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REC. 1: RELATED TO EXPANDING THE WISCONSIN EITC

- Summary of feedback
  - Include changes to also allow abused spouses to claim EITC on separate returns. This would require a change to state law.
  - Include additional evaluation measures to estimate the effectiveness of the credit on lifting people out of poverty, which would require collecting some data not currently captured on and from tax returns.
  - Increase the 1- and 2- child household state EITC credit to 16 and 25 percent, respectively, of the federal credit, to align with other legislative and gubernatorial proposals

- Revisions that will be made and do not need an amendment
  - Add evaluation components of EITC reforms

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - **1A.** Recommend state law change to allow abused spouses to claim EITC
  - **1B.** Increase 1- and 2- child household state EITC credit to 16 and 25 percent of the federal credit, respectively

Expanding the Wisconsin EITC to Help Low-wage Workers and Reduce Health Disparities

Primary Contact (and contact information) for the Recommendation:

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Kids Forward

Others Who Worked on the Recommendation:

Jon Peacock | Research Director
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Issue Statement

The Earned Income Tax Credit (EITC) 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. By expanding our state's EITC to adults without dependent children, as other states have done, and by increasing use of the federal credits, Wisconsin can improve health outcomes for low-income households, particularly people of color and low-wage workers in rural communities.

Background/ Problem Description

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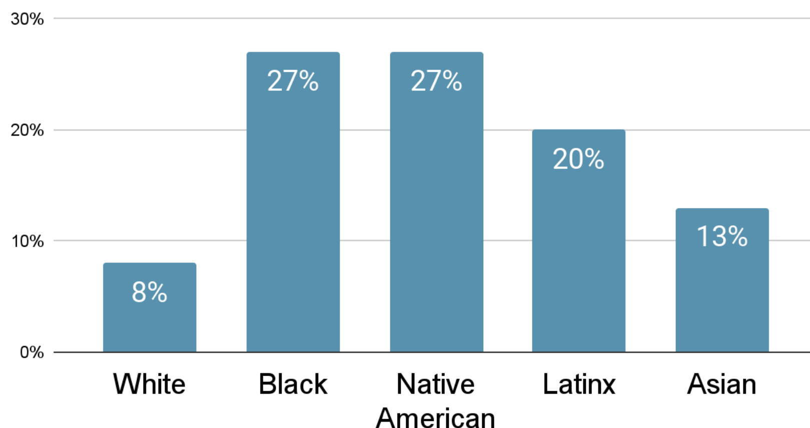
People of color in Wisconsin have substantially lower incomes and less wealth than White state residents. As the following graph illustrates, Black and Native American Wisconsinites were about three times more likely than non-Hispanic White Wisconsinites to live in poverty in 2019, and the poverty rate among Latinx Wisconsinites was more than twice the rate among White state residents. The inequitable distribution of income and wealth in Wisconsin plays a significant role in the state's severe racial disparities in health.



To combat poverty and racial inequality in health, Wisconsin policymakers should make work pay and remove barriers to workforce participation. One very effective strategy for accomplishing those intertwined goals is boosting income through the Earned Income Tax Credit (EITC).

Wisconsin's EITC and the federal credit put more money into the pockets of working parents with low and moderate incomes and help them achieve economic security. Research shows that the EITC increases workforce participation and gives a major boost to family health and well-being. The positive impacts include reducing the number of low-birthweight babies and lowering rates of cigarette smoking. Children in families that receive the EITC do better and go further in school. The benefits even reach into the next generation because individuals whose families received the EITC when they were children work more as adults and have higher earnings.

However, there is a very large gap in who benefits from the EITC. The federal credit for adults without dependent children is small and has very restrictive eligibility criteria (although both of those problems were temporarily addressed for tax year 2021 by the American Rescue Plan). Worse yet, Wisconsin provides no EITC for adults without dependent children. The result is that 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 EITC, and may have difficulties making ends meet.

Proposed Recommendation

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We recommend two strategies for using Earned Income Tax Credits to boost the income of low-wage workers who do not have dependent children and thereby reducing the poverty and economic stress that takes a toll on their health.

1. Expand the state Earned Income Tax Credit so it includes adults who do not have dependent children.
2. Direct state agencies to develop a coordinated plan for increasing the number of Wisconsinites who claim the current federal EITC, particularly among adults without dependent children.

Recommendation Rationale

Earned Income Tax Credits are an effective tool for increasing the income of low-wage workers, boosting the economies of low-income communities, and reducing the harmful health effects of poverty. Wisconsin has an Earned Income Tax Credit for low-wage workers who are custodial parents, but in contrast to the 30 other states that provide such credits, the Wisconsin EITC does not apply to workers who do not have children or to parents who are not the primary caretaker of a child.

Although some low-wage workers pay little or no income taxes, they do pay federal payroll taxes for Social Security and Medicare. Those taxes can be a disincentive for workforce participation, especially for people facing multiple barriers to staying in the workforce. Earned Income Tax Credits help make work more attractive, and they relieve the stress that contributes to chronic health problems for people living in or near poverty.

A large body of research has shown that EITCs received by custodial parents are very effective for increasing household income and workforce participation and have had a wide range of very positive indirect effects. The same research does not exist for the federal EITC for workers without dependent children because until 2021 the credits for those workers were quite small and eligibility was restricted. The American Rescue Act Plan addressed those problems by expanding eligibility and substantially increasing the size of the credits. Those changes could expire in 2022, but the proposed Build Back Better legislation would extend them for at least another year.

The following table illustrates the taxes and net income for a single woman without children who works as a cashier 30 hours per week and earns $9 per hour. In 2020 she paid $130 in federal income taxes and got a federal EITC of $160, but payroll taxes of $1,048 put her net income almost $800 below the federal poverty level. In 2021 the American Rescue Plan Act boosted her EITC by almost $1,000 and lifted her net income slightly above the inflation-adjusted poverty level.

Table 1: Effects of Federal Taxes on Net Income – Before and After the 2021 Increase in the Federal EITC (for a childless worker making $13,500 per year)

Gross income	$13,500 (30 hrs/wk. X 50 weeks X $9/hr.)

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Federal income tax	- $130
Payroll tax	- $1,048
2020 federal EITC	+ $160
2020 net income	**$12,482**
2020 federal poverty level 2020	$13,261
2021 federal EITC	+$1,116
2021 net income	**$13,598** ($29 above the 2021 poverty line)

(Source: Center on Budget and Policy Priorities)

If Wisconsin ceases to be the only state that denies its EITC to adults without dependent children, our state could help those workers get further above the poverty level and reduce the economic stress that takes a long-term toll on health.

In light of the worker shortage in Wisconsin and the effectiveness of EITCs in boosting workforce participation, we think there could be bipartisan support for expanding Wisconsin's EITC (just as there was when President Reagan endorsed improvements in the federal EITC and when Governor Thompson signed the Wisconsin EITC law in 1989). However, increasing workforce participation is just one of the reasons for supporting the expansion of the credit. Other reasons include:

- Increasing net income for about 300,000 low-wage Wisconsinites, including many rural workers and people of color who are living in poverty and are disproportionately affected by poverty and economic stress.
- Increasing the income that circulates in low-income communities.
- Helping improve birth outcomes among low-income women, particularly women of color, by increasing their income and reducing the stress that contributes to negative birth outcomes.
- Helping non-custodial parents provide support for their children.

Our second recommendation calls on the Wisconsin Department of Revenue and other state agencies to develop a coordinated plan to boost awareness of the EITC among adults who don't have dependent children. Many low-income workers do not have to file tax returns because their income is too low for them to have any income tax liability. Nevertheless, a high percentage of low-wage parents file tax returns because they are aware that they are eligible for large, refundable tax credits. Unfortunately, the same is not true for low-income workers without dependent children because the federal EITC they are eligible for was very small prior to 2021 and eligibility was quite restricted. And because most workers are not eligible for the maximum federal credit,

Table 2: Maximum Federal EITC Amounts

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Tax filer	Maximum federal credit
Single parent with 3 kids	$6,660
Single parent with 2 kids	$5,920
Single parent with 1 child	$3,584
Childless adult (2020)	$538
Childless adult (2021)	$1,540

Table 2 shows the maximum federal credits for different households and illustrates that the top amount for adults without dependent children nearly tripled in 2021. The increase is much more dramatic for some other households. Using the example shown in Table 1 of a childless worker earning $13,500 per year, the federal EITC went up almost seven-fold in 2021 to $1,116 (compared to $160 in 2020). That increase makes it far more worthwhile for a low-wage worker to file a tax return and claim the credit, and makes it far more important for state agencies (as well as businesses like utility companies) to increase awareness of the EITC among a population that previously got little benefit from the credit.

Implementation Design

Expanding eligibility for the Wisconsin EITC requires legislative approval, which would most logically be done as part of the biennial budget bill. If the next budget bill includes a tax cut package, this change could be an important part of that package. The simplest way to design the credit (for policymakers and, more importantly, for tax filers) is to make the state credit a percentage of the federal credit. The specifics of that legislation will depend on whether Congress extends the EITC changes in effect for 2021.

Although changing EITC eligibility requires legislative approval, the executive branch can work independently to develop and implement a comprehensive plan to improve awareness of the federal EITC for adults without dependent children. For example, the Department of Health Services (DHS) and Department of Revenue (DOR) could work together to ensure that all low-wage workers who receive Food Share benefits receive information about the tax credits they are eligible for and information on resources to help them apply.

To measure the effects of these policy measures, we recommend the following:

- DOR should gather data on the change in the number of adults without dependent children who receive the EITC and the amount of those credits.
- The data should include information, if possible, on the race of the recipients and their geographic distribution.
- DOR should work with a research organization, like the Institute for Research on Poverty, to estimate the effectiveness of the credit on lifting people out of poverty.

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Background Reading

Fixing the Glaring Gap in the EITC for "Childless Workers"
Center on Budget and Policy Priorities, May 24, 2016 (This is Part IV of a larger EITC publication.)
https://www.cbpp.org/research/federal-tax/chart-book-the-earned-income-tax-credit-and-child-tax-credit#PartFour

EITC and Child Tax Credit Promote Work, Reduce Poverty, and Support Children's Development, Research Finds
https://www.cbpp.org/research/federal-tax/eitc-and-child-tax-credit-promote-work-reduce-poverty-and-support-childrens

Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity
Kelli A. Komro, Sara Markowitz, Melvin D. Livingston, and Alexander C. Wagenaar
Published Online:13 Mar 2019 https://doi.org/10.1089/heq.2018.0061

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REC 2. RELATED TO MEDICAID ELIGIBILITY TO UNDOCUMENTED IMMIGRANTS FOR FAMILY PLANNING SERVICES AND EMERGENCY SERVICES

- Summary of feedback
  - Federal regulations prohibit states from using Medicaid funding to cover family planning services for individuals who are ineligible due to their immigrant status. To provide Medicaid Family Planning Services for immigrants who are ineligible for full Medicaid benefits, the Council would need to recommend creating a state-run and funded program to provide Family Planning benefits to all immigrant populations.
  - To provide Medicaid Emergency Services for childless adult immigrants who are ineligible for full Medicaid benefits, the council would need to recommend directing Wisconsin's Medicaid program to seek pathways for providing these services to this population.

- Revisions that will be made and do not need an amendment
  - Clarify that the proposal would extend family planning services available through Medicaid to populations who are ineligible for Medicaid due to their immigration status
  - Indicate GPR funding would be required to extend family planning services to ineligible immigrants
  - Direct the Medicaid program to seek pathways for extending emergency services eligibility to ineligible immigrant populations
  - Include appropriate statutory changes as needed

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Recommendation Title: Increase Access to Medicaid Coverage for Populations who are Ineligible Due to Their Immigration Status

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Every Kid. Every Family. Every Community.
Race to Equity | www.racetoequity.net
Wisconsin Budget Project | www.wisconsinbudgetproject.org

Issue Statement:
Increase access to Medicaid coverage for ineligible populations. Unequal Access to health care for individuals based on their immigration status is inhumane. Not only does it cost these individuals their lives, but it costs all of us, as taxpayers, more money because those of us who do have access to insurance pay higher premiums to cover those who are uninsured.

Background/ Problem Description

1. **What is the scope of the problem in Wisconsin? Include quantitative and qualitative impact on lives, scale of inequity, financial cost, etc.**

The purpose of this recommendation is to:
First, access to Family Planning Only Services (FPOS) would give individuals who are ineligible because of their immigration status access to preventative health care related to family planning and early detection of reproductive cancers. In the long run these services help keep individuals healthy, with better outcomes because of early detection of certain illnesses and diseases. Expanding FPOS to ineligible populations would also allow FPOS providers to share information on how health care coverage works in Wisconsin and connect this population to primary care providers and medical homes.

Second, we are asking to have more immigrants regardless of their status eligible to receive urgent health care coverage by expanding emergency services under the Wisconsin Medicaid program. With this recommendation, adults without dependent children who are ineligible only because of their immigration status, in Wisconsin, would be provided with treatment for an emergency medical condition.

The main goal of the FPOS program is to help avoid unintended pregnancy and prevent sexually transmitted diseases. Eligible people applying for this program may receive services immediately through BadgerCare Plus Family Planning Only Services Express Enrollment (FPOS EE). Upon successful submission and completion of an application for continuous eligibility, patients can be continuously enrolled for one year from the application date.

The FPOS program provides:

- Office/outpatient visits for reproductive health evaluation and management including medical history and examination by a physician or qualified health care provider.
- Ongoing medical visits for follow-up care.
- Review and provision of family planning medications as needed.

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- Insertion/removal of family planning supplies such as cervical cap, diaphragm, IUDs, and other contraceptives.
- Medical procedures related to family planning including biopsies to detect pre-cancerous cells.
- Diagnostic procedures and labs including pregnancy, Herpes, STI, HIV, and other lab tests.
- Patient prevention education.
- Telehealth access to care.

The eligibility criteria indicate that an individual must be a U.S. citizen or qualified immigrant and a state of Wisconsin resident.

A U.S. citizen or
Lawfully residing in the U.S. for at least 5 years, or
Lawfully residing in the U.S. and is a refugee seeking asylum or
From Cuba or Haiti and lawfully residing in the U.S., or
Under the age of 19 and lawfully residing in the U.S. or
Lawfully residing in the U.S. under one of the eligible immigrations statuses afforded by the Immigration and Nationally Act (INA)

This current eligibility criteria precludes undocumented and other immigrants from accessing basic health care services. Moreover, these immigrants often work as essential workers who do not receive employer sponsored insurance plans; they are also barred from purchasing insurance through the Affordable Care Act Health Insurance Marketplace (www.healthcare.gov) because of their immigration status.

Number of undocumented people in Wisconsin: Undocumented youth and adults are residents of our state, and their ability to have good health also impacts the health of our entire state. In 2016, 75,000 undocumented immigrants comprised 24% of the Wisconsin immigrant population and one percent of the total state population. (Pew Research Center, “U.S. unauthorized immigration population estimates, 2016,” February 5, 2019, www.pewhispanic.org/interactives/unauthorized-immigrants/.) Nearly 56,000 U.S. citizens in Wisconsin live with at least one family member who is undocumented. (Silva Mathema, “State-by-State Estimates of the Family Members of Unauthorized Immigrants,” University of Southern California’s Center for the Study of Immigrant Integration and the Center for American Progress, March 2017, www.americanprogress.org/issues/immigration/news/2017/03/16/427868/state-state-estimates-family-members-unauthorizedimmigrants/.) Also included in the research is that 70% of undocumented people are from Mexico (in 2016). It is likely that the estimate by the Pew Research Center is undercounting undocumented people.

Impact of Lack of Access to Care: Immigrants continue to be at much higher risk of being uninsured. In 2017, non-citizens (including those who are lawfully present and those who are undocumented) were more likely than citizens to be uninsured in 2017. Among citizens, 8% were uninsured in 2017, compared to 33% of non-citizens (Kaiser Family Foundation analysis of the 2017 American Community Survey, 1-Year Estimates).

Going without access to quality health care impacts the health and well-being of non-citizens in profound ways. The Kaiser Family Foundation reports that the uninsured receive less preventative care, and delayed care which often results in serious illness or other health problems (Rachel Garfield and Kendal Orgera. Kaiser Family Foundation Report. The Uninsured and the ACA: A Primer Key Facts about

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Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. January 2019). They are 3 times more likely to not have a medical home or have not received care over the past 12 months. They are also less likely to receive screening tests for blood pressure, high cholesterol, blood sugar, pap smears or mammograms, or colon cancer screening (Kaiser Family Foundation analysis of the 2017 National Health Interview Survey). Lack of screenings place them at increased risk of being diagnosed at later stages of diseases, including cancer, and having higher mortality rates than people with insurance or Medicaid who can access care.

2. Which groups are most impacted by inequity?

This combined proposal focuses on individuals living in Wisconsin, originally from many diverse countries around the world, who are ineligible because of their immigration status. Currently there are three states that have no immigration restrictions for access to FPOS and Medicaid. Vermont and Washington state fund the programs through state funding. California has amended its state Medicaid Plan to include individuals regardless of their immigration status, its plan being partially funded by Medicaid and partially by the state. All other states that have expanded Medicaid for family planning services have a citizenship or "legal" immigration status eligibility requirement.

Wisconsin provides only limited exceptions to the five-year bar on access to FPOS or Medicaid, those exceptions being for lawfully residing immigrant children (BadgerCare or CHIP), lawfully residing pregnant women (BadgerCare or CHIP), and pregnant women regardless of status (CHIP only). The limited exceptions prevent non-pregnant women from accessing basic health care, including family planning services.

Undocumented people and access: Access to reproductive health and emergency services is critical to the well-being of non-citizens and citizens alike. Contraceptive use helps individuals realize their own reproductive goals, which in turn helps them achieve their educational, employment, and financial ambitions. (Kinsey and Hasstedt, "Unbiased Information on and Referral for All Pregnancy Options Are Essential to Informed Consent in Reproductive Health Care," Guttmacher Policy Review 21 (2018). Unfortunately, thousands of undocumented individuals and many other immigrants face structural barriers to obtaining basic family planning health care services for themselves based solely on their immigration status.
Emergency services, which include, but is not limited to: care for heart attacks, strokes, car accidents, employment accidents, etc., is also a service not readily accessible to all financially eligible people regardless of their immigration status.

In 2018 the Commonwealth Fund completed a rapid review of peer-reviewed literature and evidence about the impact of the lack of health insurance coverage on sexual and reproductive health care services use among immigrant women in the U.S. They found:

- 34% percent of the 6.4 million non-citizen immigrant women of reproductive age were uninsured, compared to 9% of U.S.-born women. Source: Guttmacher Institute, Dramatic Gains in Insurance Coverage for Women of Reproductive Age Are Now in Jeopardy (Guttmacher, Jan. 2018).
- Among the uninsured, immigrant women are more likely than U.S.-born women to say they did not try to get health insurance coverage (68% vs. 44%).

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- The top three identified reasons immigrant women said they did not seek health insurance coverage were: 49% immigration status; 28% did not know; 10% perceived as too expensive.
- Only 50% of immigrant women had received contraceptive services or information within the previous year, compared to 66% of U.S.-born women (Jennifer J. Frost, U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010, Guttmacher Institute, May 2013).
- Immigrant women were also less likely to have used "highly effective" contraceptive methods (e.g., IUDs and implants), with variations by race and ethnicity (Tapales, Douglas-Hall, and Whitehead, "Sexual and Reproductive Health," 2018).
- Immigrant women were also less likely to receive preventative services, such as Pap tests to detect and prevent cervical cancer and screening, and vaccinations for Hepatitis B, which can be life-threatening for infants (Sandra E. Echeverria and Olveen Carrasquillo, "The Roles of Citizenship Status, Acculturation, and Health Insurance in Breast and Cervical Cancer Screening Among Immigrant Women," Medical Care 44, no. 8 (Aug. 2006): 788–92; and Greta A. Kilmer et al., "Hepatitis B Vaccination and Screening Among Foreign-Born Women of Reproductive Age in the United States, 2013–2015," Clinical Infectious Diseases (Epub ahead of print, June 1, 2018).
- Uninsured non-citizens were also significantly less likely to obtain mammograms (Adriana M. Reyes and Patricia Y. Miranda, "Trends in Cancer Screening by Citizenship and Health Insurance, 2000–2010," Journal of Immigrant and Minority Health 17, no. 3 644–51).

- When immigrant women — nearly half of whom are of reproductive age (15–44) — are unable to obtain basic care, their health, well-being, and economic security are jeopardized, as well as the well-being and stability of their families and communities. Furthermore, policies and protocols that effectively block many immigrants from access to affordable health care, including programs that their tax dollars support, demean immigrants' considerable contributions to their communities and our economy (Migration Policy Institute, Age-Sex Pyramids of U.S. Immigrant and Native-Born Populations, 1970-Present (MPI, n.d.).

Proposed Recommendation

- **Concise but thorough description of recommendation (use bullet points to show the specific components of the policy)**

The purpose of this proposal is to increase access to family planning and emergency services for all otherwise eligible individuals regardless of their immigration status. There are a few possible methods to do this:

A) Recommend the expansion of FPOS to include all otherwise eligible (regardless of immigration status) youth and adults in need of family planning services that includes reproductive health exams, provision of the range of contraceptive methods (covering medications, contraceptive supplies, testing and treatment for sexually transmitted infections and other health issues that, when untreated, can become bigger health issues.

B) Investigation of other state funding streams that would expand access to people who are not eligible for FPOS and emergency services because of their immigration status.

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- **How does the recommendation addresses equity/reduce a disparity?**
    - **At what structural/systemic lever(s) is the policy aimed?**

This recommendation is structured for system level change within the Wisconsin Medicaid Program.

Expanding Medicaid coverage to individuals regardless of their immigration status moves Wisconsin a step forward in our shared commitment to achieve long-lasting and equitable health outcomes for all Wisconsinites. Essential workers in our service industries have very little access to preventative health care, and the need to expand emergency services is critical because of the lack of preventative health care accessible for them. Access to care will help to reduce reproductive health disparities experienced by immigrants based on their race, ethnicity and immigration status. If selected for implementation, this recommendation will cover tens of thousands of people in Wisconsin who have limited or no access to health care due to their immigration status. It will remove structural barriers that effectively block immigrants from access to affordable care, including programs that their tax dollars support.

- **What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state, etc.)**

The purpose of this recommendation is to create a comprehensive plan to achieve health equity for all individuals in Wisconsin regardless of their immigration status providing access to essential reproductive health care and emergency services through Wisconsin's Medicaid program.

This joint recommendation will help achieve health equity and better health outcomes for all Wisconsinites.
Justification: People, who currently are ineligible for services due to their immigration status, become oriented to the health care system, gain information and knowledge/skills on how to access free clinics, FQHCs, and other avenues that provide preventative health care, thereby reducing the use of emergency departments, which are often the only recourse that undocumented people and other immigrants have, to obtain care.

Expansion of Medicaid through FPOS and emergency care:

- Reduces inequity by providing basic health care, a human right, to all Wisconsinites
- Improves health because access to this basic health care will lead to more knowledge of the American health care system, how to access and maneuver thru it.
- Reduces mortality through early intervention, education, and screening
- Saves money in terms of reduced hospitalization and emergency room use, which is often the only health care available for uninsured populations.

Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time) optional but recommended.

1. **What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are they inefficient or ineffective**?

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This recommendation confronts the system challenge of several local, state and national policies that limit access to government-funded health care.

The limited amount of information in population databases on the number of undocumented people in any given geographic area, and information on their health concerns/issues, make it very difficult for advocates to continue to push forth Medicaid expansion. However, we know they are living in Wisconsin, often working in essential jobs needed for the economy of our state.

2. (**If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?**

Evidence this Will Work: There is broad agreement that access to high quality, medically based services promotes overall health and well-being of women, men and the communities where they reside. Evidence also shows that immigrant women are much more likely than women who are US citizens to obtain their health care at publicly funded safety net clinics. In fact, 41% of immigrant women who obtained contraceptive care (2006-2010) did so at safety-net family planning centers, compared to 25% of their U.S.-born counterparts. Seven of 10 immigrant women who accessed care reported a safety-net site as their usual source of medical care (Frost, U.S. Women's Use, 2009).

New Knowledge: Providing residents without barring them due to their immigration status with expanded Medicaid services will increase our knowledge about the types of barriers they experience in accessing care, the health disparities they have experienced, the risk factors that place their health and well-being in jeopardy, and the healthy behaviors they are adopting. Increased data on this population will also support efforts in the public health community to analyze health care seeking differences between immigrant populations based on country and region of origin.

Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time) (optional but recommended)

1. **By what process will the recommendation be implemented?**
    - Per Zakiyyah Sorensen at UW, DHS would need to amend the state Medicaid plan to change eligibility for people who do not currently qualify due to their immigration status. For DHS to change the eligibility criteria in the state plan, the change would have to be approved by the Joint Committee on Finance because (following passage of 2017 WI Act 370) the Committee must approve any changes that have an expected fiscal effect of at least $7.5 M per year including funds from all sources).

2. **How would the impact of this recommendation be measured?**
    - Include any metrics already tracked, if possible
    - Propose new metrics, if necessary
    - Data collection by Emergency rooms to track the decrease in ER use by uninsured patients
    - Data of how many people enroll in FPOS
    - Data collection on the decrease detection of reproductive cancers at later stages
    - Data collection on the decrease of unintended pregnancies

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- Data collection on more STI testing and treatment
- Data collection on more people having primary care providers and medical homes
- Data collection on the number of Wisconsinites who are insured
- Data collection on the overall well-being of ALL Wisconsinites

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REC 3: RELATED TO MINIMUM WAGE INCREASES

- Summary of feedback
  - Include specific statutory changes needed to increase the minimum wage.
  - Additional staff would be needed to administer proposed changes and provide oversight.
  - Include provisions that would ensure that businesses are prepared, ready, and have input on the transition to $15 minimum wage.

- Revisions that will be made and do not need an amendment
  - Include a request for additional staff to effectively administer these changes.
  - Include appropriate statutory changes as needed

- Amendments the Chair will be proposing
  - **3A.** Modify the proposal to be an incremental increases to the minimum wage ($8.60, $9.40, $10.15; indexed to inflation) and for the Governor to appoint a task force of diverse stakeholders, representing the interests of government, small and large businesses, and community advocates, to develop a plan for achieving and implementing a statewide $15 minimum wage or the equivalent inflation-adjusted minimum wage. Members of the Task Force should be appointed within 6 months of adoption of recommendation and should complete an interim report within 18 months and a final report within 2 years.

- Optional changes needing an amendment
  - None

Recommendation: Increasing the Minimum Wage to $15

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Others who worked on the recommendation:
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Bellin Health

Tamarine Cornelius | Wisconsin Budget Project Director
Kids Forward

Issue statement: Raising Wisconsin's minimum wage to $15 an hour from its current level of $7.25 would improve the health of people working at low-wage jobs, and reduce health disparities. It would reduce hardship and poverty, especially for Black and Brown workers disproportionately employed in the lowest-paying jobs.

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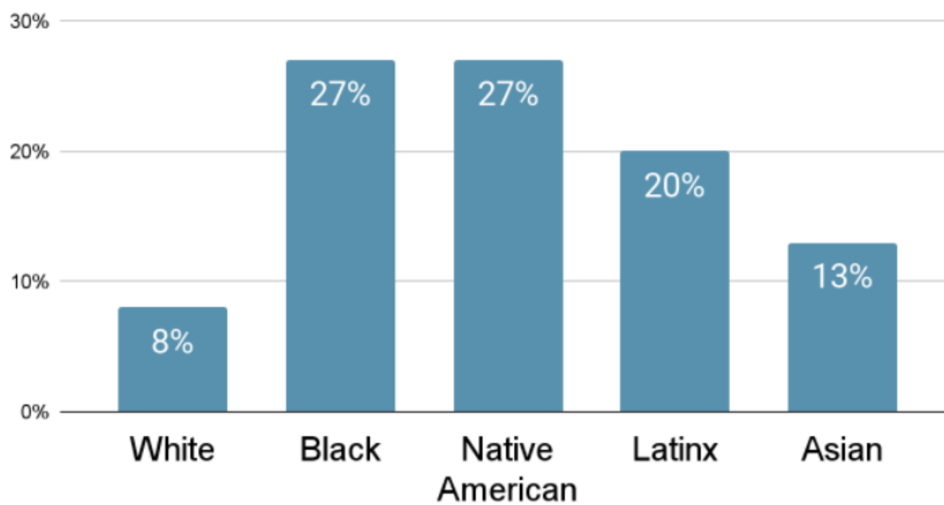
Background/problem description: In Wisconsin, people of color are far more likely to live in poverty than White people. Historical and present-day racial discrimination in Wisconsin's schools, job market, and health care system have lowered the wages of households of color. Poverty takes a toll on health, and is associated with a higher risk of adverse health outcomes, including infant mortality, heart disease, diabetes, and cancer.

About eight percent of the White Non-Hispanic population in Wisconsin lives in poverty, compared to 27% of the Black population and the Native American population, 20% of the Hispanic population, and 13% of the Asian population. This disparity means that a Black person in Wisconsin is more than three times as likely to live in poverty as a White person.



Source: 2019 American Community Survey, 1-year average

This racial difference in economic hardship is reflected in household incomes as well:

- A typical White non-Hispanic household in Wisconsin has $68,000 of income a year.
- A typically Black household, in contrast, only has about $35,000 in income, slightly over half of a typical White household. That means for every $1 in income a typical White household has, a typical Black household has only 51 cents.
- A typical Native American household makes $42,000 and a typical Latinx household in WI makes $47,000. That amounts to between 60 and 70 cents on the dollar for the income for White households.

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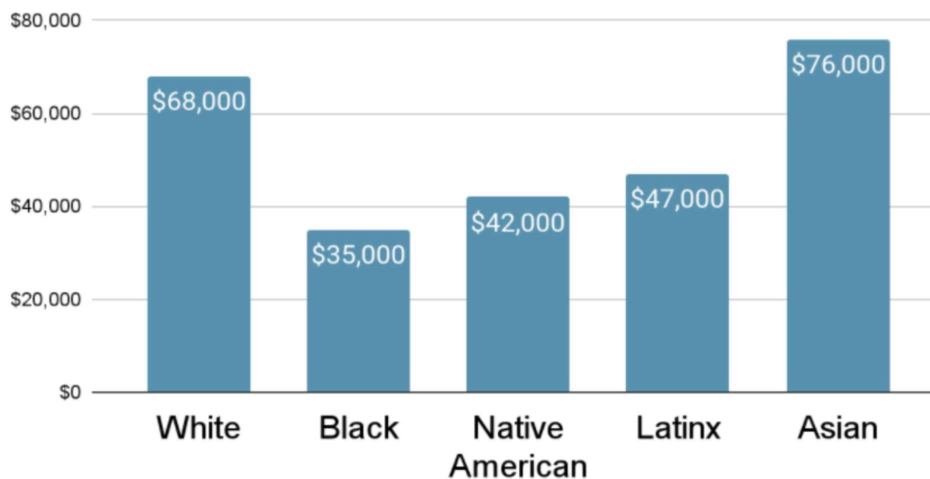

Increasing the minimum wage to $15 would lift the wages of three out of ten workers in Wisconsin, and it would especially help Black and Brown workers. Half of Black workers and over half of Hispanic workers in Wisconsin would get a raise, as well as one-third of Asian workers. It would lift the wages of one-quarter of White workers. Six out of ten workers who would get a raise are age 25 or older.

Full-time workers who get a raise would earn an additional $3,500 a year, on average.

Proposed recommendation: Increase Wisconsin's minimum wage to $15. This recommendation reduces health disparities by increasing the incomes of people who work for low wages. Working for low wages is associated with a range of adverse health outcomes.

Recommendation rationale: The connection between raising the minimum wage and improving health is well-established. The Journal of American Medicine Health Forum notes that "researchers have observed associations between increased wages and decreases in both suicide mortality and hypertension, better birth outcomes, and lower rates of sexually transmitted infections among women. Some research suggests that wage increases can improve health by influencing the individual behaviors that affect health, such as increased fruit and vegetable consumption, or even better mental health as a result of increased leisure time or job satisfaction."

An enormous body of research examining the real-world effects of minimum wage hikes finds that raising the minimum wage has a strong positive impact on workers' earnings and little, if any, negative impact on job growth. Increasing the minimum wage can improve productivity and cut down on employee turnover costs.

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Implementation design: 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. Increasing Wisconsin's minimum wage would require legislation passed by legislators and signed by the Governor. Minimum wage requirements are enforced by the state's Department of Workforce Development.

In some other states, local governments such as counties and cities can set their own minimum wages that are higher than the federal or state minimums. In Wisconsin, legislators have prohibited that practice, so that the only way to get a higher minimum wage anywhere in the state is to do it statewide.

Wisconsin should phase in its $15 minimum wage over three years, so as to allow employers time to adjust to the new standard. We recommend that the minimum wage be raised to $15 by 2025. Once the minimum wage is fully raised to the $15 level, it should then be linked to inflation, so that it incrementally goes up each year to make up for the cost of living increase. Otherwise, the minimum wage will be gradually eroded by inflation and it will require additional legislation to "catch up" later.

Tipped workers, such as waiters, have a separate tipped minimum wage. If the employee's tips combined with the tipped minimum wage fall short of the regular minimum wage, employers are required to make up the difference. This provision means that tipped workers would also earn at least $15/hour if the regular minimum wage was increased to $15, even if the separate tipped minimum was not increased.

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REC 4: RELATED TO OFFICE OF ENVIRONMENTAL JUSTICE

- Summary of feedback
  - None
- Revisions that will be made and do not need an amendments)
  - None
- Amendments the Chair will be proposing
  - None
- Optional changes needing an amendment
  - None

Governor's Health Equity Council Major Recommendation Proposal Template

Outline

Recommendation Title: Creation of a State Office of Environmental Justice
Primary Contact (and contact information) for the Recommendation: Lt. Governor Mandela Barnes, ltgovernor@wisconsin.gov
Other Members Who Worked on the Recommendation: Anahkwet Guy Reiter

(Required) Issue Statement
We recommend establishing an Office of Environmental Justice tasked with collaborating across state agencies and engaging with Black, Indigenous Nations, communities of color, low-income communities, and environmental justice advocates to design climate policies that reduce emissions and pollutants and address the cumulative and deadly impacts of their concentration within these communities.

(Required) Background/ Problem Description
Communities of color, Native Nations, and low-income communities are disproportionally impacted by compromised health disruptions of climate change. These impacts, in addition to a historical lack of access to resources and decision-making institutions, put these communities at an unjust risk to damaging health conditions caused by climate change.

Centering environmental justice in climate change discourse as a human rights movement puts a needed focus on the communities most vulnerable to climate change's impacts in its solutions. More than one in four Black and Hispanic Americans live within 3 miles of a Superfund site (place where hazardous waste is dumped with no corporate liability, forcing government to fund cleanup)– higher compared to the average American. This proximity can result in elevated levels of lead in children's blood and prolonged health issues.[1] As of 2019, Wisconsin holds a total of 36 superfund sites that span every region of the state. La

[1] https://www.whitehouse.gov/briefing-room/statements-releases/2021/11/16/the-bipartisan-infrastructure-law-advances-environmental-justice/

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Crosse County has three sites, with the Onalaska Municipal Landfill site, being one of the worst superfund sites in the United States.[2]

While Wisconsin has traditionally been viewed as a more accessible place for individuals with means, racial disparities in health outcomes are growing.[3] In Milwaukee, studies show that Black and Latinx neighborhoods attribute more of their income on gas and electric utility bills than their counterparts. Households 1.5 times below the federal poverty line spend close to 20% of their income on energy bills. The average energy burden of a Black or Latinx household is 5%, while a White neighborhood has an average energy burden of 2.1%. These averages do not account for the one in four Black families that have energy burdens at or above 15.5% or one in four Latinx families that have at least a 7.9% energy burden. Energy burdens compounded with high eviction rates and high asthma rates is disproportionately impacting families of color.[4]

Many factors affect a community's ability to prepare for, respond to, and cope with climate change's health impacts, including: 1) living in areas particularly vulnerable to climate change 2) Coping with higher levels of existing health risks when compared to other groups 3) Living in low-income communities with limited access to healthcare services 4) Having high rates of uninsured individuals who have difficulty accessing quality healthcare.

We know that wealthier individuals will have more means to move out of areas impacted by climate change or environmental degradation, while lower income families are more likely to live in neighborhoods that are susceptible to climate-related disasters and less likely able to relocate from them as well. Further, climate change is deeply affecting the environment, leading to disproportionate health impacts, and altering and disrupting the ecosystems for Native Nations whose land our state occupies.

Over the course of two decades, Wisconsinites have incurred an exorbitant amount of financial cost due to extreme precipitation – up to $100 billion. The agricultural and livestock sectors, two influential industries in the state which rely heavily on predictable weather patterns, have been negatively impacted by the volatility.[5] Climate change policy should be viewed through the lens of Environmental Justice. Current health disparities coupled with future climate irregularities will only exacerbate already existing vulnerabilities within society.

In a wider effort to address climate change and the impacts it has on our communities, on October 17, 2019, Gov. Evers issued Executive Order #52, relating to the creation of the Governor's Task Force on Climate Change. After meeting regularly in public meetings from

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[2] https://lacrosseindependent.com/2020/06/17/a-toxic-legacy-superfund-sites-in-la-crosse-county/
[3] https://www.verywellhealth.com/health-disparities-states-5211956

[4] https://energynews.us/2021/04/09/black-latinx-families-bear-the-energy-burden-in-milwaukee-study-finds/
[5] https://climatechange.wi.gov/Documents/Final%20Report/GovernorsTaskForceonClimateChangeReport-LowRes.pdf

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December 2019 through October 2020, the Task Force issued comprehensive recommendations to the Governor in December 2020.

With an overarching focus on environmental justice and equity considerations throughout the whole report, the Task Force specifically recommended the creation of an Office of Environmental Justice tasked with collaborating across state agencies and engaging with Black, Indigenous Nations, communities of color, low-income communities, and environmental justice advocates to design climate policies that reduce emissions and pollutants and address the cumulative and deadly impacts of their concentration within these communities.

The Task Force identified policy pathways for the creation of OEJ through either executive/agency action, the 2021-2023 state budget, or legislation. Accordingly, the Governor included the creation of this office in his 2021-2023 state budget proposal. Unfortunately, it was stripped from the state budget by the legislature's Joint Finance Committee and ultimately was not included in the budget as enacted.

In November of 2021, the Forward on Climate 22 bill package was introduced based on Climate Change Task Force recommendations. Each bill aims to fight climate change, create jobs, and reduce environmental injustice.[6] This set of comprehensive bills will accelerate the process of environmental justice work across Wisconsin. In September 2021, Wausau became the first city in the state to pass a resolution supporting environmental justice. This holds Wausau officials accountable as public input and environmental justice principles will weigh more heavily in decision-making.[6]

(Required) Proposed Recommendation

1. Establish the Office of Environmental Justice (OEJ) within the Office of the Secretary of the Department of Administration, with a new unclassified director position and reallocated staff positions.

2. The OEJ shall be tasked with collaborating across state agencies and engaging with Black, Indigenous Nations, communities of color, low-income communities, and environmental justice advocates to design climate policies that reduce emissions and pollutants and address the cumulative and deadly impacts of their concentration within these communities.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are they inefficient or ineffective?-

[6] https://www.jsonline.com/story/news/politics/2021/11/16/wisconsin-democrats-introduce-package-address-climate-change/8631778002/

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Historically, there has not been an intentional effort or state government mechanism to target environmental justice. Much of this work began when Governor Evers took office, most namely through Executive Order #52 relating to the Creation of the Governor's Task Force on Climate Change. This, coupled with Executive order #17 which created the Governor's Health Equity Council, provide the first true pathway to examine health equity through an environmental justice lens. The overarching challenge for advocates is the lack of priority placed on health equity and environmental justice. Environmental justice is not seen as a focus that would reap immediate benefits, as it would take longer to see results. Examples such as Wausau, point to local municipalities taking on a more proactive leadership role. However given the limitations, state and federal involvement appears to be warranted for more substantial change.

2. (If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?

This proposal mirrors efforts in several other states in the Great Lakes region to create administrative bodies overseeing environmental justice work. As noted in the Governor's Task Force on Climate Change Report, the Illinois Environmental Protection Agency has an Environmental Justice Officer who coordinates all environmental justice efforts of the agency through the Commission on Environmental Justice. Through a 2019 executive order, Michigan created an Office of the Environmental Justice Public Advocate and an Interagency Environmental Justice Response Team. New York has an Office of Environmental Justice within the state's Department of Environmental Conservation. Illinois, Michigan, Minnesota, and New York all have Environmental Justice Advisory Groups, which appoint diverse representatives from across the state to advise on inclusive and equitable policy development.

Investment into communities of color, native nations, and low-income communities will evidently aid in the knowledge of whether resources and opportunity can bridge the disparity gap. Colorado, Rhode Island, and Washington are the only three states to approve significant legislation regarding environmental justice.[8] The research points to clear connections between environmental injustice and health outcomes. With substantial systems in place to remedy injustice, it will take time to truly analyze the overall improvements that subsequently will happen.

(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

By what process will the recommendation be implemented?

This office could be established through executive action by the Governor, through the Governor's budget proposal for the next biennium, or through legislation
The Department of Administration would be charged with housing OEJ, working in collaboration with other agencies enterprise wide

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The Governor’s 2021-2023 budget proposed General Purpose Revenue (GPR)~~GPR~~ and Program Revenue (PR) ~~R~~ appropriations for a new unclassified director position and reallocated staff positions for proper administration

- $250,000 GPR in 2021-22 to create a technical assistance grant program. Provide $396,000 PR in 2021-22, $506,600 PR in 2022-23, and 4.0 PR positions annually (2.0 unclassified and 2.0 classified) for program administration. Funding and position authority would be offset in part by a reduction to DOA's enterprise resource planning system appropriation (-$179,500 PR and -2.0 PR classified positions annually).

How would the impact of this recommendation be measured?

The Governor’s budget proposal tasked OEJ generally with creating an annual report on issues, concerns, and problems related to environmental justice. This could be narrowed in scope or left broad per a number of different considerations. OEJ would have the ability to implement new programs, assess areas of concern, and facilitate further discussion. To reiterate, it will take some time to truly measure the impacts of these recommendations, but it is important that steps be taken to create a sustained environmental justice office.

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REC 5: RELATED TO ESTABLISHING GHEC PERMANENCE

- Summary of feedback
    - Identify one clear pathway as preferred method for creating sustainable permanence of GHEC work.

- Revisions that will be made and do not need an amendment
    - Primary pathway will be clarified as DHS-advisory body to OHE – aligning with work that is already happening in OHE to build this
        - Because the OHE route has limitations, the other options should continue to be explored. One of the primary goals of the advisory board within the OHE would be to plan out how to achieve these other pathways
    - Recommendation will then be re-framed to suggest exploration of additional, alternative pathways to ensure that sustainable, ongoing GHEC work can advance with a broad scope and impact – pathways include:
        - State statute
        - Join existing council (PHC)
        - Require existing B/C to have one member seat dedicated to equity perspective
        - Grassroots advocacy network

- Amendments the Chair will be proposing
    - None

- Optional changes needing an amendment
    - None

DRAFT

Governor's Health Equity Council Major Recommendation Proposal Template

Below please find an outline for **major** recommendations. You will use this to develop your major recommendations during the **DRAFTING** phase. Our hope is that you will leverage this guidance to write impactful proposals that provide enough information that your recommendation can be fully understood and implemented the way you intend it to be. Make sure to highlight the core/most importantaspects of your recommendation's design and implementation. Remember that these recommendations will likely face significant scrutiny throughout the policymaking process, and so the more detail you caninclude, within reason, the better.

Writing style guidance

- Be clear, concise, intuitive, and compelling
- Use simple/plain and accessible (non-wonky) language
- Include any necessary definitions; assume general knowledge of equity topics and public health,but not expertise or specialist knowledge
- Include tables, charts, figures, if appropriate as visuals can be a powerful tool for storytelling.
- Include references and citations where appropriate

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Outline

Recommendation Title: Exploring the sustainability and permanence of the Governor's Health EquityCouncil

Primary Contact (and contact information) for the Recommendation:

Primary Contact (and contact information) for the Recommendation: Dr. Jasmine Zapatajasmine.zapata@dhs.wisconsin.gov

Other Members Who Worked on the Recommendation: All power, access, representation subcommittee members provided input (Amy Delong, Wanda Montgomery, Stacey Clark, Mary Thau, Vipul Shukla). Community listening session input was incorporated. Information gathering and technicalsupport meetings were held with Brian Weaver, Mackenzie Gearin, TR Williams, Jennifer Ullsvik, Michelle Robinson, Nadiyah Groves, and HJ Waukau.

(Required) Issue Statement

1. Short (1-2 sentences), high level summary of what the brief will propose and why; this isyour hook

- The Governor's Health Equity Council is an important body created via executive order #17, however, there is currently no long term sustainability plan in place to prevent this body from dissolving following potential future changes in administration. We propose that the governor elevates to a high priority developing a pathway to permanence for the currently existing GHEC.

- **(Required)** Background/ Problem Description
  1. What is the scope of the problem in Wisconsin? Include quantitative and qualitativeimpact on lives, scale of inequity, financial cost, etc.

"We as citizens and patients need to have a voice. This proposal needs to become a state statute to ensurethat patient voices are heard and remain at the center."- Community listening session attendee

"This proposal is needed in order to continue to hear the diversity of voices and to continue to move forward and make progress. There is a need for health equity to be supported by our elected leaders onan ongoing basis."- Community listening session attendee

On March 19, 2019, Governor Tony Evers issued Executive Order #17 establishing the Governor's HealthEquity Council. Given the many health inequities that exist in the state of WI, according to Executive Order #17, "The purpose of the council is to address the various factors that exacerbate health disparities by creating a comprehensive plan to achieve long-lasting and equitable health outcomes for all Wisconsinites. The plan will address health disparities based on race, economic status, education level, history of incarceration, and geographic location." The Governor's Health Equity Council, however, was established under section 14.019 of the Wisconsin Statutes as a **nonstatutory committee.** According to statute 14.019(1)(b), "Any nonstatutory committee shall expire on the 4th Monday of January of the year in which a new gubernatorial term of office begins **unless the new governor, by executive order, provides for its continued existence** and in that case persons then

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serving on such committee remain members until they resign or until they are removed or replaced by action of the new governor." As a nonstatutory committee, the very existence of the GHEC may be threatened with changes in administration.

2. Which groups are most impacted by inequity?

This proposal impacts all Wisconsinites, however, will particularly impact those who experience healthdisparities in populations based on race, economic status, education level, history of incarceration and geographic location as emphasized in executive order #17.

(Required) Proposed Recommendation

1. Concise but thorough description of recommendation (use bullet points to show thespecific components of the policy)

The critically important work of the GHEC should continue to move forward despite which governor is inoffice. This is especially important from a power, access, and representation perspective.

A potential strategy to accomplish this objective would be for the GHEC to transition to a state statute established structure. The GHEC currently operates as a governor appointed and governor established council, however, there are other statewide councils that are governor appointed but state statute established. Examples include the Council of Physical Disabilities, Public Health Council and the WI Council on Mental Health. https://www.dhs.wisconsin.gov/aboutdhs/councils.htm). The GHEC transitioning to a statute established structure of a similar nature would allow for long term sustainabilityand permanence even after transitions in administration.

Given the current political landscape, however, this may not be possible in a timely manner. In order totransition to a state statute established body, there will be much political capital utilized, coordination,

and bipartisan collaboration. Therefore, an alternative strategy to consider would be for the GHEC to transition into a state budget supported agency established body. One possibility would be for the GHEC to transition into a standing advisory council established by DHS embedded within the new Office of Health Equity. Because the work of the GHEC has been so deeply embedded already within DHS, it would be a natural transition to have the work continue there. Embedding the work within the New Officeof Health Equity would be a possible strategy and this new body could synergistically work with to improve health outcomes for marginalized populations across the state.

2. How does the recommendation addresses equity/reduce a disparity?

The many health inequities that face our state require continued forward momentum to overcome and transitioning the GHEC to a more permanent structure would prevent setbacks. The potential expiration of the current GHEC in future administrations would have tremendous social impacts and would be a stepbackward in the collective fight for health equity in Wisconsin. Transitioning to a more permanent structure would facilitate continued forward momentum on issues of health equity that impact our most marginalized communities and should be a priority. This has the potential to not only improve lives but save lives.

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3. At what structural/systemic lever(s) is the policy aimed? What is the justification/rationale/business case for this recommendation? (inequity reduced, livesimproved, lives saved, financial benefit for the state, etc.)

This policy aims to increase relationships and connections, influence policy, and shift power dynamics.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible,understanding that you may not have all at this information at this time)

1. What are the systemic challenges that act as barriers to addressing this issue? And/orwhat are the current approaches to address the issue, and why are they inefficient or ineffective?

Our current political landscape serves as a potential systemic challenge to creating a state statute body. The current approach to this issue and creating a long term permanence plan in spite of the current political landscape has not been yet fully addressed or decided. That is why attention to this proposal is soparamount to further solidify a plan of action moving forward.

2. (If applicable) How is the recommendation based on best practice, or what evidenceexists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?

Best practice in public health and politics involves listening to the voices of those most impacted, therefore, it will also be important no matter which final pathway is decided to include patient voices inthe committee structure.

"Make SURE to mandate patient involvement in the structure/composition of the council (no matter if it'svia state pathway or agency pathway). Sometimes when health related organizations approach me and say

I'm invited to 'sit at the table' I say I would hope so because 'it's my table. I hope I would be invited. Ifit's without us, it's not about us" –John Linnell, Community member (shared with permission)

(Optional, but Recommended) Implementation Design (please respond to as much is feasible,understanding that you may not have all at this information at this time)

1. By what process will the recommendation be implemented?
   - Through what policy pathway does the recommendation work?
   - Which agency /department would be charged with implementing therecommendation?
   - What resources are needed for implementation? How much would it cost? Howlong would it take? How much people power would it take?

In order to create a state statute established pathway, it will be important to first identify legislative representatives from both parties willing to work together to champion this cause. The Governor could approach and collaborate with the legislature to draft language for a bill and identify champions.

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Once they are identified, a collaborative plan of action can be developed regarding the best strategic plan for getting the bill passed. Current GHEC leadership team members could also work closely with the legislative representatives to develop this plan and also involve community members and stakeholders inthe process.

Given the current political landscape, however, an alternative pathway could be to transition the GHEC into an advisory council of some sort to be embedded within the DHS Office of Health Equity. Ideally, this would include interagency collaboration (following the model of Interagency Network on Lead) as well as a diverse membership from Wisconsinites and stakeholders who are impacted by various health inequities. It is critical that people with lived experiences help advise and shape the work. This new advisory council ideally would not only provide suggestions to help advance the work of the DHS Officeof Health Equity, but could include community education aspects, inform recommendations for future budget items and assist with grant making decisions. General purpose revenue (GPR) dollars to support this new advisory body embedded within the DHS Office of Health Equity would be beneficial as well. This budget could pay stipends to members, pay for the administrative infrastructure and also potentiallyfund grant making initiatives so that the suggestions of the council can be implemented immediately.

A third hybrid option to explore would be for the current GHEC members to transition into a subcommittee of some form within The Public Health Council (which is an already existing state statute council established by Wisconsin Act 96). "By statute, the Council's purpose is to advise the Department of Health Services, the Governor, the Legislature and the public on progress in implementingthe state's 10-year public health plan and coordination of responses to public health emergencies." Wis.
Stat. §15.197(13). This is another potential model that could be explored to promote the long termsustainability and permanence of the work of the Governor's Health Equity Council.

Finally, if the above pathways are not feasible, the GHEC could dissolve and a subset of the current members could form a more grassroots community based advocacy collaborative. In this model, the governor would have less direct interaction, however, could potentially support funding for initiatives ofthis nature.

Overall, despite which pathway is decided, this overall recommendation is important because

Wisconsin's marginalized populations deserve to have councils such as the GHEC closely workingwith the governor despite changes in administration. The permanence and sustainability of the GHEC should be a priority to continue to advance the health of all Wisconsinites.

How could the impact of this recommendation be measured?

- Include any metrics already tracked, if possible
- Propose new metrics, if necessary

- The metrics to measure the impact of this proposal will be based on which pathway is ultimately decided. Broadly metrics that may be explored are GHEC in existence in some form until at least2030, % of community involvement and patient voice on council, level of interagency collaboration, $ amount of GPR funding allocated to support the council in the future, number of best practice guidelines and reports produced by the council, number of new relationships formedamong council members, policies and health outcomes impacted as a

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result of council recommendations, and more.

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REC 6: RELATED TO MATERNAL MORTALITY REVIEWS

- Summary of feedback
  - There are potential privacy concerns, especially in the case of impounded birth records, if interviews of mandatory. Currently, there are very strict restrictions on impounded birth records (e.g., adoptions), and mandatory interviews could create challenges depending on source of where the MMR panel is getting the familial information if it involves one of these records.
  - Increased staffing capacity and financial resources are necessary to implement this recommendation.

- Revisions that will be made and do not need an amendment
  - Indicate that all protocols would adhere to necessary privacy restrictions regarding the data obtained from the family interviews.
  - Include increased staff and financial resources necessary to implement change.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Governor's Health Equity Council Major Recommendation Proposal Template

Below please find an outline for **major** recommendations. You will use this to develop your major recommendations during the **DRAFTING** phase. Our hope is that you will leverage this guidance to write impactful proposals that provide enough information that your recommendation can be fully understood and implemented the way you intend it to be. Makesure to highlight the core/most important aspects of your recommendation's design and implementation. Remember that these recommendations will likely face significant scrutiny throughout the policymaking process, and so the more detail you can include, within reason, the better.

Writing style guidance

- Be clear, concise, intuitive, and compelling
- Use simple/plain and accessible (non-wonky) language
- Include any necessary definitions; assume general knowledge of equity topics and publichealth, but not expertise or specialist knowledge
- Include tables, charts, figures, if appropriate as visuals can be a powerful tool forstorytelling.
- Include references and citations where appropriate

Outline

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DRAFT

Recommendation Title: Preventing Maternal Mortality through Family Interviews: Centering Family Voice in Wisconsin's Maternal Mortality Review

Primary Contact (and contact information) for the Recommendation: Dr. Jasmine Zapata(jasmine.zapata@dhs.wisconsin.gov)

Other Members Who Worked on the Recommendation: Emily Lynch, Angela Rohan, HannahGjertson, and Emily Morian-Lozano.

(Required) Issue Statement

1. Short (1-2 sentences), high level summary of what the brief will propose andwhy; this is your hook

Wisconsin's Maternal Mortality Review (MMR) closely reviews every death during or inthe year following pregnancy to identify contributing factors and provide recommendations to prevent future deaths, however, the data sources in Wisconsin's MMR do not currently encompass the experiences of families and friends who can addunderstanding to the circumstances that affected the individual and may have contributed to their death. Conducting family interviews as a part of Wisconsin's MMRwould provide information related to social and environmental contexts (including butnot limited to experiences of stigma and discrimination) as well as experiences of care delivery and interactions with providers and systems that could inform upstream recommendations and primary prevention efforts at a community and system level.

(Required) Background/ Problem Description

1. What is the scope of the problem in Wisconsin? Include quantitative andqualitative impact on lives, scale of inequity, financial cost, etc.
2. Which groups are most impacted by inequity?

Approximately 40 people die during or within a year of pregnancy every year in Wisconsin. The racialized inequities that persist in maternal mortality in Wisconsin and across the country are painfully predictable. Pregnancy-related mortality for non- Hispanic black people is 5 times the rate for non-Hispanic white people (Wisconsin Department of Health Services, 2018). The significant racial inequities in maternal healthdemonstrate the opportunity for systematic improvements in the care of pregnant people. Social, economic, and physical conditions impact a birthing persons' health before, during, and after pregnancy. The unequal and unjust policies and practices that have discriminated against racially marginalized create hardship and stress through the lifespan, impacting the health of birthing persons and their babies.

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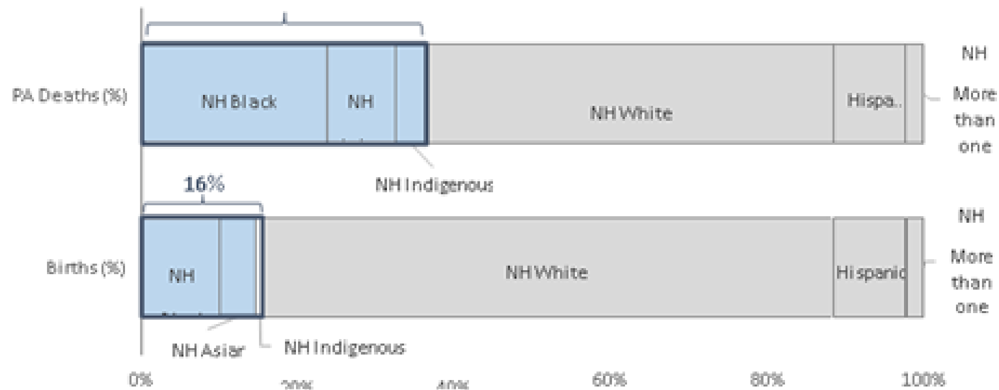
While Non-Hispanic Black, Non-Hispanic Asian, and Non-Hispanic Indigenous birthing people made up only 16% of Wisconsin births in 2016-17, they represented more than one third of all pregnancy-associated (PA) deaths* (37%) in the same time period.



*Pregnancy-associated death: a death during or within one year of pregnancy, regardless of the cause

The MMR team examines pregnancy-relatedness (a death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy) and preventability (if there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors) of each case, with the goal of identifying system gapsand other opportunities for the prevention of future maternal deaths (Wisconsin Department of Health Services, 2018). Among pregnancy-related deaths, almost two- thirds are preventable (Centers for Disease Control and Prevention, 2020).

Wisconsin's MMR relies on provider records, which is a challenge because the perceptions of care may be very different from the patient perspective and because of the lower rates of health care utilization by race and Medicaid status. In 2016, 65% of maternal deaths in Wisconsin were on Medicaid at the time of death, and 84% were on Medicaid at some point in their lives. Between 1990 and 2020 in Wisconsin, 66% of births to people insured by Medicaid received first-trimester prenatal care as comparedto 86% of births to people with private insurance (WISH, Prenatal Care Module 1990- 2020). Eighty-one% of births to white birthing people received first-trimester care in Wisconsin as compared to 63% of births to Black/African American birthing people, 63%of births to American Indian/Alaska Native birthing people, 68% of births to Hispanic birthing people, and 67% of births to Laotian or Hmong birthing people (Wisconsin Interactive Statistics on Health Query System, Prenatal Care Module 1990-2020). These statistics illustrate the need to understand why the people most affected by maternal mortality, who often sit at the intersection of racial and economic marginalization, did not or could not engage in care.

(Required) Proposed Recommendation

1. Concise but thorough description of recommendation (use bullet points to showthe specific components of the policy)

This proposal recommends that the Wisconsin Maternal Mortality Review receives theresources to conduct family interviews to provide contextual information to
complement the current data sources in Wisconsin's MMR and allow MMR members to comprehensively assess contributors to the death and inform recommendations to reduce inequities

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in maternal mortality. This recommendation would require funding forstaffing resources to conduct family interviews, developing a data gathering process andmethodology for conducting interviews, and fostering partnerships and developing outreach materials to ensure success.

2. How does the recommendation addresses equity/reduce a disparity?
   - At what structural/systemic lever(s) is the policy aimed?

Family interviews address inequities in maternal mortality by providing a mechanism toidentify factors such as stigma, discrimination, and structural racism that may have contributed to maternal deaths that are not currently captured in the data sources. TheMMR committee identifies factors that contributed to the death and, if there was at least some chance that the death could have been averted, recommendations on specific and feasible actions that, if implemented or altered, might have changed the course of events. Family interviews center community voice in identifying factors that contributed to the death and recommendations to prevent future maternal deaths. Contributing factors can include childhood abuse/trauma, quality of care, care coordination, discrimination, interpersonal racism, structural racism, violence, unstablehousing and more. The MMR committee recommendations can be made at the patient/family level, the provider level, the facility level, the system level, and the community level. Currently, Wisconsin's MMR does not have the infrastructure to incorporate family perspective in the review and recommendations, thus data from theinterviews may directly inform contributing factors and recommendations at these levels.

3. What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state,etc.)

In Wisconsin, the Foundation for Black Women's Wellness and the Saving Our Babies Initiative gathered robust quantitative and qualitative data with strikingly clear results:racism is the greatest risk factor affecting Black women's health and birth outcomes.
The prioritization of Black women's voices illuminates the root causes of Black disparities in birth outcomes and is needed to inform structural change (Peyton-Caire &Stevenson, 2021. Wisconsin's MMR currently has a blind-spot because the family perspective is missing from the review and recommendations.

There is an enormous economic and financial cost of maternal mortality. Birthing peoplewith Severe Maternal Morbidity (SMM) have higher delivery hospitalization charges.
The median hospital charges in Wisconsin between 2010 and 2014 were $8,924 for individuals with no indicators of SSM, $18,924 for individuals with one indicator of SSM,
$35,701 for individuals with 2 indicators of SSM, and $66,366 for individuals with 3 or more indicators of SSM (Wisconsin Department of Health Services, 2015). These costs only account for obstetric complications, which don't account for the additional costs ofcomplications injury, mental health, etc. during the perinatal period.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are theyinefficient or ineffective?

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The State of Wisconsin has a multidisciplinary Maternal Mortality Review (MMR) that examines each case of maternal mortality to understand the circumstances surrounding each death. Currently, the MMR relies on data sources from the state vital records office, medical records, coroner and medical examiner reports, social services records, and other relevant records that provide information and context for the maternal death.The data sources in Wisconsin's MMR do not currently encompass the perceptions, experiences, and accounts of families and friends who can add understanding regarding the social and environmental contexts of a maternal death as well as details around experiences of care and interactions with providers and systems. Family interviews would not be mandatory, but rather optional for families who want to participate. The family interview could provide information that is missing from the records that would allow the MMR team to make more equity-informed decisions and recommendations.

2. (If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately,how will this proposal generate new knowledge?

In Wisconsin, interviews have been implemented in many contexts following a death toidentify contributing factors, including fetal and infant deaths, overdose fatalities, and suicide. With growing consensus of interviews as a best practice in MMR an increasing number of MMRs across the nation have begun conducting family (or informant) interviews for maternal deaths (Review to Action: Working Together to Prevent Maternal Mortality). Some states have even established legislative authority to conductinterviews, including North Carolina, Oklahoma, Georgia, Indiana, Mississippi, New Jersey, and West Virginia (North Carolina, 2015; Oklahoma, 2019; Georgia, 2013-14; Indiana, 2017-18; Mississippi, 2017; New Jersey, 2018-19; West Virginia, 2008). While each of these states have different approaches to conducting interviews, they provide valuable insight into the process and value of interviews. We talked with four states (Georgia, Indiana, Delaware, and Mississippi) about their experiences conducting familyinterviews and incorporated their insight, advice, and recommendations surrounding best practices. Additionally, in 2019 the Centers for Disease Control and Prevention released a guide for Maternal Mortality Review Committees to conduct interviews following a maternal death that has guided our planning process (Centers for Disease Control and Prevention, 2019). Finally, the Black Mamas Matter Alliance (BMMA), a Black women-led cross-sectoral alliance that centers Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice, recently released their 2021 report summarizing findings of an environmental scan to understand the challenges and opportunities for improvement that community members experienced while engaging or attempting to engage with Maternal MortalityReview Committees (Black Mamas Matter Alliance, Research and Evaluation Department, 2021). One of their recommended strategies identified by community members was to integrate family interviews conducted by trained community health workers to provide a more comprehensive perspective than can be achieved from medical records alone (Black Mamas Matter Alliance, Research and Evaluation Department, 2021). The family interview was recommended as a strategy to provide training, guidance, and resources to strengthen the capacity of Maternal Mortality Review Committees (Black Mamas Matter Alliance, Research and Evaluation Department, 2021).

(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. By what process will the recommendation be implemented?

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- Through what policy pathway does the recommendation work?
- Which agency /department would be charged with implementing therecommendation?
- What resources are needed for implementation? How much would it cost? How long would it take? How much people power would it take?

The Department of Health Services (DHS), Division of Public Health (DPH) staffs Wisconsin's multidisciplinary MMR program and Review Team, thus would be well positioned to integrate family interviews into their current MMR program. However, thecurrent DPH team does not have the staff capacity or needed expertise (in social work or grief counseling) to conduct the interviews. This recommendation works through a budget pathway as the MMR isn't asking for a change to state statue, but rather, is asking for dollars to be assigned to this initiative. Based on our conversations with otherstates, we estimate that one interview will take between 11 and 20 hours (including researching the case/records, locating informants, outreach to informant, completing the interview, documenting the interview, and following up with specialized resources as needed), and that the family interviewer would need ~750 hours to spend on ~50 interviews (estimating an average of 15 hours per interview). Given these estimates, we recommend that DHS hire a 0.5 LTE appointment. We estimate the annual cost for DHS to hire a 0.5 LTE staff member to conduct family interviews would range between
$54,938- $66,861 and the total annual cost of conducting family interviews would rangebetween $61,488 and $73,411. The total annual cost includes the 50% LTE, interview equipment, office supplies for outreach materials, custom graphics developed for materials, thank you gift card or remembrance memento, and travel/conferences.

2. How would the impact of this recommendation be measured?
   - Include any metrics already tracked, if possible
   - Propose new metrics, if necessary

Measuring the impact of conducting family interviews will be multifactorial, includingevaluating both the process and outcomes. To measure process, we would measure participation in the interviews (response rate) and create a survey for the MMR teammembers to assess how the interview added to the MMR review process and recommendations. New performance measures could assess the outcome of the
interviews on MMR team member's decisions and recommendations as well as if the family interviews shifted the types of recommendations proposed and implemented. Tracking the number of recommendations that directly resulted from information in theinterview and whether the recommendations were successfully implemented would be key performance measures. Additionally, measures to evaluate community partner review of the process and impact could be developed to track success. Long term, we would continue to track Wisconsin's maternal mortality rate overall and by race/ethnicity to measure the impact on racial inequities.

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Wisconsin Department of Health Services. (2015). P-01125. Severe Maternal Morbidity amongWisconsin Residents, 2010-2014. https://www.dhs.wisconsin.gov/publications/p01125.pdf.

Wisconsin Interactive Statistics on Health (WISH) Query System. Prenatal Care Module 1990-2020. https://www.dhs.wisconsin.gov/wish/prenatal-care/form.htm.

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REC 7: RELATED TO RURAL BROADBAND

- Summary of feedback
  - Include citations to both the Task Force report as well as the PSC State Broadband report. Both documents are to be updated in coming months; using these updated reports will ensure GHEC's recommendations align with current best practices.
  - Incorporate more of the framing language from PSC reports on Access, Affordability, and Adoption challenges in rural and urban areas that lack access to broadband and high-quality connectivity. Affordability continues to be a central challenge in many parts of the state.

- Revisions that will be made and do not need an amendment
  - Add reference to, and include relevant recommendations from, the PSC State Broadband Report, the Task Force report, and their updates.
  - Add language that more clearly highlights issues affecting affordability are a significant barrier (in addition to access, adoption challenges, and quality).

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - **7A.** Add language to reflect broadband challenges in both rural and urban areas

Governor's Health Equity Council Major Recommendation Proposal Template

Below please find an outline for **major** recommendations. You will use this to develop your major recommendations during the **DRAFTING** phase. Our hope is that you will leverage this guidance to write impactful proposals that provide enough information that your recommendation can be fully understood and implemented the way you intend it to be. Makesure to highlight the core/most important aspects of your recommendation's design and implementation. Remember that these recommendations will likely face significant scrutiny throughout the policymaking process, and so the more detail you can include, within reason, the better.

Writing style guidance

- Be clear, concise, intuitive, and compelling
- Use simple/plain and accessible (non-wonky) language
- Include any necessary definitions; assume general knowledge of equity topics and publichealth, but not expertise or specialist knowledge
- Include tables, charts, figures, if appropriate as visuals can be a powerful tool forstorytelling.
- Include references and citations where appropriate

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Outline

Recommendation Title: Improve Access to Telehealth in Rural Areas via Broadband Expansion

Primary Contact (and contact information) for the Recommendation: Dr. Jasmine Zapata

Other Members Who Worked on the Recommendation: (Regina Vidaver, PhD, Mark Wegner,MD, MPH, …..)

(Required) Issue Statement

1. Wisconsin's rural residents are used to being self-sufficient. However, their health care needs often require them to travel great distances to access appropriate care, particularly for medical specialists. Advances in telehealth havethe potential to dramatically improve the quality of life for rural residents, by improving access to regular and specialty health care, and reducing travel times. However, the promises of telehealth cannot be realized until broadband is accessible for all rural residents.

(Required) Background/ Problem Description

1. The Governor's Task Force on Broadband Access determined that 21.8% of rural residents are without access to broadband service with a minimal speed allowing reliability and optimal usability: 25 megabits per second download and 3 megabits per second upload (25/3 Mbps). Without access to 25/3 Mbps minimal broadband speeds, more than one in five rural Wisconsin residents are disproportionally unable to access telehealth services, even when they are available through their health care providers.

(Required) Proposed Recommendation

1. The Governor's Health Equity Council recommends adoption of all of therecommendations contained within the 2021 Governor's Task Force on Broadband Access to improve rural access to telehealth services. In particular, the following recommendations are likely to provide focused improvements forrural areas:
    - Explore hybrid models of broadband infrastructure development andownership.
    - Increase Broadband Expansion Grant Program funding.
    - Establish a State Internet Assistance Program, both for individuals, andfor companies wishing to provide access at reduced/complimentary rates.
    - Establish a statewide Digital Equity Fund to fund, strengthen, and supportdigital inclusion activities and ideas that lead to all residents having the information capacity needed to fully participate in society.
    - Develop and fund a statewide Digital Navigator program to assist

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under- connected people. Digital Navigators should be embedded in organizations with strong and trusting community relationships, with theorganizational capacity and cultural competency to make an impact.

- Align, coordinate, and maximize present and future federal funding.
- Increase state and municipal funding for broadband administration.
- Create planning and implementation grants for regions and communities.

2. By implementing these recommendations, more rural areas and households willbe able to be served by reasonable broadband speeds. Expanding access to ruralhouseholds will allow greater uptake of telehealth services, thus improving health care access, particularly for specialty care, which is often limited to urbancenters.
   - The recommendations of the Task Force are designed to comprehensively address the systemic forces that purposely or accidentally limit broadband access in rural areas. They also provide specific recommendations for how to implement structural approachesto reduce broadband access disparities.
3. If these recommendations are implemented, rural residents will have less inequality in access to health care, particularly specialty care, and consequently, their health outcomes will improve. Furthermore, there are known cost-savings with the use of telehealth, predominantly for the consumer who no longer has to incur the time or financial costs of taking time off of work to travel to distant locations for care. There also may be financial benefits to the state, if more Medicaid members are able to access more timely high quality care, thus potentially preventing disease progression, and preventing hospital admissions and readmissions. Health systems would also likely see cost savings for the samereasons.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. Availability and affordability are barriers to internet adoption. Many rural areas of the state have *no* internet provider. Often, even if there is internet available, itis limited to a single provider, which essentially has a monopoly and can charge high rates for services. The quality of service is also not uniformly acceptable for telehealth use. Furthermore, there are elements of state law that inhibit the ability of local municipalities to foster broadband access. Recommendations for overcoming these barriers, cited from the report:
   - Create access to a cost-model report tool approved by the Public ServiceCommission, to reduce the hurdle of producing a total cost

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report for communities pursuing publicly owned broadband infrastructure.
    - Create legislative specifics on the manner, timeframe and court in whichany challenge or grievance must be filed when communities actively pursue broadband infrastructure investments.
2. Another barrier to adoption is digital literacy. Many individuals have not receivedtraining in or exposure to methods of engaging with others through technology beyond telephones. Recommendations for overcoming these barriers, cited fromthe report:
    - Create programs to expand internet and digital literacy and skills. K-12schools, technical colleges and universities, UW-Extension, senior centers, libraries, non-profits, healthcare institutions, banks and creditunions were cited as examples of providers of such programs.
    - Provide ongoing technical assistance for individuals seeking to use digitalskills on a regular or infrequent basis.
    - Develop a publicly available clearinghouse to raise awareness of andaccess to low-cost offers, digital literacy classes, and organizations promoting and assisting with digital equipment and tech support.

   These recommendations come directly from the committee charged with improving access to broadband, thus they have been well-researched, equitablydeveloped, and vetted by experts.

(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. We recommend the Governor's Health Equity Council provide a full endorsement ofthe Governor's Task Force on Broadband Access, noting the opportunity to improveaccess to telehealth services, thus improving health outcomes for rural residents. The report lays out specific recommendations for improving access to broadband services statewide. These recommendations would require engagement from:
    - The legislature, to modify state statutory language currently inhibiting localinnovation
    - County resources, to provide project management
    - The PSC, to provide oversight, with a focus on equitable provision of servicesand access to digital literacy resources
    - The internet provider industry, to identify opportunities for public/privatepartnership
    - Local municipalities, to identify opportunities for public/private partners,public engagement, and, in some cases, public utility

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expansion or development

2. The impact of this recommendation could be measured by:
    - Change in percentage of state residents with regular access to 25/3 Mbpsservice (minimal speeds reliable for telehealth purposes) at home or via easily-accessible community resources
        - Sub-analysis of change in percentage of rural residents with access toreliable broadband service
    - Change in percentage of state residents with access to internet servicecosting less than $60/month
        - Sub-analysis of change in percentage of rural residents with access tolow cost internet services
    - Change in percentage of state residents accessing telehealth services in thepast 12 months
        - Sub-analysis of change in percentage of rural residents accessingtelehealth services in past 12 months

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REC 8: RELATED TO TRANSGENDER EMPOWERMENT AND SAFETY

- Summary of feedback
  - Needs more specifics about how DOA will help support the interagency council – e.g, analogous to the Interagency Council on Homelessness
  - Sharpen the recommendation so that it is clearer how the recommendation will take effect.

- Revisions that will be made and do not need an amendment
  - Update language to specify format as interagency council
  - Modify title and policy pathways to clarify the intent of the recommendation.
  - Add language to ensure council will be composed of diverse membership including by race, ethnicity, geography, economics, and ability.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Recommendation Title: Transgender Empowerment and Safety

Primary Contact (and contact information) for the Recommendation: Vipul Shukla

Other Members Who Worked on the Recommendation: Stacy Clark, Syd Robinson

(Required) Issue Statement

2. Short (1-2 sentences), high level summary of what the brief will propose and why; this is your hook

According to the Williams Institute, there are 1 million individuals within the USA that identify as transgender (1). Many of these individuals are unable to live their lives safely, and face stigma and discrimination based on gender identity. This leads to lowered mental and physical health outcomes overall. The 2019 Wisconsin Transgender Needs Assessment was performed to obtain information on the needs and health disparities faced by transgender individuals living within Wisconsin. Based on the results of the Needs Assessment, numerous changes at the agency and legislative level would be required to improve the lives of transgender individuals residing in Wisconsin.

(Required) Background/ Problem Description

3. What is the scope of the problem in Wisconsin? Include quantitative and qualitative impact on lives, scale of inequity, financial cost, etc.
4. Which groups are most impacted by inequity?

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There are over 19,000 transgender individuals that live in Wisconsin (2). The Wisconsin Communicable Disease and Harm Reduction section at the Wisconsin Department of Health Services (DHS) conducted a transgender needs assessment in 2019; transgender residents of Wisconsin were asked to provide input and discussion of personal experiences regarding transgender health and disparities. Based on data from the 2018 Wisconsin Transgender Needs Assessment, a majority of respondents identified needs for health care (73%), legal protections (65%), and employment free of discrimination (62%). The following statements and themes were brought to the attention of DHS: ""Transgender people need support in all areas of their lives, and visibility. Transgender people are not frequently in traditionally recognized positions of leadership but are doing "acts" of leadership, often unobserved by people in positions of power." In order to improve health outcomes of transgender individuals, various recommendations were made:

- Directives and leadership need to take ownership for creating inclusive environments; issues of inclusion should not be employee led but board of directors and executive leader driven
- Creation of gender neutral spaces
- Have more visible leadership by Trans people, so that the transgender community (and cisgender people) can see transgender people leading
- Remove requirements for providing extensive gender identity documentation for health insurance and other systems

To further obtain information on the lived experiences of transgender individuals, the drafting team sent a survey of five questions to transgender organizations and community members that live within the state of Wisconsin. Some common themes that were discovered were: limited opportunities for gainful employment, unsafe housing, limited access to health care providers with expertise in transgender health, access to administrative support (to update names, birth certificates, passports, etc.). A creation of a transgender empowerment and safety council, consisting of transgender individuals in leadership roles, would be the best proponent for improving the lives of transgender individuals.

(Required) Proposed Recommendation

- Concise but thorough description of recommendation (use bullet points to show the specific components of the policy)

The creation of a transgender empowerment and safety council, consisting of transgender individuals in leadership roles, would be a multifaceted development in the effort to improve the lives of transgender individuals living in Wisconsin. This leadership council will focus on the following goals:

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- **Goal 1:** Increase awareness and understanding of LGBTQ+ disparities, unmet treatment needs, minority stress, evidence based practices (EBPs) and best practices, workforce challenges, and opportunities among practitioners, families, youth, states, and communities through regular provision of free, publicly-available, coordinated Training and Technical Assistance (TTA)
- **Goal 2:** Increase practitioner knowledge and skills about effective strategies to decrease health disparities and stigma including through evidence-informed, evidence-based, and best practices
- **Goal 3:** Accelerate adoption and implementation of EBPs through the implementation of evidence-based LGBTQ+ group clinical models as well as training and coaching models for the workforce

Based on the responses from transgender residents of Wisconsin, an inter-agency approach is required. The transgender empowerment and safety council requires community engagement and involvement; this will allow for the identification of specific strategies to ensure a coordinated and seamless approach to transgender empowerment and safety. This should include key stakeholders and transgender individuals with lived experiences that focus on numerous aspects of transgender health equity.

- How does the recommendation addresses equity/reduce a disparity?
  - At what structural/systemic lever(s) is the policy aimed?

These recommendations are focused on the Executive and Agency levers.

Policies and practices that exclude transgender and gender-nonconforming people have a negative impact on gender minority health by permitting discrimination and reinforcing stigma. The transgender safety and empowerment council advocates for the adoption and application of inclusive policies and practices that recognize and address the needs of people and communities identifying as transgender or gender nonconforming. Inclusive policies and practices are those that recognize transgender and gender-nonconforming identities as deserving of equal consideration and treatment. Inclusive policies and practices are critical to reduce health inequities experienced by transgender and gender-nonconforming people.

Policies and practices that exclude transgender and gender-nonconforming populations have a negative impact on transgender and gender minority health by permitting discrimination and reinforcing stigma (3–14).

Policies and practices that discriminate against transgender and gender-nonconforming people increases the likelihood of social alienation, homelessness, financial instability, substance use (as a coping mechanism for transphobic discrimination and mistreatment), HIV vulnerability, incarceration, psychological distress, suicidal ideation, suicide attempts, suicide, and homicide (15,16–19).

These recommendations reduce disparity by:

- Urging State legislatures to fund research to better understand and promote transgender and gender minority health, including research that monitors the effects of policies and practices on health.

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- Urging public and private workplaces to institute nondiscriminatory policies and practices inclusive of transgender and gender-nonconforming people.
- Encouraging public health and health care practices that are inclusive of transgender and gender-nonconforming people.
- Encouraging public and private entities to adopt policies and practices inclusive of transgender and gender-nonconforming people in different settings and across all sectors.

  - What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state, etc.)

Transgender people face health and economic disparities that interrupt core aspects of life. Many of these disparities exacerbate key gaps we see in respect to equity and empowerment of transgender individuals. Having access to a council of transgender individuals with lived experiences will help alleviate the gaps in health equity and disparities affecting this population. Transgender visibility and representation in agencies and community based organizations helps curve the inequities in the transgender community. By having transgender individuals in leadership positions on the council, there will be increases in the culturally responsive services for this marginalized community.

Many factors that affect transgender individuals are specific to this population; the transgender empowerment and safety council will focus on the goals and recommendations listed above. Focusing on these goals and recommendations will allow for the council to collaborate with key community stakeholders to decrease the disparities affecting the transgender community in Wisconsin.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time)

3. What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are they inefficient or ineffective?

There have been approaches to addressing the disparities that affect transgender individuals residing in Wisconsin. The most common approaches and their inefficiencies are described below:

a. Capacity building: Although various instances of capacity building and education exist within the state of Wisconsin, many transgender individuals lack the means to access these services.
b. Community Organizations: There are community organizations that provide assistance and resources to improve the lives of transgender individuals; however, these organizations are located in major cities within Wisconsin. Many individuals

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that do not reside in these cities may travel great distances to receive services, or may be unaware of the community organizations.

4. (If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?

Numerous councils have been created that aim to improve the lives to people living in Wisconsin. Although these councils have documented and demonstrated improvements in the areas of need that they focus on, they do not focus on transgender health equity and safety.

(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

3. By what process will the recommendation be implemented?
    - Through what policy pathway does the recommendation work?

This recommendation will be implemented via the agency policy pathway.

- Which agency /department would be charged with implementing the recommendation?

This recommendation will be implemented using an interagency approach. The Communicable Disease and Harm Reduction Section in the Department of Health Services will champion this recommendation. They will have assistance from the Department of Administration.

- What resources are needed for implementation? How much would it cost? How long would it take? How much people power would it take?

4. How would the impact of this recommendation be measured?

Using a combination of qualitative research with the quantification of survey research often yields deep and sometimes surprising new insights (20). Some benefits of this combination approach are: enrichment of data, better understanding of the data, increased exploration of results, and verification of results. The impact of this recommendation will be measured using this combination approach. The following tools will be used to measure impact:

- Pre and post qualitative interviews of council members and stakeholders/community members: this approach will allow for community feedback and provides a deeper understanding of the Council’s work.

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- Quarterly site visits with the council: these check-ins are to assess the work of the council and address any issues that may arise. Some variables that will be assessed include attendance, survey responses, open discussions
- Training evaluations:
  - A key aspect of the council will be providing training and capacity building to organizations regarding transgender health, safety, and empowerment.
  - At the end of each training, an evaluation will be sent to participants to complete. This evaluation will assess the importance of the training, improvements required, and participant opinions regarding the presenters
  - Data gathered from the trainings will include: attendance, improvements occurring post-training (assessed every 3 months)
- Community listening sessions: Community members will be asked to provide input on a quarterly basis via a virtual community listening session.

Glossary of Terms: Definitions from the Oxford English Dictionary (21)

1. Cisgender – describing or connected with people whose sense of personal identity and gender is the same as their birth sex

2. Gender non-conforming – Denoting or relating to a person whose behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their gender.

3. Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) – Lesbian, gay, bisexual, transgender, and queer

4. Transgender – Denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex.

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REC 9. RELATED TO PROVIDING TUTION WAIVERS

- Summary of feedback
  - As written, it is not clear that the proposal was intended only for enrolled members of tribal nations of Wisconsin

- Revisions that will be made and do not need an amendment
  - Text will be revised to clarify that enrolled members of tribal nations of Wisconsin are the focus of this proposal

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Governor's Health Equity Council Major Recommendation Proposal Template

Recommendation Title: Tuition Waiver for WI American Indian Undergraduate Students

Primary Contact (and contact information) for the Recommendation: Dr. Amy DeLong(amy.delong@ho-chunk.com)

Other Members Who Worked on the Recommendation:

(Required) Issue Statement

1. Short (1-2 sentences), high level summary of what the brief will propose andwhy; this is your hook

A tuition waiver for Wisconsin American Indian undergraduate students to attend a public four- year college or a two-year college or technical school will eliminate one of the financial burdens for American Indian students and their families, thereby diversifying the work force and increasing the pool of American Indians who wish to pursue a graduate education. In addition, atuition waiver for Wisconsin American Indian students will serve as a powerful recruitment tactic for students who are often the first to attend college in their families and who often do not have the family resources to afford a higher education.

(Required) Background/ Problem Description

1. What is the scope of the problem in Wisconsin? Include quantitative andqualitative impact on lives, scale of inequity, financial cost, etc.
2. Which groups are most impacted by inequity?

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Based on national data, less than one fifth of enrolled college students ages 18-24 were Native American in 2016, the lowest of any subgroup[1]. At the University of Wisconsin-Madison in 2019, Native Americans made up 0.224% of the enrolled students, the lowest of all the groups (65% White, 6.6% Asian, 5.5% Hispanic or Latinx, 3.3% two or more races, 2% Black)[2]. Native American students represent the smallest percentage of enrolled college students at both the national and Wisconsin state levels. While there are multiple reasons for low enrollment of American Indian students at the college level, this proposal seeks to eliminate one aspect of thefinancial burden, specifically tuition.

Eliminating the cost of college tuition for American Indian students is appropriate for several reasons. First, the national median household income for American Indian and Alaska Natives (AI/AN) is $49,906, as compared to $71,664 for non-Hispanic white households in 2019. Also in2019, 20.3 percent of the AI/AN population live at the poverty level, as compared to 9.0 percent of non-Hispanic whites and the overall unemployment rate for AI/AN was 7.9 percent,
as compared to 3.7 percent for non-Hispanic whites[3]. Similar to the national level, the rate of poverty among Wisconsin American Indian people is approximately 20% compared to 12% for the total state population. An estimated 56% of working age (ages 18-64) American Indian adults are employed (either full-time or part-time) compared to 68% of the state population of working age adults[4]. It is clear that more American Indian students come from families affectedby poverty and unemployment than the general state population.

Wisconsin residents living in low income households, defined by a household income of less than two times the federal poverty threshold, are significantly more likely to be in fair/poor health than those living above the low income threshold[6]. Wisconsin American Indian people living in low income households are significantly more likely to be in fair or poor health than the total low-income population of Wisconsin[4]. According to the Wisconsin health family survey, younger American Indian adults (18-44 years of age) are almost three times as likely as the totalstate population to be in fair or poor health. The proportion of American Indians in fair or poor health is approximately a quarter of the population regardless of age. In contrast, the proportion of the total state population in fair or poor health increases with age, exceeding a quarter of the population only in those who are 65 years of age or older[4].

Educational achievement is an important predictor of long-term health and economic outcomes. Adults with a college degree live longer and have lower rates of chronic disease thanthose who did not graduate from college[5]. For example, in 2011 the prevalence of diabetes in the United States was 15 percent for adults who did not complete high school. That was twice as high as the rate among college graduates[6]. In Wisconsin, American Indian students are more likely to come from low income families, are the least represented group in college enrollment,and one quarter of the 18-44-year olds are in fair or poor health. While education is not a panacea for poverty, chronic disease, and unemployment, it plays a critical role in lessening these gaps.

(Required) Proposed Recommendation

1. Concise but thorough description of recommendation (use bullet points to showthe specific components of the policy)

The annual cost of tuition at UW-Madison for a WI resident is $10,720.00 for the 2020-2021academic year[8]. Tuition is determined by UW System Board of Regents, based on budgets approved by the Wisconsin governor and legislature.

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Based on **2019** numbers:

- Total number of UW-Madison students was =44,257 (both undergraduate and graduate,full- and part-time students).
- American Indians make up 0.224% of student population, or a total of 99 students.
- Tuition is $9273.
- The total cost of a tuition waiver for American Indian students at UW-Madison in 2019would be $918,027 for full-time students.
- Tuition is $4530 at Madison College (MATC) for 2019-2020
- Enrollment at MATC in 2018-19 at MATC was 10,596, with 1% of the students beingAmerican Indian[9]
- The total cost of a tuition waiver for American Indian students at MATC in 2019 wouldbe $480,180 for full-time students.
- The estimated annual budget for a tuition waiver for American Indian students in WI is $2,000,000.

2. How does the recommendation addresses equity/reduce a disparity?
    - At what structural/systemic lever(s) is the policy aimed?

A tuition waiver would result in Wisconsin having a more diverse work force. In the American Academy of Pediatrics article on "The impact of Racism on Child and Adolescent Health", it reports, African American students who have one African American teacher in elementary school are more likely to graduate from high school and enroll in college than their peers who do not have an African American teacher; the proposed mechanism for this improved long-termeducational outcome is the exposure to a role model early in the educational experience[5].
Exposure to role models for any students of color has the ability to positively affect multiple arenas such as support, retention, and academic performance, as I can personally attest to as aNative physician.

3. What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state,etc.)

A WI state budget that includes approximately two million dollars to ease some of the financialburden for Wisconsin American Indian students to attend college is a small price to pay, especially since the investment will positively impact the health and the employment rates of the American Indian people residing in Wisconsin, thereby reducing the exorbitant medical andsocial costs associated with chronic disease and unemployment.

Secondly, making it financially easier for American Indians, as well as for other marginalized groups in Wisconsin, to attend college could result in more people of color working as teachers,health care professionals, and tradespeople like plumbers and carpenters, thereby sustaining and growing the pipeline for students of color in Wisconsin.

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(Optional, but Recommended) Recommendation Rationale (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are theyinefficient or ineffective?

The primary systemic challenges to addressing inequities in health, education, and income are overcoming both implicit and explicit biases.

Definitions: According to The Perception Institute, thoughts and feelings are "implicit" if we are unaware of them or mistaken about their nature. We have a bias when, rather than being neutral, we have a preference for (or aversion to) a person or group of people. Thus, we use theterm "implicit bias" to describe when we have attitudes towards people or associate stereotypes with them without our conscious knowledge.

Explicit bias, on the other hand, refers to the attitudes and beliefs we have about a person or group on a conscious level[9]. These biases act as barriers because they prevent decision makers from understanding the full context of American Indians' health status, education or income levels. In the *Reshaping the Journey* article published by the Association of American Medical Colleges (AAMC) and the Association of American Indian Physicians (AAIP) in 2018 regarding therecruitment and retention of American Indian/Alaska Native medical students, the same questions asked of medical schools must also be asked of undergraduate institutions and technical schools:

- Are there any exclusionary practices operating here at our institution that have createdfunctional barriers that would prevent the enrollment of Native students?
- Are there any screening or selection biases at play in our admission processes when itcomes to considering Native student applicants?
- Do we practice conscious inclusion, and are we intentional in our outreach andrecruitment to include Native students?
- Are the admissions committee members intentional about considering Native studentswhen reviewing the applicant pool being considered for interviews?[10]

The third bullet is most pertinent to the tuition waiver proposal. By offering a tuition waiver to less than one percent of the student population, the state of Wisconsin decision makers are actively doing something that says "We want you here at our University or College" and "we want to make it financially easier for you to be here" and "you belong here". For far too long in Wisconsin, American Indian people have represented the lowest population of enrolled collegestudents, and therefore, are overrepresented in the state for poverty and poor health.

Current approaches include but are not limited to:

- UW Board of Regents approves tribal consultation policy on December 10, 2021

Under the policy, the UW System will consult with tribes on numerous issues affecting Nativepeople, including:

- The recruitment, enrollment, and retention of American Indian students.
- Research and other activity on land controlled by a tribe.
- Educational programs intended for tribal students or employees.

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UW System Board of Regents approves tribal consultation policy | News (wisconsin.edu)

- Wisconsin State Tribal Initiative from 2019 by Governor Tony Evers
  Wisconsin State Tribal Initiative

- American Indian College Fund publishes report on ways for tribal colleges and educationinstitutions to increase graduates in the health field

American Indian College Fund Publishes Report on Ways for Tribal Colleges and Education Institutions toIncrease Graduates in Health Fields | American Indian College Fund

- Creating visibility and Healthy Learning Environments for Native Americans in HigherEducation

Creating Visibility and Healthy Learning Environments for Native Americans in Higher Education |American Indian College Fund

- WI Department of Public Instruction and the American Indian Studies Program

American Indian Studies Program | Wisconsin Department of Public Instruction

(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

1. By what process will the recommendation be implemented?
   - Through what policy pathway does the recommendation work?

The tuition waiver proposal for American Indian students would work through the BiennialBudget and Legislative Action policy pathways (this is open for feedback).

- How long would it take?

The tuition waiver would ideally be implemented in time for the 2022-2023 academic year.

2. How would the impact of this recommendation be measured?
3. Include any metrics already tracked, if possible

At present, the National Center for Education Statistics tracks college enrollment and graduation rates by race and ethnicity and other demographic factors.

UW and MATC also track enrollment and graduation rates by race and ethnicity.

It is important for other WI schools to track enrollment and graduation by race and ethnicity to determine if a tuition waiver results in higher matriculation and graduation.

1. Indicator 19: College Participation Rates (ed.gov)
2. University of Wisconsin-Madison | Data USA
3. American Indian/Alaska Native - The Office of Minority Health (hhs.gov)
4. American Indian Health in Wisconsin, 2015 Release Results from the Wisconsin Family

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HealthSurvey

5. The Impact of Racism on Child and Adolescent Health (mnaap.org)
6. Learning Matters: How Education Affects Health (aafp.org)
7. http://aspe.hhs.gov/poverty/figures-fed-reg.cfm
8. https://uwhelp.wisconsin.edu/pay-for-college/tuition-costs/#calculator
9. https://www.communitycollegereview.com/madison-area-technical-college-profile
10. Explicit Bias Explained - Perception Institute
11. https://store.aamc.org/downloadable/download/sample/sample_id/243/

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REC 10: RELATED TO COMMUNITY HEALTH WORKERS

- Summary of feedback
  - Clarify pathway for Community Health Worker certification.
  - State law changes are needed to expand Medicaid benefits to include services provided by community health workers.

- Revisions that will be made and do not need an amendment
  - Add pathway for Community Health Workers certification.
  - Include statutory changes necessary to expand Medicaid benefits to include services provided by CHWs.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Advancing Health Equity Through Community Health Workers

Primary Contact (and contact information) for the Recommendation: Sandy Brekke, sabrekke@gundersenhealth.org

Other Members Who Worked on the Recommendation:

Issue Statement

Community health workers (CHWs) are frontline public health workers who are uniquely positioned to address the racial health disparities that disproportionately affect communities of color. Despite the effectiveness of CHWs to create health equity, questions remain around the scope of their work, licensure requirements, and available funding sources to build a capable workforce. To build on the successes of existing CHW programs, these programs need stronger political and financial support at the state level to address these challenges.

Background/ Problem Description

According to the American Public Health Association, "a community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHWs to serve as a link between health/social services and the community to facilitate access and to improve the quality and cultural appropriateness of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy" (https://www.apha.org/apha-communities/member-sections/community-health-workers).

In 2010, The Bureau of Labor Statistics assigned an occupational code to Community Health Workers: *Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure*

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*screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091)(*https://www.bls.gov/oes/current/oes211094.htm)

The Wisconsin CHW Census conducted by United Voices in partnership with the Wisconsin Department of Health Services, Chronic Disease Prevention Program identifies CHW's in 47 of 72 Wisconsin counties including all 11 tribal areas. According to the Bureau of Labor Statistics, there are roughly 350 CHW's employed in Wisconsin, the state has one of the lowest employment location quotients at 0.13 per 1000. The majority of CHWs in Wisconsin are noted to reside in the communities where they work. CHWs serve people in their communities through community education and outreach, assistance in scheduling and attending health care services, obtaining health coverage and medications, assistance with transportation barriers and linking with appropriate resources, services, and programs. (https://www.wichwnetwork.com/)

As interest in CHWs has grown, various stakeholders have expressed frustration with the limitations of the profession in the state.

CHWs face a:

- lack of sustainable funding for their work
- lack a standard core curriculum for certification and professional advancement
- lack integration with mainstream healthcare delivery

  - The full scope of CHW services need to be integrated into the mainstream of our state's health care, public health, mental health and oral health systems. Sustainable funding mechanisms are vital. CHWs have mainly been funded under "program" or "project" grants and contracts, which are often short-term (two to three years), subject to appropriations or private philanthropic decisions, and commonly focused on specific goals. This type of funding does not afford CHWs or their employers the latitude to apply the full range of CHW capabilities to community needs. Loss of program or project funding commonly leads to CHWs being laid off or reassigned. For the employer, this means a loss of valuable skills, investment in cultivating those skills, and a loss of relationships developed with the community and with individual clients/patients. For the CHW it often means loss of employment. Many options for stable funding depend on documentation of core training and certification.
  - Advancing health equity using CHWs must be envisioned as linked to supporting their personal and professional growth. Wisconsin is without a statewide standardized core training program with opportunity for certification, well defined career paths are lacking, as are systematic skills sets and credentials recognized across work settings that are designed to articulate with other health professions preparation programs in nursing and allied health. Completion of a standardized core training would allow employers the knowledge that a job candidate has a basic level of qualification. A clearly defined and structured educational training program would help define this profession and determine a clear scope of practice compared with other health and social service professions. This is a valuable workforce for which career advancement benefits health systems addressing health disparities.
  - The CDC has highlighted the effectiveness of CHWs in improving chronic disease health outcomes and has therefore promoted their integration into care teams. Research shows that when CHW programs are integrated into the health system, they can improve patients' use of prevention services, medication adherence and chronic disease management, health behavior, and culturally competent care. Only one in three CHWs work within a health system in the state of Wisconsin, and less than half report working with healthcare staff. Despite the promise that the CHW workforce has shown for years (recognition from the Institute of Medicine (IOM, 2010), the Affordable Care Act, and the Department of Labor) it still has not been widely replicated or brought into the mainstream health care delivery. This lack of integration

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prevents CHWs from realizing their maximum effectiveness to improve the health of individuals, families, and communities.

Which groups are most impacted by inequity?

CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. According to the National Association of Community Health Workers, the workforce itself is made of 77% of people identifying as BIPOC with 45% being bilingual. As a predominantly marginalized workforce, it is important to understand and recognize of the role of intersectionality to further widen perspectives and build trust in creating equity and reduce health disparities.

Proposed Recommendation

- Badgercare (WI Medical Assistance) to provide coverage for care coordination and diagnosis related patient education services provided by a CHW who has completed required education and training. Care coordination and patient education services include but are not limited to services relating to oral health and dental care.

- Working with the Wisconsin Community Health Worker Network, create a statewide CHW competency-based education program and certification of completion at the state level, which recognizes the work of CHWs and facilitates Medicaid reimbursement for CHW services. Programs to allow for on the job training and continuing education.
  Core programing to be offered at accredited post-secondary schools blended with field-based learning managed by the Wisconsin Community Health Worker Network.

  - *Standardizing a core CHW curriculum would create a system of training and competency's that would define this health equity profession and provide CHWs with opportunities to be funded by third parties such as Medicaid.*

  - *Development of a statewide CHW educational program based in accredited post-secondary schools designed to articulate with other health professions preparation programs in nursing and allied health services allows for career advancement. 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.*

  - *Provisions for grand mothering CHW's who are currently practicing to be determined by the Wisconsin CHW Network.*

- Study the best practice and barriers to integrating community health workers into health care teams with respect to agenda, identity, scope of work, and integration.

  - *The CHW workforce has captured the attention of health care organizations looking to hit value-based payment targets that are heavily influenced by the social determinants of health. As a result, they increasingly are transitioning from their grassroots, community-based origins to become integrated members of health care teams. The marriage of community health and formal health*

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care is powerful, but not straight forward. If CHWs lose their identity and become medicalized, their effectiveness in the community is lessened.

How does the recommendation addresses equity/reduce a disparity? At what structural/systemic lever(s) is the policy aimed?

There is rapidly growing awareness of the potential that large-scale CHW programs have for improving population health, decreasing health disparities, and creating health equity. The CHW workforce is predominantly composed of members of the same minoritized communities that they support, and their effectiveness is rooted in their continual confrontation and navigation of the very structural factors they work with others to overcome. As a community-based public health workforce, CHWs are cost-effective, patient-centered, and reduce chronic disease disparities in low-income, ethnic minority communities. As the CHW workforce expands, one natural outcome that will benefit everyone will be increased diversity in the health care workforce resulting in equity and decreased disparities.

? structural lever

What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state, etc.)

Health system transformation will succeed and remain sustainable only if it also addresses the long-standing health and health care inequities that affect communities of color and other underserved groups. Members of racial and ethnic minorities and underserved communities generally experience poorer overall health status, lower levels of access to health care, and lower life expectancy than the general population. They are also burdened disproportionately by chronic disease. The higher burden of disease and lack of preventive care among minorities contributes to higher costs for health services.

The involvement of CHWs in health services benefits communities by overcoming and reducing cultural and other barriers to services. CHWs also promote the use of health services and encourage people to adopt healthier lifestyles. CHWs add services for a more diverse health care workforce and serve as a link between clinical services and social services. Other advantages of CHWs are that they can provide services outside of traditional clinical settings and improve understanding of services for patients. CHWs can help to reduce the demand on the health care system by conducting outreach and prevention education, coordinating care, improving patient communication and compliance, and facilitating early diagnosis in underserved communities.

(Optional, but Recommended) Recommendation Rationale (please respond to as much is

5. What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are they inefficient or ineffective?
6.
7. (If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge

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(Optional, but Recommended) Implementation Design (please respond to as much is feasible, understanding that you may not have all at this information at this time)

5. By what process will the recommendation be implemented?
   - Through what policy pathway does the recommendation work?
   - Which agency /department would be charged with implementing the recommendation?
   - What resources are needed for implementation? How much would it cost? How long would it take? How much people power would it take?
6. How would the impact of this recommendation be measured?
   - Include any metrics already tracked, if possible
   - Propose new metrics, if necessary

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REC 11: RELATED TO HEALTH CARE PARTNERSHIPS

- Summary of feedback
  - Clarify that grant funding would be awarded competitively
  - Consider pathways for re-licensing immigrant providers whose credentials not recognized.
  - Include working with the school systems and DSPS to help support recertification and licensing of foreign-born individuals to help diversify the workforce and strengthen communities by providing access to linguistically and culturally appropriate health care providers.
  - The Department of Public Instruction would be an instrumental partner in this effort and should be included as a partner in the recommendation.

- Optional changes not needing an amendment
  - Modify recommendation to suggest exploration of developing pathways to re-license immigrant providers.

- Revisions that will be made and do not need an amendment
  - Modify recommendation to indicate competitive process for awarding grants
  - Include the Governor, DPI superintendent, and the whole of DPI as critical partners in supporting a more diverse healthcare workforce.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Healthcare Partnerships to Diversify the Workforce

Primary Contact for the Recommendation: Dr. Julie Mitchell (julie.mitchell@anthem.com)
Other Member who worked on the Recommendation: Lilliann Paine (lpaine@birthequity.org)

Issue Statement

As Wisconsin's population diversifies, it is paramount that the healthcare workforce reflects these changes, and yet, Wisconsin's workforce continues to underrepresent racial and ethnic minorities in the state. Evidence shows that healthcare organizations with diversified workforces increase their likelihood of providing more culturally competent care, which is associated with better patient engagement and health outcomes.

Therefore, this proposal seeks to increase diversity in Wisconsin's health care workforce by impacting pressure points in the career continuum.

Background/ Problem Description

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5. Racial and ethnic minorities continue to be underrepresented in the healthcare workforce. A recent analysis in JAMA of occupational data found that Black and Hispanic/Latino individuals were underrepresented across 10 healthcare professions when compared to their proportion of working-age adults. Black individuals made up between 3% and 11% of health professions in 2019 despite accounting for approximately 12% of the working age population, and Hispanic/Latino representation in health professions ranged from 3% to 11% despite making up 18% of working-age adults. This gross underrepresentation is also evident in Wisconsin stats: 9 of 10 health professions including speech therapy, physician 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.
6. There are several broad reasons to increase the diversity of the healthcare workforce. First, there is a substantial body of evidence showing that workplace diversity helps to eliminate health disparities (HRSA). Greater diversity of experiences and perspectives yields innovative public health approaches and stronger evidence and better training related to health equity (JPHMP). Second, all students learn better when the student body is diverse (from "In the Nation's Compelling Interest.") Third, there is a business case: there are "customer service and competitive advantages" when the workforce is "linguistically and culturally attuned to the consumer base (Health Affairs).
7. The Diversity Matters report describes barriers to increasing the representation of Black and Indigenous people of color in healthcare, such as the lack of visible minority role models and mentors to provide social support and encouragement, as well as educational, institutional, and psychological barriers. There are a lack of proper advising programs, lack of access to advanced placement programs, feelings of exclusion, and discouragement and racism resulting from unsupportive campus cultures.
8. Marginalized and minoritized patients have and will suffer disproportionally during the COVID-19 crisis due to inequities in society perpetuated by systemic practices (AMA). Health care and public health institutions have fallen short in fully including people of color, LGBTQIA and folks with disabilities/not able bodied. Additionally, women, and particularly women in marginalized populations, are underrepresented in many leadership areas in healthcare. The definition of anti-racism is the active, on-going process of dismantling systems of racial inequity and creating new systems of racial equity. Anti-racism demands that this work be done at the individual, organizational/ institutional, and cultural levels in order to effectively address systemic racism. Anti-racism is an approach, not an end-point, and thus provides a useful frame for an

organizational change process (CommunityWise Resource Centre). Thus, solutions must be built with an anti-racism approach.

9. What would be the impact if Wisconsin's healthcare workforce better represented populations that are historically disadvantaged? We improve care for Wisconsinites of all cultures, we broaden access to healthcare, we expand the healthcare research agenda, and we develop better administrative guidance for the healthcare system (Health Affairs).

Proposed Recommendation

Incorporating our recommendations for expanded capabilities would position the Governor and his Cabinet to prevent exclusion of and ensure just representation of Black, Indigenous, and Latinx communities in the healthcare workplace. These recommendations will provide inclusive, culturally safe, and equitable access to education and care. The Governor and his Cabinet can help build power in and shrink disparities for these communities by equipping health care workers to improve health and advance equity (AMA).

This proposal seeks to address diversity workforce issues in Wisconsin in three ways. Please note the more detailed rationales for these recommendations follow in the next section.

1. **Health Care Employer Navigator Positions**: Create health care "navigator" positions that will work directly with school districts, technical colleges, and universities to proactively foster long-term relationships with employers in their regions with the purpose of providing secondary students with direct access to and meaningful experience with health care careers.
    a. These positions could be marketed as a pilot, collaborating with two regions of the state to track outcomes before going statewide. The two regions may be chosen based on areas where this work is started, but still needs assistance. For example:
        i. M Cubed in Milwaukee is an already successful partnership between Milwaukee Public Schools, Milwaukee Area Technical College, and University of Wisconsin-Milwaukee. They are looking to expand their employer connections in the region but currently do not have the resources. A navigator position could work with M Cubed to focus on Milwaukee area health care employers to foster these relationships. Please see the appendix for M Cubed's model.
        ii. Inspire Sheboygan is an already successful partnership between the Sheboygan Chamber of Commerce and the area school districts to connect students to future employers. They have been so successful that they now partner with school districts outside of Sheboygan County. For this reason, they are transitioning to Inspire Wisconsin, and are interested in expanding their services statewide. A navigator position

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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 Green Bay, and the University of Oshkosh.

   b. If these navigators are state positions, they could be four-year PR funded project positions housed within one of several relevant agencies (e.g. DPI, DWD, WEDC, DHS) to measure their efficacy before transitioning into permanent GPR funded positions.

2. **Create Incentives for More Healthcare Career Pathways.** In Wisconsin, the UW system, Wisconsin technical colleges, and K-12 public education are structurally separate entities. Collaboration across these entities and with healthcare employers bolsters the pipeline for diverse candidates in healthcare fields.

   Wisconsin technical colleges already have the opportunity to apply for competitive, state-funded grants for career pathways and core industry. Our proposal recommends building on these grants that are already currently available to develop specifically health care related pathways.

3. **Reimagine Dual Enrollment Eligibility and Better Educate Students and Families about Dual Enrollment Options.** Dual enrollment in high school and a technical or 4-year college makes high school studies more relevant, piques a deeper interest in career planning, and creates efficiencies in achieving a post-high school degree.

   Too often, the focus of programs like dual enrollment is on students who are performing at the top of their class. This proposal recommends the establishment of 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 to be disseminated to all Wisconsin students and families about dual enrollment. The goal would be for all Wisconsin school districts to be actively reaching out to their student base to educate them each year on their current dual enrollment programs to increase participation.

   a. This could take the form of a DPI Webinar shared with students during the school day (in anticipation of the following semester) on what dual enrollment is, how it is used, and how it can be useful for students.
   b. It would be important for school districts to be able to incorporate the webinar into a more tailored approach that includes opportunities specific to that district.
   c. All Wisconsin school districts do not have equal capacity for this work and may not have current resources needed to focus on dual enrollment options. A

financial component of this part of the proposal could focus on offering grants to school districts in underserved communities to help them prioritize this effort.

Recommendation Rationale

Our proposal to diversify the workforce using community partnerships with schools and industry matches proven strategies. Known tactics to increase workforce diversity are to address the educational pipeline, develop partnerships starting from primary education, examine admission policies, invest in a positive institutional culture, and reach beyond the traditional applicant pool (Health Affairs). A series of recent focus groups of Black health professionals found eight key motivators: desire to help the community, race or racial identity, mentorships, social support, family or parental support, social justice or need to address disparities, lived sickness or injury, and finances (J African American Studies). Experiential learning, community connections, and internships have been shown to build these motivations for healthcare careers, particularly in high school students (J Natl Med Assoc). Others have developed programs for tech school or undergrad students. For example, UCLA developed a program including peer mentors, community partnerships and experiential learning to increase engagement of undergraduate students to public health careers (Pedagogy in Health Promotion). See their model of how these partnerships interact in the figure in the appendix.

Further rationale for this proposal follows, paired with each of the three recommendations.

1. **Health care employer navigator positions**
    a. Secondary students often lack the access to or experience with many health care careers that are in high demand/low supply in Wisconsin today. Sometimes the best scenario for a student is learning of a job by reading about it. This proposal seeks to improve a student's access to real life health care experience, especially in their own communities. A student is far more likely to pursue a health care career if they can picture themselves doing it in their own mind. Therefore, the goal of the health care employer navigators is to connect students with real employers, where they can see the work and experience the job firsthand.
    b. There may be small pockets of the state that are successful in prioritizing these connections for their students (like Inspire Sheboygan, and Fabrication Laboratories across the state), but the goal of this proposal is to find meaningful and actionable ways the state can support all areas of the state in prioritizing this need for all Wisconsin students, and to focus specifically on health care careers that are already in workforce crisis mode.
    c. These navigator positions can increase diversity in the health care workforce by helping to increase access to relationships with potential employers for ALL students.
    d. Navigators can assist with implementing strategies that will lead to long-term involvement of community institutions, organizations and individuals in health

promotion, assessment and evaluation activities that will ensure healthier outcomes for students by way of changing community conditions.

e. Speaking to long-term involvement in community, Wisconsin has a problem with "brain drain," or the emigration of trained, intelligent, or otherwise talented people out of state. If our proposal increases a student's ability to engage meaningfully engage in their school and with employers in their area, it is more likely that this student will have a higher sense of hometown pride and is more likely to stay in the state of Wisconsin after school, or return to Wisconsin after their schooling is completed out-of-state. This helps Wisconsin's workforce overall, but if this entire proposal is successful, it will also help Wisconsin's workforce remain *diverse*.

2. **Create Incentives for more health care career pathways**
    a. UW System and WTCS actively work together to create pathways and continuity between the two systems. However, the health care workforce crisis calls for all hands on deck in developing as many on-ramps to needed health care credentials and careers as possible. Unfortunately, higher education institutions have a long list of priorities. Incentivizing tech colleges to create these on-ramps will help to prioritize *health care pathways* more immediately.
    b. Creating more direct pathways from tech colleges to universities helps a more diverse student body to have access to four year credentials.

3. **Reimagine dual enrollment eligibility and better educate students and families about dual enrollment options**
    a. Dual Enrollment is an amazing way to connect students to careers early, but is a program that could be better utilized if students and families knew more about it and how it can positively impact their career continuum.
    b. Dual enrollment programs often only enroll the highest performing students, based on grades or test scores, which skew to majority or advantaged communities. This part of the proposal can help diversify the workforce by diversifying the dual enrollment program first. This story speaks to how reimagining eligibility is working for St. Thomas in Minnesota.
    c. Diversifying the dual enrollment program may require financial assistance to school districts in underserved communities who do not have the same access to resources as more affluent districts in the state.

Implementation Design

This section discusses considerations of implementation and measurement of outcomes.

1. **Health care employer navigator positions**
    a. We primarily saw this part of the proposal through the executive budget lens, but could also be run as a health care diversity legislative package. As mentioned

above, these positions have some relevancy for many departments. DPI would be a good fit because of their strong partnerships with the state's school districts. DHS would be a good fit because of their health care workforce connections. WEDC and DWD would be good fits because of their focus on workforce and economic development.

   b. Costs for the positions are currently not known. A market study would need to be done to determine the nature of the job eligibility needs.
   c. The impact of the recommendation could be measured in terms of students connected with employers in the region. This could be presented to the Governor and the Legislature after a certain period of time. It will take time for these positions to collaborate and develop meaningful connections with all stakeholders involved.

2. **Create incentives for more health care career pathways**
   a. Provide additional GPR funding to this already existing grant program, but create an additional requirement for the additional funding that the pathways created by health care pathways. It would not require a new appropriation in Ch. 20 of Wis. Statutes, but could require non-stat language requiring the Wisconsin Technical College System to direct grants to schools proposing health care pathways in their applications.
3. **Reimagine dual enrollment eligibility and better educate families about dual enrollment options**
   a. This proposal would be a better fit for a Governor-led initiative to bring the right people together – an opportunity to influence.
   b. If a financial component would be added, it would be state funding to school districts, maybe based on a particular percentage of students attending the district that receive free or reduced lunch (which speaks to the amount of students and their families who are below a certain percentage of the Federal Poverty Level (FPL)).

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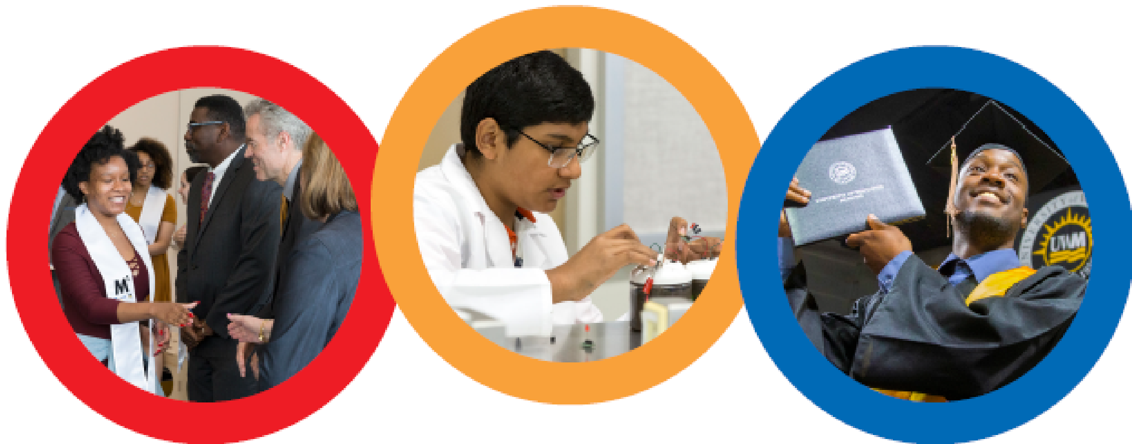
APPENDIX

M-Cubed Model

M³ (pronounced M-cubed) is transforming the future of our young people and Milwaukee communities through the power of public education by multiplying the impact of Milwaukee Public Schools, Milwaukee Area Technical College and the University of Wisconsin-Milwaukee.



WE ARE COMMITTED TO CLOSING EQUITY GAPS SO ALL STUDENTS SUCCEED.

CONNECTING LEARNING

- Building and supporting individual academic and career plans for every student through an equity lens
- Creating curriculum connections in English, math and science for grades K-16
- Bringing MPS, MATC and UWM faculty together to strengthen culturally responsive teaching practices, better understand our students, grow capacity across multiple modes of learning

TRANSITIONING SUCCESSFULLY

- Connecting MPS students through experiences and programs at MPS, MATC and UWM that support transition to college
- Expanding M³ College Connections and in school dual enrollment courses with MATC and UWM so students can earn college credits prior to graduation
- Empowering families to support their children's success through the M³ Parent Institute and other resources

DRIVING COMPLETION

- Improving advising and student support to increase success
- Increasing FAFSA (financial aid) completion and scholarships so more students can access college
- Creating opportunities for work-based and experiential learning including internships

WE'RE EMPOWERING STUDENTS AND FAMILIES TO BUILD THE FUTURE THEY WANT AND DESERVE, AND ENSURING OUR YOUNG PEOPLE AND OUR REGION THRIVE. LEARN MORE AT UWM.EDU/M-CUBED.

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One example of a program of community partnerships and experiential learning

Original Research

PEDAGOGY IN HEALTH PROMOTION

Pedagogy in Health Promotion: The Scholarship of Teaching and Learning
2021, Vol. 7(1S) 51S–62S
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SAGE

Community Partnerships and Experiential Learning: Investing in the Next Generation of a Diverse, Qualified Public Health Workforce

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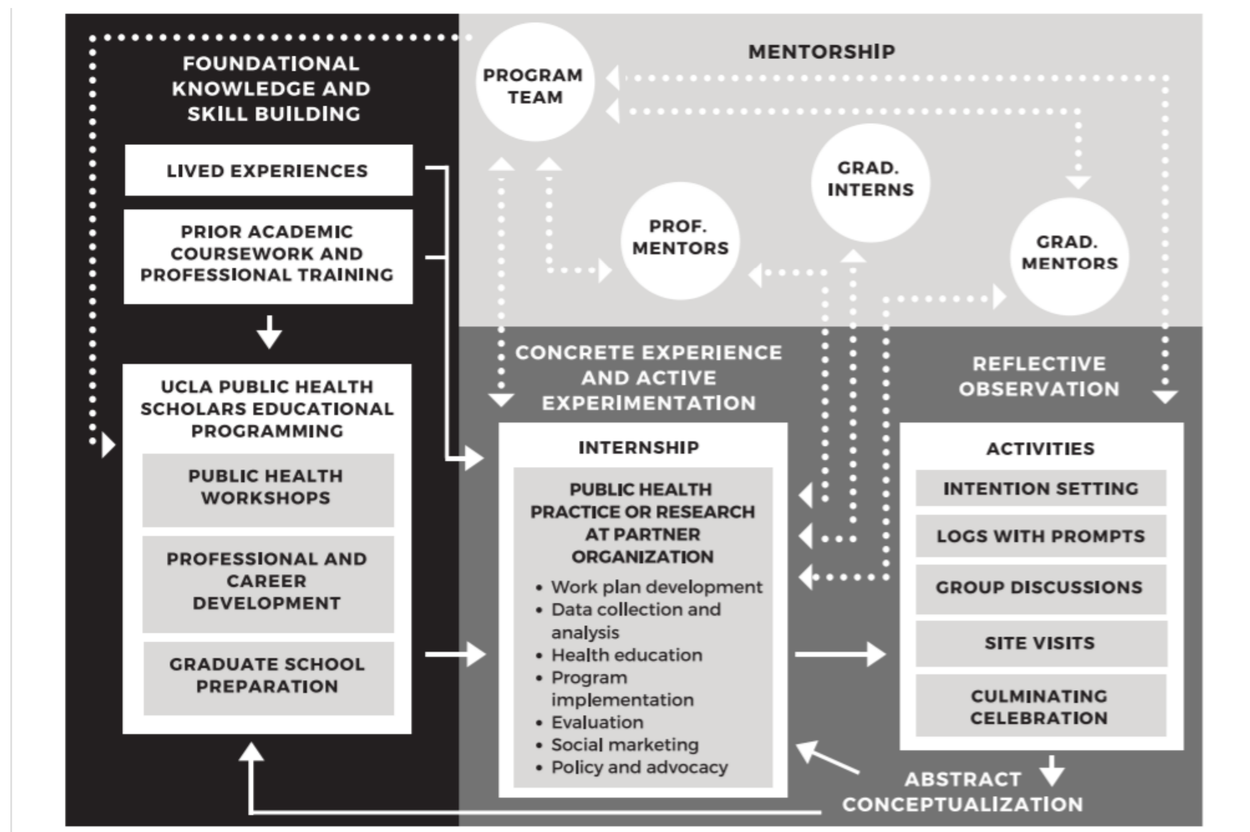
Available at: https://journals.sagepub.com/doi/pdf/10.1177/23733799211046974



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REC 12. RELATED TO MATERNAL HEALTH AND BIRTH OUTCOMES

- Summary of feedback
  - Highlight current and proposed legislation at the state and federal level to related to this recommendation, reinforcing the importance of the issue.
  - Provided details of how the Division of Medicaid Services would extend post-partum coverage
  - Include description of existing work within Medicaid to provide housing benefits to members. The Division of Medicaid Services is in the process of creating a new Medicaid benefit to provide housing and support services for eligible BadgerCare Plus members. This benefit will reimburse homeless assistance providers for helping eligible members who are experiencing homelessness find and sustain stable housing.
  - To achieve priority for pregnant people and people parenting children under one year old, Council could direct DMS to work with HMOs to coordinate uptake and access to these benefits and specialized services, or it could ask the Department to give pregnant people and parents of young children priority when assigning housing placements or other resources.
  - Could include a proposal to expand WIC/SNAP benefit amounts for pregnant people and people parenting children under 5.

- Revisions that will be made and do not need an amendment
  - Include relevant and proposed legislation and provide implementation details for the 12-month post-partum recommendation
  - Include language supporting the Wisconsin Medicaid program's initiatives related to creating a housing benefit.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - **12A:** Add to this recommendation an increase to the WIC and SNAP benefit amounts and priority in receiving Medicaid housing benefits for pregnant people and parents.

Governor's Health Equity Council Major Recommendation Proposal Template

Recommendation Title: Support for Woman and Infants to Improve Maternal and Birth Outcomes

Primary Contacts for the Recommendation:

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Issue Statement

3. Short (1-2 sentences), high level summary of what the brief will propose and why; this is your hook

   We propose extending WI State Medicaid coverage to a full year for the mother to improve mortality rates and health outcomes of mom and baby. As noted by 25 state healthcare associations and the American College of OBGYN's an extension from 60 days to a full year will provide additional support and case management to mothers and families who may be dealing with significant social determinant of health issues including lack of adequate housing and food insecurity during pregnancy and after the birth of their child.

Background/ Problem Description

10. **What is the scope of the problem in Wisconsin?**
    - In Wisconsin, more than two out of three pregnancy-related maternal deaths occur postpartum (https://www.dhs.wisconsin.gov/publications/p02108.pdf).
    - Achieving positive health outcomes for mothers and babies requires follow-up beyond the current 60-day period postpartum care including recovery from childbirth, follow-up on pregnancy complications, management of chronic health conditions, resolving oral health issues, addressing mental health concerns and assistance with housing and food insecurity.

    Which groups are most impacted by inequity?

    - According to the state's Maternal Mortality Review, black women in Wisconsin are five times more likely than white women to die during or within one year of a pregnancy. Overall pregnant women of color in Wisconsin, experience higher rates of maternal mortality before and after childbirth than whites and those same women of color are disproportionately impacted by the current state Medicaid rules (1).
    - Fifteen Black infants died per 1,000 live births in 2017, the most recent year for which data has been published by the Wisconsin Department of Health Services. This is more than double the state's average infant death rate and three times that of white infants. Black babies were also more likely to be born premature or at a low birth weight.

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- Rural residents have a 9% greater probability of maternal mortality or morbidity compared to urban residents. Rural areas face unique challenges related to access to care (https://ccf.georgetown.edu/2020/06/12/rural-disparities-racial-disparities-and-maternal-health-crisis-call-out-for-solutions/).

- A shortage of affordable and available housing is severe across WI, placing extremely low-income residents including families and pregnant women at high risk for housing instability, homelessness, and subsequent poor health outcomes. According to the National Low Income Housing Coalition, there's a shortage of more than 119,000 rental housing units in Wisconsin (https://www.postcrescent.com/story/news/2021/09/27/apartments-northeast-wisconsin-housing-experts-share-advice-renters/8210127002/#:~:text=There%27s%20a%20shortage%20of%20more%20than%20119%2C000%20rental,according%20to%20the%20city%27s%202020%20housing%20market%20study).
- Food insecurity has been associated with poor pregnancy outcomes, including low birth weight and gestational diabetes. Food insecurity might have particular importance for women during pregnancy: nutrient demands are higher, the effort required for food preparation may be more difficult, and pregnant women may be obliged to leave the workforce (https://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf).

    (1) https://www.dhs.wisconsin.gov/mch/maternal-mortality-and-morbidity.htm

Proposed Recommendation

- **Concise but thorough description of recommendation**

    - Currently new mothers supported by Medicaid receive only 60 days of postpartum care which is insufficient because the health of both the mother and the newborn are at risk for infections, disease and even death. While yet to be enacted Wisconsin Act 58 extended coverage an additional 30 days; extending Medicaid coverage a full year will reverse the rates of illness and provide additional support to mothers and families.

- Create a new Medicaid benefit alongside Department of Health Services that will cover housing support services for eligible Badger Care Plus and Medicaid pregnant and postpartum members. This benefit will reimburse homeless assistance providers for helping eligible members who are experiencing homelessness find and sustain stable housing. This would be a joint state and

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federal initiative aimed at improving health outcomes and quality of life by ensuring stable housing for eligible new moms and babies.

- Ensure Food Share, WIC and SNAP benefits are consistently extended to any Medicaid eligible offering mothers and families and create programs to increase uptake. Create programs alongside Department of Health Services that 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. Coverage should range from 20 weeks into their pregnancy and continue through the twelfth month after birth (allassistanceprograms.com/wic-eligibility-requirements/).
- **How does the recommendation addresses equity/reduce a disparity?**
  - The proposed extension will ensure continuity of care past the current 60-day coverage for new moms and address racial equity, economic inequality, and geographic disparities related to pregnancy complications, chronic health conditions, oral health issues, mental health issues, inadequate housing and food insecurity routinely observed among postpartum women in WI.

- **What is the justification/rationale/business case for this recommendation?**
  - Under current law, state & federal Medicaid covers eligible pregnant women (incomes from 100% to 300% federal poverty levels) through the end of the month in which her 60-day post-partum period ends, at which point her eligibility is redetermined and they are unable to have uninterrupted postpartum care. While Medicaid covers the new infant from the date of birth through the end of the month in which the child turns one year old, assuming the mother was eligible for Medicaid at the time of birth. Interrupted health care coverage threatens maternal health at a particularly vulnerable time, increasing the likelihood new mothers will experience poor health outcomes, up to an including death. Preserving eligible moms' access to services for a full year will ensure moms have uninterrupted access to the full suite of post-partum services and other medical care (https://link.springer.com/article/10.1007/s10995-020-02924-4).
  - Extending post-pregnancy coverage for a full year would increase average monthly Medicaid enrollment by 6,150 members and the members are projected to incur ~$354 per month, on average.
  - The total annualized cost of this increased enrollment is projected to be $23.1mm ($10.4mm WI. General Purpose Revenue) compared to the current 60-day eligibility period.
  - This proposed extension furthers the intent of Wisconsin Act 58, which extended the post-partum from 60 days to 90 days, but it requires a Department of Health Services to receive a demonstration waiver which

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could take up to two years. Act 58 appropriated $2.5mm ($1mm WI. GPR) in FY23 fund costs associated with extending enrollment from 60 days to 90 days.

- Extending the postpartum rule also has a positive effect on providers, health systems and payers. Studies show that 55% of women with Medicaid coverage at delivery experience a coverage gap in the following six months compared to 35% of women with private insurance. This can lead to higher administrative costs for the state, less predictable expenditures, and higher monthly care costs due to pent-up demand for health care services
- Housing instability during pregnancy and during the first years of life, is linked to increased health care utilization postpartum, including length of hospital stay, an ER visit and hospital readmission. Beginning in the prenatal period and extending throughout childhood, any duration of homelessness – from the briefest experience to extended periods – is associated with adverse child physical, mental, and developmental outcomes. Homelessness is associated with pregnancy complications, preterm birth, and low birth weight; these adverse outcomes are leading causes of maternal and infant mortality in the United States.
- Pregnancy and infancy are sensitive times in which many Medicaid eligible families are particularly vulnerable to food insecurity which has been linked with poor pregnancy outcomes, including low birth weight and gestational diabetes.

Recommendation Rationale

8. **What are the systemic challenges that act as barriers to addressing this issue? And/or what are the current approaches to address the issue, and why are they inefficient or ineffective?**

   Wisconsin is one of only 14 states who decided not to expand Medicaid, choosing instead to fund their own programs.

   - Initial ARPA funding created an additional incentive to extend postpartum benefits, but a state amendment is still necessary. 21 states and the District of Columbia have taken recent action to extend coverage within the last year. Broad extension will help standardized the level of care available to moms and babies.
   - The Build Back Better Act (BBB) recently passed in the US House includes health benefits for eligible individuals who reside in states like Wisconsin that have not expanded Medicaid. The legislation also includes a 1-year postpartum provision that if signed into law would be effective after the first quarter after it was signed. However, the BBB has not passed in the US Senate.

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- State Sen. Joan Ballweg recently called for the passage of Senate Bill 562, which if passed would extend postpartum benefits to a full year. A similar bill was introduced in the Assembly by Rep. Amy Loudebeck. A legislative session needs to be called and the proposed bills need to be voted on. If the bipartisan bills pass it could be implemented on April 1, 2022 and would not require a federal waiver (https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women).

9. **(If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?**
32 state healthcare associations have already announced their support of Senate Bill 562. The American College of OGBYN's also supports this expansion and other expansions being sought in other states. According to Dr. Ann Windsor, head of OGBYN services at Advocate Aurora Health, doctors view the proposed extension as being practical because some mothers who have chronic diseases like hypertension and diabetes won't receive sufficient treatment within 90 days for those diseases. Moreover, mental health, substance abuse, postpartum depression may not be managed appropriately within a 60 day or 90-day timeframe and family planning would be managed more effectively. For example, making women eligible for one year of postpartum care also makes them eligible for contraceptives which will decrease the negative impact of having multiple births too close together. Finally, additional time for care is seen by some physicians as a way of more effectively managing no show rates and insures both mom and baby get the appropriate level of care during the baby's first year.

Implementation Design

7. **By what process will the recommendation be implemented?**
   - **Through what policy pathway does the recommendation work?**
     - This legislation or policy would require the Department of Health Services to file for an extension of postpartum coverage to the end of the twelfth month post-birth for Medicaid eligible women and work to establish housing assistance and food insecurity programs
   - **Which agency /department would be charged with implementing the recommendation?**
     - State of Wisconsin Department of Health Services - Medicaid
   - **What resources are needed for implementation? How much would it cost? How long would it take? How much people power would it take?**

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- This proposal is estimated to increase average monthly Medicaid enrollment by 6,150. See our response to Question #3 to ascertain costs for extending postpartum coverage a full year.

8. How would the impact of this recommendation be measured?

- Include any metrics already tracked, if possible
  - Rate of maternal death per 1,000 births for full year after birth
  - Rate of infant death per 1,000 births for full year after birth
- Propose new metrics, if necessary
  - Patient satisfaction scoring focused on trust and access
  - Additional screenings can identify stress or social determinant of health issues
  - Development milestones for the child
  - Housing Assistance Services provided to pregnant / new moms
  - Food security programs provided to pregnant / new moms

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REC 13: RELATED TO ORAL HEALTH

- Summary of feedback
  - Current Medicaid incentives for oral health providers do not provide the Department the flexibility needed to overcome data gaps and structures the program has. For example, the Department does not currently collect data on patient referrals.
  - Adult dental health needs are also pressing, and additional financial support and investments are needed to improve access to all populations. Program staff recommended expanding the program so that CDHC services were available to both children and adults.
  - Explain how CDHCs are different than dental therapists and how this model would help increase access to care.

- Revisions that will be made and do not need an amendment
  - Clarification on how CDHCs can become Medicaid covered providers for purposes of receiving Medicaid reimbursements.
  - Broaden reimbursement incentive language to give DHS the flexibility it needs in designing the most effective incentive program.
  - Add background on how the recommendation builds on and differs from other policy proposals, including those regarding dental therapists.
  - Include language that access to dental health services remains a challenge for adults as well and that the state should continue to advance solutions that address comprehensive reform in the future.

- Amendments the Chair will be proposing
  - None

- Optional changes needing an amendment
  - None

Recommendation Title: Improving Access to Oral Health Care for WI Children Who Participate in Medicaid

Primary Contact for the Recommendation:

Elizabeth Valitchka, MPH
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elizabeth.valitchka@wisconsin.gov
(608) 422-6897

Issue Statement (Required)

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This proposal aims to improve oral health outcomes for low-income children participating in Medicaid across WI by addressing issues of access using a two-pronged approach: funding Community Dental Health Coordinators and strategically incenting Medicaid reimbursement for dentists.

Background/ Problem Description **(Required)**

Oral health is an important component of overall systemic health and well-being. Teeth serve important functions for nutrition, speech and language, and self-esteem.

According to the Centers for Disease Control and Prevention (CDC), dental caries, or cavities, are one of the most common, preventable chronic illnesses of childhood

According to the Centers for Disease Control and Prevention (CDC), dental caries, or cavities, are one of the most common, preventable chronic illnesses of childhood [1]. Nationally, untreated dental decay impacts 20% of children age 5-11, and children from low-income families are twice as likely to have cavities as those from non-low-income families.[1,2] Data from the CDC's 2019 Oral Health Surveillance Report indicates that over 52% of children have experienced a cavity in their primary teeth by age eight and that significant disparities exist based on race and socioeconomic status.[3] The racial and economic disparities seen in childhood oral health outcomes persist throughout adulthood as well.[4]

Data for low-income children, Black, Latino, and Asian children in Wisconsin mirror national statistics. The 2014 Oral Health of Wisconsin's Head Start Children report revealed the following:[5]

- 40% of children age 3-5 have experienced tooth decay in at least one tooth.
- 25% of children age 3-5 need treatment for tooth decay.
- 69% of Asian children had caries experience (treated or untreated decay) compared 36% of white children.
- 42% of Asian children and almost 20% of Black and Hispanic children had early childhood caries compared to 15% of white children.

A child who is experiencing pain due to dental caries or abscess may not be able to eat or speak comfortably which in turn impacts nutrition, learning, behavior, and overall systemic health. Given the location of the mouth near the sinus cavities and brain, untreated dental decay can lead to infection and in the most severe cases, death.[6] Early access to consistent and routine preventive care and treatment is critical for ensuring good short- and long-term oral health outcomes across the lifespan.

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[1] https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html
[2] https://www.cdc.gov/oralhealth/fast-facts/index.html
[3] https://www.cdc.gov/oralhealth/publications/OHSR-2019-dental-caries-primary-teeth.html
[4] https://nihcm.org/assets/articles/NIHCM_OralHealthWebinar_Chalmers.pdf
[5] https://www.dhs.wisconsin.gov/publications/p01702.pdf
[6] https://abcnews.go.com/Health/Dental/story?id=2925584&page=1

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In the US, only 43% of dentists accept Medicaid or CHIP; in WI, only 38% do.[7] According to the 2016 WI Medicaid Plan for Monitoring Access, of the dentists enrolled in Medicaid, only 47% were actively participating in the program, 37% had limited participation, and 20% were considered inactive.[8] The same report indicated that statewide, only 43% of children enrolled in Medicaid utilized dental care.[8] In WI, the lack of dentists who accept and actively participate in Medicaid is a significant driver of oral health inequity for children in both rural and urban communities alike. This in turn negatively impacts access to preventive and therapeutic dental care for children living in the state: WI ranks last in the nation in providing preventive dental care for children who receive Medicaid.[9]

Working with families of young children to understand and navigate oral health systems and working with providers to help control the flow of care coordination of Medicaid patients are critical to ultimately improving oral health outcomes for children. Funding Community Dental Health Coordinators as well as strategically incenting Medicaid reimbursement for oral health providers are two effective strategies for addressing these issues and helping improve access to oral health services for children. Utilizing both approaches can help build a more sustainable, widespread network of dentists and hygienists who accept Medicaid and will see children under the age of six. It will also help get more kids in WI the preventive and restorative dental care they need. Addressing the oral health needs of children now sets them up for a healthier future as adults.

Proposed Recommendation (Required)

Concise but thorough description of recommendation (use bullet points to show the specific components of the policy)

This proposal seeks to improve access to preventive and restorative dental care for children participating in Medicaid in two ways:

- Funding Community Dental Health Coordinators (CDHCs) by:
    a. Establishing CDHCs as a reimbursable provider type through Medicaid
    b. Reimbursing services provided by CDHCs including care coordination
    c. Administering CDHC services via federal matching funds
    d. Creating statewide regional hubs to provide CDHC oversight and service delivery coordination

- Incenting providers to accept children with Medicaid through targeted reimbursement strategies such as:
    a. Accepting referrals from school-based clinics

[7] https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes/insights-on-medicaid-programs
[8] https://www.dhs.wisconsin.gov/publications/p01565.pdf
[9] https://www.wpr.org/wisconsin-pilot-program-aims-increase-access-dental-care-low-income-children

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b. Accepting referrals from Head Start/Early Head Start programs
c. Opening appointments for children age six and under

How does the recommendation addresses equity/reduce a disparity?

Started as a pilot program in 2006 by the American Dental Association (ADA) to help address the oral health needs of dentally underserved communities, CDHCs are typically dental hygienists who function as navigators, educators, and case managers for both families and dental providers.[10] The primary focus of CDHCs centers on prevention and oral health promotion.[11] According to the ADA, CDHCs also work to address the social determinants of health that impact oral health such as transportation, continuity of care, health literacy, and language and cultural barriers.[10] CDHCs are often trusted members of the communities they serve, providing a unique opportunity to bridge the personal and professional connection between families and oral health providers resulting in timely access to services, enhanced care coordination, and improved oral health outcomes. In addition, CDHCs can serve as a compliment to, and work in collaboration with, Community Health Workers (CHWs) to comprehensively support families.

In addition, CDHCs can work in a variety of settings within a community including:[12]

- School-Based Clinics
- Head Start and Early Head Start Programs
- Local Public Health Departments and WIC Clinics
- Emergency Departments (ED)
- Nursing Homes
- Federally Qualified Health Centers (FQHCs)
- Pediatric and Family Practice Medical Clinics
- Private Dental Practices
- Social Service Organizations

Given the flexibility of their position, their focus on prevention and care coordination, and their emphasis on addressing the social determinants of health, CDHCs are an essential part of the solution when it comes to reducing oral health inequities for WI's children.

Utilizing CDHCs across the state, while also strategically incenting providers who accept children enrolled in Medicaid, can improve short- and long-term oral health outcomes, resulting in decreased disease burden and increased cost savings.

At what structural/systemic lever(s) is the policy aimed?

This proposal could be moved forward as a:

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[10] https://www.ada.org/publications/ada-news/2021/march/community-dental-health-coordinator-program-celebrates-15-years
[11] https://www.ncbi.nlm.nih.gov/books/NBK219681/
[12] https://www.nnoha.org/nnoha-content/uploads/2014/08/Grover-Final-Community-Dental-Health-Coordinator-New-Member-of-the.pdf

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- Possible biennial budget request
- Reimbursable provider type under Medicaid

What is the justification/rationale/business case for this recommendation? (inequity reduced, lives improved, lives saved, financial benefit for the state, etc.)

CDHCs help increase access to oral health services and interventions. Data from a study in Alabama found that utilizing CDHCs within WIC clinics as part of a community-based rotation for dental students increased the number of appointments for children under six, increased the number of students performing restorative care on children, and increased the number of dental students who continued to see Medicaid patients after they had graduated.[13]

In Tennessee, the Smile On 60+ program employed four CDHCs to provide case management for low-income older adults with unmet oral health needs, resulting in increased access to care for 2500 individuals.[14] And in a New Jersey FQHC, eight CDHCs working in an integrated capacity with the medical and dental providers to address oral cancer increased HPV vaccination rates among boys and girls ages nine to eighteen from 12% to 31% in less than a year.[15]

CDHCs also help increase revenue and decrease costs within a practice setting. According to evaluation data provided by the ADA, a CDHC working in conjunction with an Indian Health Service clinic saw 240 children in a 10-month period resulting in $105,000 in billable services.[16] Another evaluation found that a community clinic that utilized a CDHC doubled its clinical productivity in a year resulting in $231,551 in billable services, which was two and a half times higher than the previous year.[12]

In WI, CDHCs are being successfully utilized within the CDC-funded Wisconsin Dental Pain Protocol (WDPP) pilot program in three different sites across the state to help connect patients presenting to ED and urgent care settings for non-traumatic dental pain with dental homes. These sites include:

- **Dane County** (Madison) – More Smiles of Wisconsin, a safety net clinic
- **La Crosse County** (La Crosse) – within the local health department
- **St. Croix County** (Hudson) – United Way of St. Croix Valley 211 Center

In La Crosse County, 90% of all patients referred to the WDPP identified as not having a dental home, 57% had public insurance, and 16% of the total visits were for patients between the ages of 0-18. In Dane County, ED visits for dental pain were cut in half and a similar decrease was seen in urgent care settings.

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[13] https://onlinelibrary.wiley.com/doi/10.1002/jdd.12593
[14] https://www.tridhascholars.org/pdfs/community-dental-health-coordinators-bringing-healthy-smiles-to-underserved-older-adults-in-tennessee-CRDS-02-1014.pdf
[15] https://www.scivisionpub.com/pdfs/dental-interventions-improve-youth-hpv-vaccination-rates-to-help-prevent-oral-cancer-1314.pdf
[16] https://nhoralhealth.org/blog/wp-content/uploads/2016/11/Jane_Grover_Nov11-CDHCP-2016.pdf

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Each community participating in the WDPP program has unique needs and resources available to its population, and the flexibility of the CDHCs to work in and leverage these assets has been a key to their success. There is no one-size-fits-all approach in terms of where CDHCs are located within a geographic area. Instead, the position is responsive to the specific needs of the families, communities, and providers it works with, building off existing community strengths and relationships. Ensuring this same flexibility for CDHCs working specifically with young children, their families, and dentists will be critical.

Recommendation Rationale (Optional, but Recommended) (please respond to as much is feasible, understanding that you may not have all at this information at this time)

What are the systemic challenges that act as barriers to addressing this issue?

Current systemic barriers and challenges to addressing this issue include the following:

- Dentists not accepting Medicaid
- Limited or no active participation by current Medicaid providers
- Administrative burden of becoming a Medicaid provider for independent practices
- Dental practices not seeing children under age six for preventive or treatment needs
- Location of dental practices accepting Medicaid not located near families who have Medicaid
- Varying degree of quality among providers who do accept Medicaid
- Oral health services for children happening at school-based clinic without long-term connections to ongoing dental homes
- Provider discomfort with seeing young children, especially those with special health care needs
- Concerns over Medicaid patients not showing up for appointments
- Lack of available and timely appointments in practices that do accept Medicaid
- Low reimbursement rates for Medicaid patients
- Provider fear of being inundated by Medicaid patients if identified as a Medicaid provider
- Lack of parental knowledge about children's oral health
- Child and parental fear of dental services/dentists based on previous personal experience
- Parental lack of understanding about and/or experience with navigating the oral health system (e.g. insurance, scheduling appointments, expectations, periodicity schedule, etc.)
- Lack of CDHC training and certification programs within existing dental hygiene programs in WI

And/or what are the current approaches to address the issue, and why are they inefficient or ineffective?

Evaluation of WI's enhanced dental services reimbursement pilot found that simply increasing Medicaid reimbursement rates alone did not result in a significant utilization rate of oral health

services for children.[17] This finding is supported by a National Bureau of Economic Research study which indicated that increasing Medicaid payment rates to dentists was statistically significant yet had a relatively small effect in terms of the number of children utilizing services.[18]

Care coordination, navigation, education and outreach are all essential components that need to be utilized in conjunction with increased reimbursement rates. Strategically incenting reimbursement for providers who see children under six may also help improve access to oral health services for children. Despite the recent biennial budget increase for Medicaid reimbursement for dental providers, data indicates that money alone will not improve access for children.

(If applicable) How is the recommendation based on best practice, or what evidence exists that this recommendation will work conceptually? Alternately, how will this proposal generate new knowledge?

As stated above, data from a study in Alabama found that utilizing CDHCs within WIC clinics as part of a community-based rotation for dental students increased the number of appointments for children under six, increased the number of students performing restorative care on children, and increased the number of dental students who continued to see Medicaid patients after they had graduated.[13]

According to evaluation data provided by the ADA, a CDHC working in conjunction with an Indian Health Service clinic saw 240 children in a 10-month period resulting in $105,000 in billable services.[16] Another evaluation found that a community clinic that utilized a CDHC doubled its clinical productivity in a year resulting in $231,551 in billable services, which was two and a half times higher than the previous year.[12]
This recommendation provides the opportunity to enhance the oral health strategies being utilized across the state by adding in a critical navigation and case management component for both families and providers that is currently lacking.

<u>Implementation Design</u> (Optional, but Recommended)

By what process will the recommendation be implemented?

Through what policy pathway does the recommendation work?

This proposal could be moved forward as a:

- Possible biennial budget request
- Reimbursable provider type under Medicaid

[17] https://docs.legis.wisconsin.gov/misc/lfb/jfcmotions/2019/2019_06_04/002_health_services/008_paper_365_dental_access_incentives
[18] https://www.nber.org/papers/w19218

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Which agency /department would be charged with implementing the recommendation?

DHS would be charged with implementing this recommendation. There may additional collaboration and coordination with DCF if Head Start/Early Head Start programs are involved. In addition, leveraging existing partnerships with the WI Technical College System and School of Dentistry at Marquette University will be critical.

What resources are needed for implementation? How much would it cost? How long would it take? How much people power would it take?

Depending on the model utilized for CDHCs, there could be one per county or possibly a more regionalized model with 3-5 CDHCs serving multiple counties, families, and providers. The CDHC would be flexible in terms of where the position is located within a county or region depending on the specific needs and relationships within the community or geographic area (e.g. local public health, WIC clinics, Family Resource Centers, school-based clinics, etc.). Collaboration with existing oral health programs, stakeholder coalitions, and families will be critical.

How would the impact of this recommendation be measured?

The impact of this recommendation could be measured by utilizing Medicaid claims data and referral data from oral health providers. Claims could be analyzed by age and demographics. Annual Head Start and Early Head Start Program Information Reports (PIRs) from both individual programs, regions, and the state as a whole can be utilized to measure the number of children who have a dental home, who are up-to-date on preventive care, and who have received recommended treatment when identified. Similar metrics could be used for school-based clinic data or Medicaid claims.

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REC 14: RELATED TO DATA VALUES STATEMENT

- Summary of feedback
  - None
- Revisions that will be made and do not need an amendment
  - Word choice and other minor edits for clarity
- Optional changes needing an amendment
  - None
- Amendments the Chair will be proposing
  - None

"A modern public health data system must execute a plan for governance, decision-making, and community engagement that centers addressing structural racism and creating equity in its design and operation. This means transparency, accessibility, and interoperability in all aspects of how the public health data system runs, how the system interacts with other systems, and how it takes in new information to respond to emerging and ongoing health issues." –RWJF

EQUITABLE USE OF DATA

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 can't tell us.

Because data, and the conclusions drawn from data, plays a key role in this 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 the emergent themes from this Council's work.

Capture and track data about the many social determinants of health

Call out box: The social determinants of health are "the conditions in the environments where people are born, live, work, play, worship, and age, that affect a wide range of health,

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functioning, and quality of life outcomes" (Healthy People 2030). These determinants go well beyond simply access to health care. They are themselves a product of how power, politics and policy; histories and economies, as well as decisions, governance, and justice, have played out over long periods of time to create the conditions of our lives today. Addressing these underlying conditions is vital to improving health equity in Wisconsin.

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 have 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 identified needs, gaps and opportunities; and that the questions being pursued are rooted in equity commitment to justice. As a process, these steps creates 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 in spite of adversity, and avoid only highlighting the struggles and challenges that marginalized communities face, this is how we can more effectively represent the full

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breadth and depth of people's lived experiences and present needs. This requires building relationships rooted in trust and shared understanding with marginalized communities in order to effectively work alongside these communities to create these 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?

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REC 15: RELATED TO NARRATIVE AND PRINICPLES STATEMENT

- Summary of feedback
  - None
- Revisions that will be made and do not need an amendment
  - Word choice and other minor edits for clarity
- Optional changes needing an amendment
  - None
- Amendments the Chair will be proposing
  - None

PRELUDE

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 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 current pandemic, the unexpected event which has consumed our lives and likely, your lives, for much of the past two years. While consuming our attention and focus, the pandemic has also caused in some cases substantial and long-lasting illness and has taken the lives of far too many others. 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 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, over-policing and incarceration, 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 and greedy.

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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, they are economically short-sighted 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.

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 and greedy 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 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 of quo of exclusion, embrace and facilitate a new standard of radical inclusion. 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.

1. **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.
2. **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.

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3. **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.
4. **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.
5. **We know making Wisconsin better for all of us means we have to change 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.
6. **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.

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REC 16: RELATED TO RECOMMENDATIONS FROM FRAMING SUB-COMMITTEE

- Summary of Feedback
  - Delete first recommendation regarding Ch. 250 changes as it does not affect current operations.
  - Revise second recommendation regarding creation of statutory process for health equity assessments; instead recommend the establishment of an EO that tasks agencies with developing health equity assessments under the direction of DHS' Office of Health Equity (OHE). OHE would be tasked with establishing a process, providing direction and technical assistance, and evaluating and approving plans. To support this work, OHE will require program administration support, which may include hiring of LTEs and other program operating costs not yet calculated.
  - Organize several recommendations as goals under the recommendation regarding directing cabinet level agencies to review data sharing agreements, etc.

- Revisions that will be made and do not need an amendment
  - Organizing recommendations 7, 8, 9, 10, 15, 16, and 17 as goals under recommendation 14

- Amendments the Chair will be proposing
  - **16A.** Remove recommendation regarding Ch 250 changes
  - **16B.** Revise recommendation regarding health equity assessments to be a directive to the Office of Health Equity at DHS

- Optional changes needing an amendment
  - None

RECOMMENDATIONS

Statutory

1. Modify Wis. Stat. § 250.20(2) (Statutes governing DHS' responsibility related to health disparities) to include direction to DHS to reduce and eliminate health disparities on the basis of race and other characteristics, in addition to on the basis of economic disadvantage in (2)(a)-(g).

2. Modify Wis. Stat. § 227 (Statutes governing the rule-making process) so that health equity assessments are a required component of agencies' rule making process, when the rule or program has expected costs greater than $5 M.

3. Include in Wis. Stat. § 153 requirements for health care data-aggregation entities with relationships to the Department of Health Service to publically report disparities in health care access and outcomes, as can be elicited from health care claims data.

Program Administration and Policy Making

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4. Direct state agencies to make policies and decisions with consideration of the racialized differences within the context of differences in age and life-course stage of those people and groups that policies are being targeted towards.

5. Direct state agencies responsible for cash assistance, health and social services, including the Department of Health, Children and Families, Corrections, and Employee Trust Funds, and other health-adjacent services and functions to submit analyses of beneficiaries' and customers' time and task (administrative) burdens and corrective actions to reduce these burdens.

6. Direct Medicaid and other health and human service programs to significantly increase pay-for-performance payments contingent on meeting equity related performance standards.

Data Collection

7. Direct State agencies to create and implement more granular and nuanced race and ethnicity data collection standards to improve agencies' ability to disaggregate administrative and program data according to racial and ethnic groupings. Presently, the minimum federal standards establish by OMB for collecting race and ethnicity data are those often used in surveys and other data collection efforts.

8. Direct the Department of Health Services to create and maintain a dataset of non-health care determinants of health, using publically available federal data, program and administrative data of from state agencies, and other, local and granular sources of information.

Data Reporting and Analysis

9. Require birthing hospitals to collect and report standardized, more granular and nuanced race and ethnicity data on infant feeding practices.

10. State? agencies should ensure their data is collected with accurate age information and take steps to age-adjust, race-disaggregated outcome data.

11. Direct the Department of Health Services, alongside the state public health association and the association of local public health agencies (WPHA and WAHLDAB), 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.

12. 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.

13. 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.

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Data Sharing

14. Direct Cabinet-level agencies of Wisconsin to: review existing data sharing agreements, identify useful data held by other Departments, 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 to effective and comprehensive data sharing.

15. Increasing Data-Sharing Capabilities – allow Medicaid HMOs access to the Homeless Management Information System.

16. Increasing Data-Sharing Capabilities – Identify and address barriers to allowing healthcare payers access to Wisconsin Immunization Registry across all lines of business.

Data Systems

17. Improve public health infrastructure by modernizing the Wisconsin Immunization Registry (WIR) and making it more accessible to groups working toward health equity.

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