 minimum wage would help millions of struggling households in small and mid-sized cities achieve self-sufficiency.” Brookings Institution. 2021. [A \\$15 minimum wage would help millions of struggling households in small and mid-sized cities achieve self-sufficiency \(brookings.edu\)](#)

Center on Wisconsin Strategy. “What a \$15 Minimum Wage Means for Working Wisconsin.” Center on Wisconsin Strategy. 2021. [What a \\$15 Minimum Wage Means for Working Wisconsin – COWS – UW–Madison](#)

Wisconsin Budget Project. “Give Wisconsin a Raise: Increasing the Minimum Wage to \$15 Would Increase Pay for a Broad Range of Workers.” Wisconsin Budget Project. 2021. [Give Wisconsin a Raise: Increasing the Minimum Wage to \\$15 Would Increase Pay for a Broad Range of Workers - Wisconsin Budget Project](#)

## **Earned Income Tax Credit**

► **What We Should Do:**

- Extend eligibility for the state's Earned Income Tax Credit (EITC) to adults without dependent children
- Direct state agencies to develop and implement a plan to increase the number of Wisconsinites who receive the federal Earned Income Tax Credit, particularly among adults without dependent children
- Increase the credit for households with children.
- Allow spouses who are survivors of domestic violence to claim the credit regardless of marital status



► **Why It Matters:**

The Earned Income Tax Credit is a tax credit that gives people back money earned from a job. The Earned Income Tax Credit has been an effective tool for boosting the income of low-wage working parents and thereby reducing the detrimental effects of poverty on the health of those workers and their families. Documented positive health effects of the credit include reducing the number of low-birthweight children and lowering rates of cigarette smoking. Also, adults work a greater number of hours and have higher earnings when, as children, their families received Earned Income Tax Credit payments.

However, there is a very large gap in who benefits from the Earned Income Tax Credit. The federal credit for adults without dependent children is small and has restrictive eligibility criteria. Worse yet, Wisconsin is the only state with a state Earned Income Tax Credit that has not expanded it to adults without dependent children. These low-wage workers pay millions more in state and local taxes than they otherwise would, miss out on the health and economic benefits that are associated with receiving the tax credit, and may have difficulties making ends meet. Expanding eligibility for this tax credit would improve health outcomes for low-income people, particularly people from marginalized communities and low-wage workers in rural communities.

Both the federal and state Earned Income Tax Credit help make work more attractive by increasing the income of low-wage workers. One shortcoming of the Earned Income Tax Credit, and other tax credits, is that people must file a tax return to receive it, even if they owe no taxes. This prevents many eligible people from receiving it. A high percentage of low-income parents file tax returns because they are aware they are eligible for tax credits. This is not true for low-income workers with no children.

► **What We Need to Think About:**

The Governor's Health Equity Council recommends extending state Earned Income Tax Credit eligibility to adults without dependent children. This would require a change to state law. The recommendation also calls for state agencies to develop and implement a plan to increase the number of Wisconsinites who receive the federal Earned Income Tax Credit, particularly adults without dependent children. Increasing awareness of tax credits, along with information about tax filing assistance, is one way to increase federal Earned Income Tax Credit payments to Wisconsinites.

At the same time, while expanding the Earned Income Tax Credit eligibility for adults without dependent children, the Governor’s Health Equity Council also recommends increasing the Wisconsin credit for households with children to make sure that Wisconsin is doing all it can to support healthy kids and families. Wisconsin statutes set the Wisconsin Earned Income Tax Credit as a percentage of the federal credit, depending on the number of dependents of the filer. On average, the credits for households with one and two dependents were \$88 and \$372 in 2017. Under this recommendation, this tax credit would increase to around \$352 and \$845.

Finally, the Governor’s Health Equity Council wants survivors of domestic violence, whose filing status would otherwise not allow them to qualify, to remain eligible for the Wisconsin Earned Income Tax Credit. This would require a change in state law and implementing this would require consultation with subject area experts and people with lived experience, such as the Governor’s Council on Domestic Abuse.

► **Where You Can Learn More:**

Center on Budget and Policy Priorities. “Fixing the Glaring Gap in the EITC for ‘Childless Workers.’” Center on Budget and Policy Priorities. 2016. [Chart Book: The Earned Income Tax Credit and Child Tax Credit | Center on Budget and Policy Priorities \(cbpp.org\)](https://www.cbpp.org/chart-book/the-earned-income-tax-credit-and-child-tax-credit)

Marr et al. “EITC and Child Tax Credit Promote Work, Reduce Poverty, and Support Children’s Development, Research Finds.” Center on Budget and Policy Priorities. 2015. [EITC and Child Tax Credit Promote Work, Reduce Poverty, and Support Children’s Development, Research Finds | Center on Budget and Policy Priorities \(cbpp.org\)](https://www.cbpp.org/eitc-and-child-tax-credit-promote-work-reduce-poverty-and-support-childrens-development-research-finds)

Komro et al. “Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity.” Health Equity. 2019. [Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity | Health Equity \(liebertpub.com\)](https://liebertpub.com/eitc)

## **Guaranteed Income Pilots**

► **What We Should Do:**

- Implement a guaranteed income pilot program to reach individuals living in poverty in five economically marginalized communities throughout the state

- Rigorously evaluate the program's economic and health impacts to participants and communities

► **Why It Matters:**

Income is closely tied to health, perhaps in no starker terms than the close association between one's level of income and with risk of disease onset and premature death. Income shapes health outcomes through a variety of pathways over the entire lives of individuals and families — including by impacting access to high-quality health care and housing, nutritious foods, opportunities for physical activity, and exposures to any variety of physical stressors. For those who are economically marginalized — people experiencing greater obstacles to contributing to and benefiting from the economy — income and health create health-poverty traps, where less income contributes to poor health, and poor health further reinforces low economic status.

Systemic issues impacting educational and economic opportunity contribute to poverty and income inequality across Wisconsin. For example, per capita income in rural areas (\$49,842) is more than 13% lower than in urban areas (\$57,586). Nearly three times the proportion of Black and Native American Wisconsinites are living in poverty (27.3% each) than white, non-Hispanic Wisconsinites (7.9%). Refugee and recent immigrant groups similarly face economic barriers and inequities in Wisconsin. The wealth gap in the United States is also significant. For every \$1 of wealth held by a white family a Black family holds only \$0.12. These patterns repeat across many indicators of economic success, indicating systemic origins of the inequalities.

Guaranteed income programs increase income, thus reducing poverty which can help lessen the economic hardships experienced by individuals and families experiencing economic marginalization. This allows them to dedicate a greater portion of their time and money to essential daily functions, including pursuing employment and educational opportunities, maintaining stable housing and food security, and tending to their mental and physical health — activities which support an individual's ability to be self-sufficient.

And these programs have been successfully piloted internationally and, less extensively, in locations across the United States. Some examples include:

- The SEED program in Stockton, California, provided 125 residents randomly selected from below-median income neighborhoods with \$500 per month for two years.

- The Magnolia Mother’s Trust in Jackson, Mississippi, provided 130 Black mothers living in affordable housing with \$1,000 per month for 12 months.
- The recently launched Just Income GNV in Alachua County, Florida, will provide 115 individuals who are formerly incarcerated or beginning felony probation with an initial \$1,000 payment, then \$600 in each of the following 11 months.
- The State of California is starting the first state-level, taxpayer funded guaranteed income program in the US, with \$35 million over five years to provide up to \$1,000 a month to individuals who are pregnant and young adults who recently left foster care.

► **What We Need to Think About:**

The Wisconsin pilot program would be implemented in five marginalized communities throughout the state and would reflect geographic (rural and urban), and demographic diversity. Pilot locations may be selected through a competitive application process open to city- and county-level governmental agencies in partnership with community-based organizations.

The details of pilot program target populations, how much funding each participant receives, and other details related to the scope of pilot programs could be decided on and described by the applicant city/county in their application. The Governor Health Equity Council recommends that participating households in the pilot receive monthly payments of at least \$500 and qualify if their income is at or below 200% of the federal poverty level. The pilots should protect participant’s access to and eligibility for critical income-based support programs, such as Medicaid.

After the pilot, a rigorous evaluation would provide policy makers and the public with an opportunity to observe the economic and health effects of the approach by measuring financial stability, career advancement, health behaviors, and health outcomes.

► **Where You Can Learn More:**

The Stockton Economic Empowerment Demonstration. “Key Findings.” Stockton Demonstration. [SEED \(stocktondemonstration.org\)](https://www.seedstockton.org/)

Springboard to Opportunities. “The Magnolia Mother’s Trust.” Springboard to Opportunities. The Magnolia Mother’s Trust - [Springboard to Opportunities](https://www.springboardtoopportunities.org/)

Just Income GNV. “Guaranteed Income for Our Justice-Impacted Neighbors.” Just Income GNV. [Just Income GNV \(jignv.org\)](http://jignv.org)

California Department of Social Services. “Guaranteed Income Pilot Program.” California Department of Social Services. [Guaranteed Basic Income Projects \(ca.gov\)](http://ca.gov)

## **Baby Bonds – Child Savings Accounts**

### ► **What We Should Do:**

- Provide an initial payment to all babies born in the state.
- Make an additional annual payment ranging from \$100 to \$2,500 based on family income
- Funds would be available when the child turns 18
- Funds would be eligible for expenses such as education, purchasing a primary residence home, starting or expanding a business, obtaining a license or certification, retirement investment, and medical expenses
- Create a taskforce to be charged with developing implementation policies for administering the program

### ► **Why It Matters:**

A person’s income-level is strongly associated with their health outcomes. For adults and children, across and between races and ethnic groups, the lower your income, or the income of your parents, the more likely you are to be not in very good health.

Baby bonds are one strategy the state can employ to foster economic security, close the wealth gap, and facilitate good health. Implementing a baby bond program would provide our state with a powerful tool to combat persistent inequities for future generations of Wisconsinites across race-, income- and place-based disparities. Our state’s future rests on the well-being of its children who will grow up to be its future leaders. These children will make up the essential workforce we will need as a state to continue to progress forward.

The proportion of aging people in our state is growing, which is placing more pressure on working-age people. One of the drivers of this pattern is migration out of the state, especially among young people. A study looking at migration patterns in the state between 2015 and 2016 found that Wisconsin lost 7,078 individuals, or .015% of its population. Most of this loss came from people under the age of 26. The baby bonds initiative is one way to incentivize young people to not only come to Wisconsin, but to remain in Wisconsin, start families, and contribute to the state’s economy.

Additionally, the costs of pursuing higher education and acquiring housing and establishing business continues to rise. A baby bonds initiative can provide an essential lifeline to Wisconsin's future adults, providing them with resources that can help empower them by removing barriers to making choices that they may not be able to make without those resources.

Finally, given how income inequality is distributed in our state by race and place, a baby bonds initiative would allow Wisconsin to not only invest in each child birthed in our state, but to do so in a way that would allow us to reach children born in the most vulnerable and marginalized situations. By investing in the futures of our state's children, we are investing in a strategy that will help protect and preserve the economic health and well-being of our state and its future leaders.

► **What We Need to Think About:**

The program would consist of an initial payment to every child born in Wisconsin and ongoing annual payments to qualifying children. The money would be deposited into an interest-bearing account and would become available to the child upon their eighteenth birthday. Upon birth, all children would receive an initial payment of \$3,600. Children would receive additional annual deposits ranging from \$100 to \$2,500 until they reach the age of 18. The annual amount deposited would be based on factors like household income, foster care status, and parents' incarceration status. Baby bond funds would be able to be used for a variety of purposes, including educational expenses, purchase of home, business start-up or expansion costs, rollover to retirement accounts, or other purposes as determined by the taskforce.

The Governor's Health Equity Council recommends a taskforce be created and charged with providing policy and implementation guidance. Most significantly, the Council recommends Wisconsin's Baby bond program be statutorily authorized and made available to all children born in the state.

► **Where You Can Learn More:**

Kent and Ricketts. "Has Wealth Inequality in America Changed over Time? Here are Key Statistics." Federal Reserve Bank of St. Louis. 2020. [Wealth Inequality in America over Time: Key Statistics | St. Louis Fed \(stlouisfed.org\)](https://www.stlouisfed.org/wealth-inequality-in-america-over-time-key-statistics)

Braveman et al. “Wealth Matters for Health Equity.” Robert Wood Johnson Foundation. 2018. [Health and Wealth: Wealth Matters for Health Equity - RWJF](#)

Kijazaki and Carther. “How Baby Bonds Could Help Americans Start Adulthood Strong and Narrow the Racial Wealth Gap.” The Urban Institute. 2020. [How Baby Bonds Could Help Americans Start Adulthood Strong and Narrow the Racial Wealth Gap | Urban Institute](#)





# Further Reading

Avila C., Frakt, A. Raising the Minimum Wage and Public Health. *JAMA Health Forum*. 2021;2(1):e201587. doi:10.1001/jamahealthforum.2020.1587

Barrett, R. The digital divide is not just in rural America. In poorer urban neighborhoods, internet access remains elusive. *Milwaukee Journal Sentinel*, Dec. 8, 2021. <https://www.jsonline.com/in-depth/news/2021/12/08/millions-urban-households-cant-afford-decent-internet-service/8742282002/>

Coates, T. The Case for Reparations. *The Atlantic*, June 2014.

Cook, L.D. Violence and economic activity: evidence from African American patents, 1870–1940. *Journal of Economic Growth* 19, 221–257 (2014). <https://doi.org/10.1007/s10887-014-9102-z> .

Office of Management and Budget. Study to Identify Methods to Assess Equity: Report to the President. July 2021

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Smedley B., et al., editors. Washington (DC): National Academies Press (US); 2003. PMID: 25032386.

Komro, K., et al. Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity. *Health Equity*, 2019;3(1): 61-67. <http://doi.org/10.1089/heq.2018.0061> .

LaVeist T., et al. Estimating the economic burden of racial health inequalities in the United States. *International Journal of Health Services*, 2011;41(2):231-238. doi: 10.2190/HS.41.2.c. PMID: 21563622.

Ray, V., Herd, P., Moynihan, D. Racialized Burdens: Applying Racialized Organization Theory to the Administrative State. *Journal of Public Administration Research and Theory*, 2022; <https://doi.org/10.1093/jopart/muac001> .

Report to the Governor: Governor’s Investigating Committee on Problems of Wisconsin’s Spanish Speaking Communities. Madison, WI: Governor’s Investigating Committee on Problems of Wisconsin’s Spanish Speaking Communities, 1971.

Report of the Secretary’s Task Force on Black and Minority Health. Washington, DC: US Dept. of Health and Human Services; 1985

Thomas S., Casper E. The burdens of race and history on Black people’s health 400 years after Jamestown. *American Journal of Public Health*, 2019;109(10): 1346-1347.

Wisconsin Department of Administration. Tribes of Wisconsin. Updated February 2022. [https://doa.wi.gov/DIR/Tribes\\_of\\_Wisconsin.pdf](https://doa.wi.gov/DIR/Tribes_of_Wisconsin.pdf)

Wrigley-Field, E., et al. COVID-19 Mortality At The Neighborhood Level: Racial And Ethnic Inequalities Deepened In Minnesota In 2020. *Health Affairs*, 40:10.

Wrigley-Field, E. US racial inequality may be as deadly as COVID-19. *Proceedings of the National Academy of Sciences*, 2020;117(36):21854-21856; DOI: 10.1073/pnas.2014750117.

Zimmerman F., Anderson, N. Trends in Health Equity in the United States by Race/Ethnicity, Sex, and Income, 1993-2017. *JAMA Network Open*. 2019;2(6):e196386. doi:10.1001/jamanetworkopen.2019.6386.





# Appendices



## Governor's Health Equity Council Member Biographies\*

**Maria Barker** is the Director of Latinx Programs and Initiatives for Planned Parenthood of Wisconsin, Inc. (PPWI). Most of Maria's programs are facilitated in Spanish to meet the needs of the communities she serves throughout Wisconsin. Maria is a graduate of the Latino Nonprofit Leadership Program through the University of Wisconsin-Milwaukee and Cardinal Stritch University. She is a certified Sexuality Educator by Planned Parenthood of Western Washington and Centralia College.

**Lt. Governor Mandela Barnes** serves as Wisconsin's 45th Lieutenant Governor. He graduated from Alabama A&M University and then worked for the city of Milwaukee mayor's office and as an organizer for Milwaukee Inner-City Congregations Allied for Hope, a Milwaukee-based interfaith coalition that advocates for social justice. In 2012, Lt. Governor Barnes was elected to the Wisconsin State Assembly, where he served two terms. Within his current role, Lt. Governor Barnes serves as the Chair of the Governor's Task Force on Climate Change and also serves on the Wisconsin Criminal Justice Coordinating Council, Wisconsin Missing and Murdered Indigenous Women Task Force, Governor's Council on Financial Literacy and Capability, and the statewide 2020 Census Complete Count Committee.

**Shiva Bidar-Sielaff**, MA, is the UW Health Vice President for Diversity, Equity and Inclusion and University of Wisconsin Associate Dean for Diversity and Equity Transformation. She completed her undergraduate degree at Ecole d'Interprètes Internationaux in Mons, Belgium, followed by a Master of Arts in International Policy

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\* As of December, 2022.

Studies at Monterey Institute of International Studies in California. In 2015 she earned a Certificate in Diversity Management from Georgetown University. In 1997 she first joined the health system to establish UW Health's medical interpretation services program. She became director of community partnerships for UW Health, and then UW Health Chief Diversity Officer. Bidar-Sielaff served as an alder on the City of Madison Common Council, co-chairs the Latino Health Council of Dane County, and is a member of the Madison Community Foundation Board.

**Sandra Brekke** works as a Senior Consultant to the Office of Population Health at Gundersen Health System. She holds a Bachelor of Science in Nursing and master's degree in Servant Leadership.

**Stacy Clark** is a community health and equity champion whose professional work highlights the importance of cross-pollinating HIV prevention interventions into political platforms and policies that help marginalized communities of color through empowerment and increase awareness of HIV. Stacy studies Public Health at the University of Wisconsin- Milwaukee as he works forward to eliminate HIV and provide a voice for vulnerable populations.

**Dr. Amy DeLong** is a family physician, medical director, and a Ho-Chunk tribal member who has worked for the Ho-Chunk Nation Department of Health since 2006. She received her Bachelor of Science from the University of Michigan, completed medical school at the University of Minnesota and completed her training in family medicine at Hennepin County Medical Center in Minneapolis, MN. She earned her Master's in Public Health in the maternal child health track while completing an adolescent health fellowship through the University of Minnesota Department of Pediatrics. Her passions include public health efforts to prevent chronic disease like obesity, especially in childhood, promoting healthy pregnancy outcomes, reducing health disparities by diversifying the workforce, and being outdoors with her family.

**Diane Erickson** is a member of the Red Cliff Band of Lake Superior Chippewa Indians. In 2017, she was hired as the Health Services Administrator. She has twenty plus years of experience in Health Administration. Her education includes a bachelor's degree in Accounting/Finance and a master's degree in Organization Change Leadership. Outside of her Tribal position, she served on the Board of Directors for the NorthLakes Community Clinic for five years.

**Gina Green-Harris** is director of the Wisconsin Alzheimer's Institute Regional Milwaukee Office, as well as director of the UW School of Medicine and Public Health Center for Community Engagement and Health Partnerships (CCEAHP) in Milwaukee, director of the All of Us Research program in Milwaukee, and director of the Lifecourse Initiative for Healthy Families (LIHF). Green-Harris has expertise in the areas of health equity, diversity and inclusion, cultural competency, leadership development, and research. She has received numerous awards and recognition for her work, including a 2019-2020 UW-Madison Outstanding Woman of Color Award. In September 2020, she was appointed to chair the Governor's Health Equity Council. Green-Harris received her Master of Business Administration from Franklin University in Columbus, OH and her Bachelor of Science at Central State University in Wilberforce, OH.

**Janel Hines** is the Vice President of Community Impact for the Greater Milwaukee Foundation. She joined the Foundation in January 2011 and provides strategic leadership and oversight of the Foundation's discretionary grantmaking, civic engagement, and collaboration efforts. Ms. Hines facilitated the development and implementation of a racial equity and inclusion framework to incorporate in the Foundation's discretionary grantmaking, research, and public policy work. Before joining the Foundation, she worked for the Wisconsin Departments of Children and Families, Health and Family Services, and Workforce Development. Prior to her



time with the state government, she worked in nonprofit management and administration. She attended the University of Wisconsin – Madison, where she received her Bachelor of Art and Juris Doctorate degrees.

**Dr. Tito Izard** is president and chief executive officer of Milwaukee Health Services Inc. He oversees the health of more than 30,000 low-income residents in Milwaukee. A graduate of the Milwaukee Public Schools system, Izard also graduated from Marquette University and the University of Wisconsin-Madison’s School of Medicine and Public Health. Izard has more than 12 years of experience as an educator, instructor and director of medical practices focused on urban health issues. He has been recognized nationally for his model of recruitment and retention of providers committed to working with disparate populations, and currently employs more underrepresented minority physicians and practitioners than any other medical practice in the state.

**Gale Johnson** is the Director of the Wisconsin Well Woman Program in the Department of Health Services. Ms. Johnson is a past Chair of the CDC Council for Breast and Cervical Cancer Prevention and Control. For three years she was also a member of the CDC’s National Breast and Cervical Cancer Early Detection and Control Advisory Committee. For many years, Ms. Johnson has been a very active member of the Wisconsin Women of Color Network. She has also been a member of the African American Health Network of Dane County since its inception in 2003. Recognizing the importance of women living long healthy lives, Ms. Johnson has coordinated health programs for both organizations.

**Vincent P. Lyles** is system vice president of Community Relations at Advocate Aurora Health. He served as the president and CEO of the Boys & Girls Clubs of Greater Milwaukee from 2011 to 2018. Prior to joining Boys & Girls Clubs of Greater Milwaukee, Lyles served as president of M&I Community Development Corp (CDC), was a vice president with Robert W. Baird & Co. providing financial advice to Wisconsin municipalities, school districts and special taxing units, and worked for the City of Milwaukee under Mayor John Norquist as an election commissioner. Prior to becoming a member of the mayor’s cabinet, he was the executive director of the City of Milwaukee’s Emerging Enterprise Program. Lyles began his professional career in Milwaukee as an assistant district attorney in the Milwaukee County District Attorney’s Office.

**Dr. Julie Mitchell** provides clinical expertise, population health leadership, and medical direction of care management to drive strategic priorities for the Anthem Wisconsin Commercial Health Plan. Dr. Mitchell partners with other health plan leaders to increase value for members, focusing on managing health care cost and improving quality. Dr. Mitchell has 20 years of experience in primary care and population health. Prior to joining Anthem in 2018, she served as the Chief Population Health Management Officer for the Medical College of Physicians, a multi-specialty practice comprising 1500 physicians and advanced practice providers in an academic medical center. She continues to practice in a teaching primary care clinic. Dr. Mitchell is a licensed, board-certified, and practicing specialist in Internal Medicine. She earned her bachelor’s degree and medical degree from the University of Wisconsin-Madison. She completed her residency at the University of Pittsburgh and her fellowship in Women’s Health along with Master’s in Population Health at the University of Wisconsin-Madison.

**Patty Metropulos** has served as President & CEO of Kathy’s House since 2012. Under her tenure, agency operations have tripled, and Kathy’s House is now recognized as a vital link in the SE Wisconsin health care supply chain. Patty spearheaded an effort to build a larger facility, which opened in June of 2021 and serves as a national model in hospital guest housing. She is passionate about providing equitable access to the social determinants of health, including housing, nutrition, and the support of family. Honors include Milwaukee Business Journal Women of Influence, a Milwaukee BizTimes Health care Hero, a “Betty” from Milwaukee Magazine and appointment to the WI Governor’s Health Equity Council. Patty has a bachelor’s in Political



Science and Economics from Indiana University and a master's in Public Administration from the University of Washington, Seattle.

**Isaak Mohamed** works as a Community Liaison officer for Barron School District and as a Community Health Worker for Barron County department of Health Human Services. Isaak holds a bachelor's degree in Social Worker and Social Administration.

**Wanda Montgomery** received a Master of Science in Educational Policy and Leadership from Marquette University and a Bachelor of Science in Community Education from UW-Milwaukee. Until her recent retirement, Wanda served as Director of Community Partnerships at Children's Hospital of Wisconsin.

Wanda has served on numerous boards and committees in Wisconsin and nationally. Wanda was elected to the National Black Child Development Institute Board of Directors (BCDI) in 2010 and served through December of 2015. She also served as BCDI-Milwaukee President until November 2020. Wanda was an ad hoc instructor with the School of Education at UW-Milwaukee for more than ten years and published three books on quality childcare programming. In 2018 Wanda was elected as a trustee to the Village of Brown Deer board, and in 2019 she was elected President of the Village of Brown Deer. In June of 2020 Wanda became the author of "Influence | It's More Than A Position."

**Tia Murray** is the Founder and CEO of Harambee Village Doulas. She is a certified Birth Doula, through DONA (Doulas of North America International), and a certified lactation counselor. Mrs. Murray is also a Ph.D. student at the University's School of Human Ecology, studying the intersections of Reproductive Justice and Human Development and Family Studies. Tia has passionately worked with parents, children, and families in multiple capacities throughout her professional career. Her work has focused heavily on social justice, reproductive justice, access to culturally inclusive maternal and child health care, and the promotion of community-based intervention and prevention programming. Tia, an aspiring Midwife, also has specialized training in Infant Mental health and is certified in the Newborn Behavioral Observation (NBO) system through the Brazelton Institute.

**Tamra Oman** is the new statewide director for the FREE Campaign which strives to develop spaces to lift the voices of women impacted by the justice system and empower them to address the unique challenges they, and others face. Prior to this role, Tamra worked 12 years for the Wisconsin Department of Health Services as a Human Services Program Coordinator Recovery Support Specialist at the Wisconsin Resource Center. Tamra is the 2015 recipient of the State of Wisconsin's Virginia Hart award. She is a national speaker, consultant, group facilitator, and believes deeply in cultivating a culture of hope, healing, and compassion for all. She is a co-founder of Hope Road – Soul Punch Skill Training (with love), a consulting business. Over the last 17 years she has been working with individuals in the criminal justice system with addiction and mental health challenges. She has also been an AODA Counselor for 10 years.

**Lilliann M. Paine**, MPH is the Director for Technical Assistance for the National Birth Equity Collaborative (NBEC). She is responsible for leadership and project management and the coordination of delivery of training and technical support on behalf of the Technical Assistance Team. The NBEC current portfolio includes Safer Childbirth Cities Initiative, Commonwealth Fund and Robert Wood Johnson Foundation Birth Justice Fund. Ms. Paine brings nine years of experience in public health, technical assistance, and project management. She is the architect behind the Wisconsin Public Health Association's (WPHA) 2018 Resolution: "Racism Is a Public Health Crisis." She facilitated the resolution's adoption in Milwaukee, which marked the first municipality to do so. Ms. Paine received a Master of Public Health degree with a concentration in Community and Behavioral Health Promotion as a premiere graduate of the UW-Milwaukee Zilber School of Public Health.

**William Parke-Sutherland** William is the senior health policy analyst at Kids Forward where he pursues policy solutions so that all Wisconsinites, especially those in cycles of poverty and experiencing health inequities, have access to affordable, quality health care, moving toward universal coverage. He leads Kids Forward's work in Medicaid policy, immigration-related health issues, and the Affordable Care Act. William serves on the pediatric policy council of the American Academy of Pediatrics Wisconsin Chapter, and the Office of Children's Mental Health. Prior to that, William served as the executive director for Grassroots Empowerment Project, a mental health advocacy and training organization where he engaged policymakers, health providers, advocates, and other partners to empower people with mental health challenges.

Lisa Peyton-Caire is the Founding CEO & President of The Foundation for Black Women's Wellness. Lisa previously served as Assistant Vice President of Life, Learning and Events at Summit Credit Union (2014-2018) where she and her team led the company's efforts on Diversity & Inclusion, Employee Wellness, Financial Education, Community Giving, and Corporate Events. Lisa serves on the board of Unity Point-Meriter Health, the Center for Resilient Cities, and the UW Population Health Institute Advisory Board; and previously served on the boards of Sustain Dane and A Fund for Women. Lisa holds a Master of Science degree in Educational Leadership & Administration and a Bachelor of Arts in Sociology from the University of Wisconsin-Madison.

**Guy (Anahkwet) Reiter** is the Executive Director of Menikanaehkem Inc. and a Menominee Indian Organizer. Anahkwet is a traditional Menominee who resides on the Menominee Reservation.

**Dr. Michelle Robinson** is the Director of the Wisconsin Department of Health Services' Office of Health Equity. Dr. Robinson previously served as the Director of the Office of the Inspector General (OIG) and the Equity and Systems Change Research and Policy Officer (ESCRPO) at the Wisconsin Department of Children and Families (DCF). Dr. Robinson brings a wealth of expertise in the field of health equity and systems changes including as a member of the Race to Equity Project at Kids Forward. Dr. Robinson, who earned a doctorate degree from the University of Wisconsin-Madison last year, has since continued to use research-based approaches to identify the best ways to address racial inequities in Madison.

**Ellen Sexton** is the Senior Vice President of Specialty Business at Humana. Prior to Humana, Ellen served as the CEO for UnitedHealthcare's Wisconsin Medicaid Health plan. Early in her career, Ellen worked in a number of finance leadership roles at Northwest Airlines and Honeywell. Ellen is active in her community and serves on the Milwaukee Public Library Foundation board, was the 2021 Chair of American Heart Association's Milwaukee Heart Ball and is a member of the Health and Wellness Committee for Impact 100 Milwaukee.

**Mary Thao** currently serves as an IT consultant for Marshfield Clinic Health System. She is an Aspirus Foundation Board member and graduate of the Wausau Region Chamber of Commerce Leadership Excellence Program. Thao has a master's in business administration from Hamline University and 19 years of experience in information technology.

**Karen Timberlake** is the former Secretary-designee for the Wisconsin Department of Health Services. She previously worked at Michael Best Strategies, supporting initiatives in health care and human services transformation. Before that, she directed the Population Health Institute at the University of Wisconsin School of Medicine and Public Health, worked to ensure higher quality health care at a lower cost with the Wisconsin Health Information Organization, and was an Assistant Attorney General with the Wisconsin Department of Justice. She served as Secretary at the Wisconsin Department of Health Services from 2008-2010, guiding Wisconsin through the H1N1 pandemic virus response.

**Paula Tran** serves as the State Health Officer and Administrator of the Division of Public Health at the Wisconsin Department of Health Services. In this role she leads the vision for statewide public health and health

equity strategies. Prior to joining the Wisconsin Department of Health Services, Paula served in a variety of roles, including Director for the University of Wisconsin Population Health Institute Mobilizing Action Toward Community Health (MATCH) group, Health Promotion State Specialist at the University of Wisconsin, Division of Extension, and Assistant Director at the University of Wisconsin Center for Community and Nonprofit Studies. Paula has her Master of Public Health degree and Bachelor of Science in Biology from the University of Wisconsin-Madison.

**Elizabeth Valitchka** works as a Strategic Advisor for the Wisconsin Department of Children and Families. She holds a master's degree in Public Health in Maternal and Child Health.

**Jerry Waukau Sr.** is the Health Administrator of the Menominee Tribal Clinic. He serves as Chairman of the Wisconsin Tribal Health Director's Association, which represents the eleven federally recognized tribes in the State of Wisconsin. Jerry serves as faculty on the Pediatric Integrated Care Core Collaborative — Indian Health Service – Johns Hopkins – PICC Team, which focuses on implementing trauma informed integrated care in Native communities. Jerry received his Bachelor of Arts degree in Economics from Ripon College in 1978. Jerry was born and raised on the Menominee Indian Reservation.

**Andrea Werner** is a Senior Vice President for Population Health Strategy & Transformation at Bellin Health in Green Bay. Areas of responsibility include Business and Community Health; Digital Care Strategies; Marketing and Communications; Learning and Innovation Center; Care Beyond Walls; Contact Center; and Lifestyle Medicine. Prior to this, Andrea has 13 years of experience as the senior leader of cardiovascular care, orthopedics and sports medicine, neurosciences, and system diagnostics. Andrea has her BSW from Marquette University, MSW from the University of Iowa, and completed the Improvement Advisor Training Program with the Institute for Healthcare Improvement in Boston, Massachusetts. Andrea has worked at Bellin for 25 years.

**Dr. Jasmine Zapata** is a double board-certified physician specializing in the fields of Pediatrics and Preventive Medicine. She currently serves as the Chief Medical Officer and State Epidemiologist for Community Health at the Wisconsin Department of Health Services. She is also an assistant professor at the University of Wisconsin School of Medicine and Public Health where she practices clinically in the newborn nursery and is involved in a variety of scholarly activities aimed at increasing diversity in medicine and promoting health equity. She has many lived experiences that help her uniquely connect with the communities she serves and is well known for her infectious energy, passionate advocacy, and heart for service. Her ultimate mission in life is to "heal, uplift, and inspire."

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- <sup>1</sup> American Indians in Wisconsin: Overview. The Wisconsin Department of Health Services. <https://www.dhs.wisconsin.gov/minority-health/population/amind-pop.htm>.
- <sup>2</sup> Hmong in Wisconsin. The Wisconsin Historical Society. <https://www.wisconsinhistory.org/Records/Article/CS1754>.
- <sup>3</sup> Farming and Rural Life. The Wisconsin Historical Society. <https://www.wisconsinhistory.org/turningpoints/tp-061/>.
- <sup>4</sup> The Rural Challenge. <https://www.wisconsinhistory.org/turningpoints/tp-061/>.
- <sup>5</sup> Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>.
- <sup>6</sup> What is Health Equity? Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>.
- <sup>7</sup> Braveman
- <sup>8</sup> University of Wisconsin Population Health Institute. [https://uwphi.pophealth.wisc.edu/wp-content/uploads/sites/316/2022/03/2021WIPopHealthEquityReportCard\\_FINAL.pdf](https://uwphi.pophealth.wisc.edu/wp-content/uploads/sites/316/2022/03/2021WIPopHealthEquityReportCard_FINAL.pdf)
- <sup>9</sup> Mortality in the United States, 2020. The National Center for Health Statistics. <https://www.cdc.gov/nchs/products/databriefs/db427.htm>.
- <sup>10</sup> Population Estimates, 2022. U.S. Census Bureau.
- <sup>11</sup> Low birthweight module. WISH Query. <https://www.dhs.wisconsin.gov/wish/lbw/index.htm>.
- <sup>12</sup> Percentage of Babies Born Low Birthweight By State. The National Center for Health Statistics. [https://www.cdc.gov/nchs/pressroom/sosmap/lbw\\_births/lbw.htm](https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm).
- <sup>13</sup> Percentage of Births Born Preterm by State. The National Center for Health Statistics. [https://www.cdc.gov/nchs/pressroom/sosmap/preterm\\_births/preterm.htm](https://www.cdc.gov/nchs/pressroom/sosmap/preterm_births/preterm.htm).
- <sup>14</sup> Infant Mortality Rates by State. The National Center for Health Statistics. [https://www.cdc.gov/nchs/pressroom/sosmap/infant\\_mortality\\_rates/infant\\_mortality.htm](https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm).

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## Acknowledgements

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