

# Healthy Metric

Advancing Health Equity in Wisconsin

# 2024

## Primary Care Utilization and the Health of Adult Women of Childbearing Age in Wisconsin

A Healthy Metric Report for Wisconsin

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FUNDING PROVIDED BY:



ADVANCING A HEALTHIER  
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UNIVERSITY OF WISCONSIN  
SCHOOL OF MEDICINE AND PUBLIC HEALTH

# Acknowledgments

## Funders

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**Advancing a Healthier Wisconsin Endowment (AHW):** Driven by a vision for a healthier Wisconsin, the Advancing a Healthier Wisconsin Endowment reaches statewide, propelling the most promising work and ideas to build a healthier Wisconsin for generations to come.

**Wisconsin Partnership Program (WPP):** WPP represents a far-reaching commitment by the University of Wisconsin School of Medicine and Public Health to greatly improve the health of people in Wisconsin for years to come.

## Healthy Metric

Healthy Metric is a partnership between the University of Wisconsin–Madison, the Medical College of Wisconsin, Marshfield Clinic Research Institute, the Wisconsin Collaborative for Healthcare Quality, and the Wisconsin Health Information Organization that aims to eliminate health disparities in Wisconsin through collaboration, measurement, and interventions.

## Suggested citation for this report:

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# Executive Summary

Healthy Metric developed this report to inform and accelerate programs aimed at addressing and eliminating health disparities for adult women of childbearing age in Wisconsin. For this important population, achieving equitable health outcomes in primary care visits, diabetes A1c control, blood pressure control, and depression screening will require collaboration among healthcare organizations, health plans, health departments, policymakers, community organizations, researchers, employers, and other stakeholders.

This report focuses on the achievement of:

- **Primary Care Visits:** Regular visits to a healthcare provider.
- **Diabetes A1c Control:** Effective management of blood sugar levels.
- **Blood Pressure Control:** Maintenance of healthy blood pressure levels.
- **Depression Screening:** Universal screening for depression.

We selected these measures because they represent critical aspects of outpatient care for women of childbearing age. This report utilizes electronic health record data from the Wisconsin Collaborative for Healthcare Quality (WCHQ) and administrative healthcare claims data from the Wisconsin Health Information Organization (WHIO).

By publicly reporting differences in primary care utilization and health care and outcomes for diabetes, blood pressure, and depression in Wisconsin, the Healthy Metric program aims to draw attention to these disparities, promoting accountability and informing improvement efforts by all healthcare stakeholders.

This report will help stakeholders identify opportunities to develop approaches within their communities to address these disparities and create a healthier Wisconsin for all.

## KEY FINDINGS

### Primary Care Visits

- In 2022, only about two-thirds of insured adult women of childbearing age had a primary care visit. Substantial disparities were observed across regions and counties.
- Ten counties reported particularly low rates of primary care visits.
- Women in urban underserved areas were the least likely to have primary care visits, while those in rural areas were the most likely.

### Diabetes A1c Control, Blood Pressure Control, and Depression Screening Outcomes

- Diabetes A1c control was generally low, with only slightly more than half of adult women of childbearing age with diabetes achieving control. There was substantial geographic disparity: urban underserved areas had the lowest control rate, while urban advantaged areas had the highest rate. White women had the highest rate of A1c control, and Black women had the lowest rate.
- Approximately 1 in 4 adult women of childbearing age with hypertension in urban areas had poor blood pressure control. Rates were slightly better in rural advantaged areas but remained suboptimal. White women had the highest rate of blood pressure control, while Black women had the lowest rate.
- Depression screening rates were lowest in urban advantaged areas and highest in urban underserved areas. Asian/Pacific Islander and Black women had the lowest screening rates, while White women had the highest rate.

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# Introduction

During stakeholder engagement for the Healthy Metric project, maternal and child health emerged as a high priority for addressing disparities. Maternal mortality is a key indicator of a community's health and healthcare quality. According to the Wisconsin Maternal Mortality Review Program, 30 Wisconsin women die during or within one year of pregnancy each year, on average. Substantial disparities exist, with the pregnancy-related mortality rate for non-Hispanic Black mothers being five times higher than that for non-Hispanic White mothers.<sup>1</sup> These deaths significantly impact families and communities and are often preventable.

Approximately 1 in 5 pregnancies are complicated by high blood pressure, gestational diabetes, premature birth, or low birth weight.<sup>2</sup> Blood pressure disorders in pregnancy have nearly doubled over the past decade. Depression screening is crucial for women of childbearing age as it helps identify and manage depression early, which can significantly improve maternal and infant health outcomes.<sup>3</sup> Optimizing health before pregnancy is crucial to improving health outcomes for both mother and child during and after pregnancy.

The goal of this report is to provide valuable data on adult women of childbearing age (18-44) in Wisconsin, including recent claims data on insured women seen in primary care, as well as electronic health record data on key measures such as depression screening, blood pressure control, and blood sugar control in diabetes.

This report offers actionable insights, along with resources for taking action to reduce disparities in women's health. While the listed opportunities and resources are not exhaustive, they are intended to guide stakeholders across the state.

Healthy Metric believes that by identifying and publicly reporting these disparities, this report will draw attention to the issues, promote public accountability, and encourage improvement and action by multiple stakeholders.

## Definition of Disparities

We use "disparities" to define a difference between selected groups of people in healthcare utilization, screening, and outcomes. Health and healthcare disparities often refer to differences that are not explained by variations in health needs, patient preferences, or treatment recommendations and are closely linked with social, economic, and/or environmental disadvantages.<sup>4</sup>

## Insurance Types

Disparities in health insurance coverage may exist due

to differences in the populations that are insured, or due to variation in coverage, cost-sharing (e.g. co-pay and deductible amounts), or the amount paid for medical services. This report categorizes insurance into two types: Commercial and Medicaid. In disparities evaluation, Medicaid is often used as a proxy for people with a lower income.

## Race and Ethnicity

Nationally, disparities in health outcomes and health care exist for people of color (even when controlling for insurance status and income).<sup>5</sup> These disparities are preventable and are often related to the social determinants of health, unequal distribution of power and resources, or other factors. This report utilizes race and ethnicity categories of American Indian, Asian/Pacific Islander, Black, Hispanic/Latino, and White.

## Geography

Geographic disparities may exist due to differences in income levels, the distribution of health care service providers, and access to health-promoting or health-harming resources. This report uses a grouping of Wisconsin ZIP codes developed by researchers and staff at UW-Madison that reflects different levels of health-related characteristics.<sup>6,7</sup> The six geographic groups are: rural underserved, rural, rural advantaged, urban underserved, urban, and urban advantaged. More information about the ZIP code groups can be found here: <https://www.hipxchange.org/RuralUrbanGroups>.

## Data

WHIO receives medical and pharmacy claims and insurance eligibility records from 15 Wisconsin health plans, a large self-funded employer coalition, a pharmacy benefits management organization, and the Wisconsin Medicaid program (BadgerCare). Among other data elements, these records contain diagnoses and procedure codes, and indicators of service location and type which were used to create the measure results in this report. Disparities in statewide performance are presented for adult women of childbearing age by insurance type and geography.

WCHQ member organizations submitted standardized clinical data from 2022, which was aggregated to provide a statewide snapshot that identified disparities across measures. Differences in statewide performance are presented separately for populations defined by race and ethnicity, and geography (rural and urban ZIP code group of patients' residence). For all WCHQ measures, higher performance is considered better.

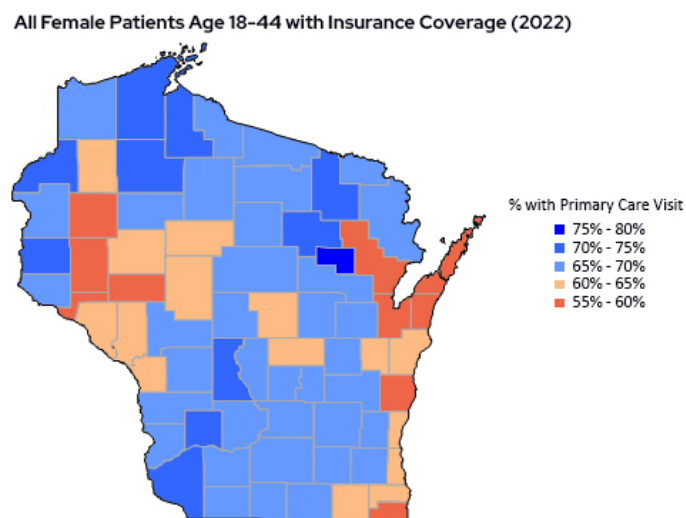
# Primary Care Visits for Women of Childbearing Age

## Background

This section presents information on primary care visits for adult women of childbearing age stratified by insurance type and geography in 2022 using the WHIO data. Primary care is indispensable for women of childbearing age, offering a broad spectrum of services that support overall health, manage chronic conditions, facilitate reproductive health, and ensure equitable access to healthcare.<sup>8-12</sup> Continuous and comprehensive primary care not only improves individual health outcomes but also enhances the well-being of families and communities.

## Geographic Variation in Primary Care Access

Overall, 65% of insured adult women of childbearing age had at least one primary care visit in 2022. However, there was significant variation across Wisconsin regions. The percentages ranged from a low of 55%-60% in some regions to a high of 70%-80% in others.



**Implication:** Many adult women of childbearing age are not seen regularly in primary care despite having health insurance. The wide variation in primary care visits suggests a need to understand the sources of this variation and to develop targeted efforts to increase primary care access and utilization in specific regions of the state.

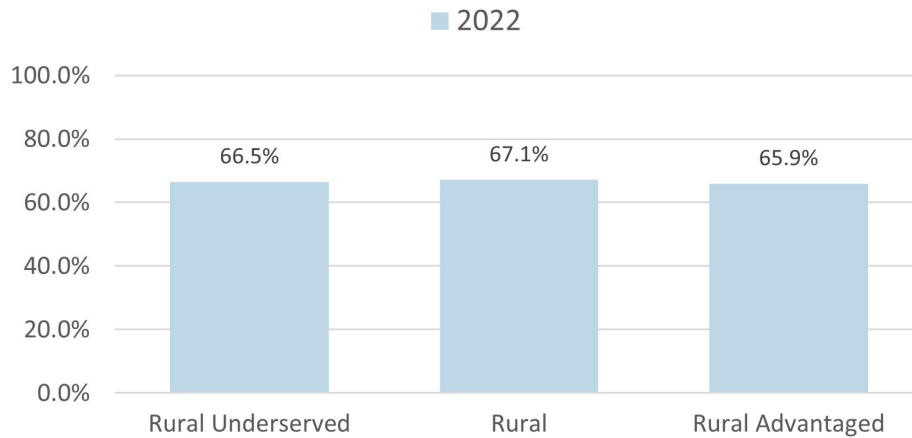
## Rural and Urban Disparities

### KEY FINDINGS

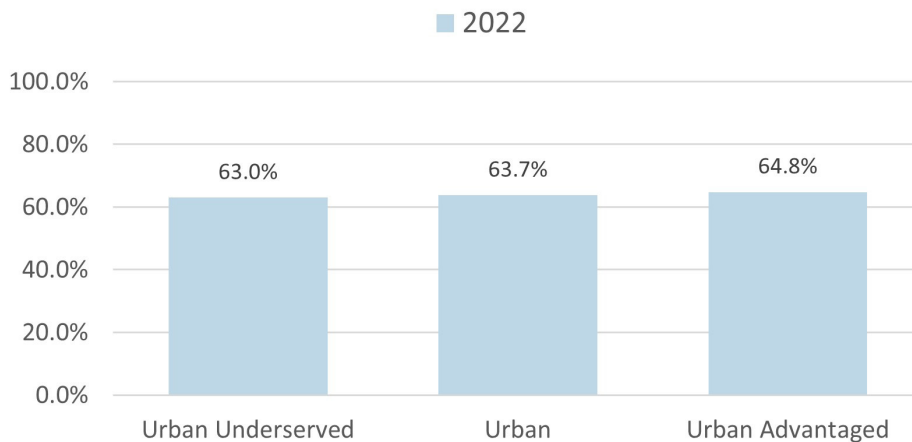
We evaluated the percentage of adult women of childbearing age with health insurance who had at least one primary care visit in 2022, broken down by rural and urban groups. While we found no substantial disparities, differences are noted.

- Adult women of childbearing age in rural areas that were neither underserved nor advantaged had the highest rate of primary care visits at 67.0%.
- Adult women of childbearing age in urban underserved areas had the lowest rate of primary care visits at 63.3%.
- Other notable differences include rural advantaged at 65.7%, rural underserved at 66.4%, urban at 63.8%, and urban advantaged at 64.8%.

## PRIMARY CARE VISIT RATE BY RURAL GEOGRAPHY



## PRIMARY CARE VISIT RATE BY URBAN GEOGRAPHY



**Implication:** Adult women of childbearing age in urban underserved areas are somewhat less likely to have had a primary care visit compared to those in rural areas that were neither underserved nor advantaged. This indicates a need for targeted efforts to increase primary care access and utilization among women in urban underserved areas.

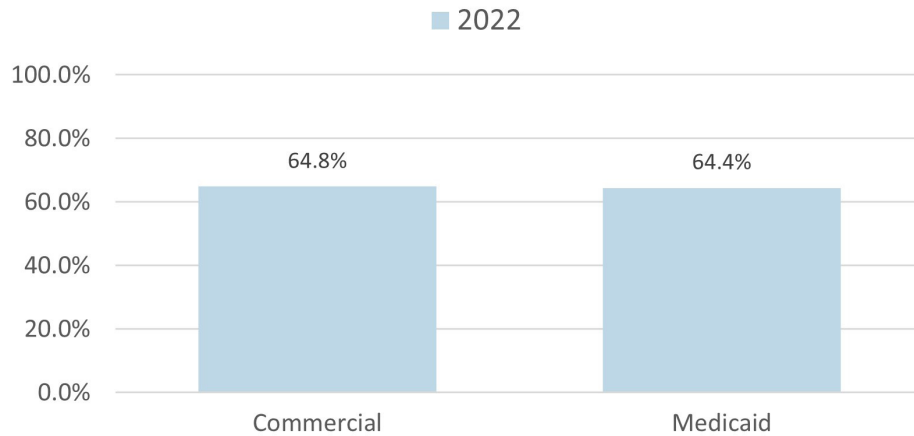
## Payer Disparities

### KEY FINDINGS

We evaluated the percentage of adult women of childbearing age (aged 18–44) with health insurance who had at least one primary care visit in 2022, broken down by payer type. We found no notable differences.

- Adult women of childbearing age with commercial insurance had a primary care visit rate of 64.8%.
- Adult women of childbearing age with Medicaid had a primary care visit rate of 64.4%.

## PRIMARY CARE VISIT RATE BY PAYER



**Implication:** The primary care visit rates for adult women of childbearing age with commercial insurance and Medicaid are very similar, indicating that access and utilization of primary care services are comparable for these two groups.

## Primary Care Visits for Women of Childbearing Age Summary

The data reveals disparities in primary care visit rates for insured adult women of childbearing age in 2022:

- There is wide variation across Wisconsin regions in the rate of primary care visits.
- Rural areas have the highest rates of primary care visits, while urban underserved areas have the lowest rates.
- No notable differences were found by payer.



# Chronic Disease Care for Women of Childbearing Age

## Prevalence

To understand the extent of chronic conditions for the population presented in our report, we estimated the prevalence of diabetes, hypertension, and depression screening in Wisconsin for adult women of childbearing age.

**Methodology:** We extracted age band prevalence estimates for Wisconsin in 2022 from the Behavioral Risk Factor Surveillance System (BRFSS).<sup>13</sup> These estimates were adjusted by sex prevalence to calculate final estimates for females aged 18-44.

Condition	Prevalence Estimate
Diabetes, including pre-diabetes and gestational diabetes	5.00%
Hypertension	10.83%
Depression - any form	37.84%

## Diabetes A1c Control

### Background

Effective blood sugar control in diabetes is crucial for reducing the risks of heart disease, kidney disease, eye disease, and other complications including complications of pregnancy. This is particularly important for women of reproductive age. In the U.S., approximately 1-2% of pregnant women have preexisting diabetes, a number that has been increasing in recent years. Poorly managed blood sugar levels can significantly increase the risk of complications during pregnancy, including, very large birth weight (macrosomia) leading to Cesarean births, preeclampsia, infant birth injury, perinatal depression, preterm birth, birth defects, miscarriage, and stillbirth.<sup>14</sup>

Women with diabetes need to consult their healthcare provider before pregnancy to discuss their care and achieve good blood sugar control for several weeks before conception. Proper management of diabetes before and during pregnancy can substantially reduce the risk of complications for both the mother and the baby.

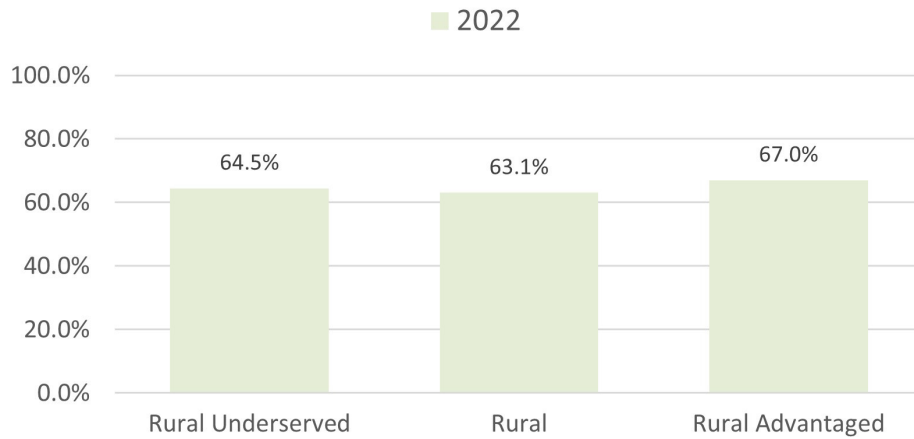
Analysis of health outcomes for women aged 18-44 across different geographic areas and racial/ethnic categories reveals substantial disparities in diabetes A1C control.

## Rural and Urban Disparities

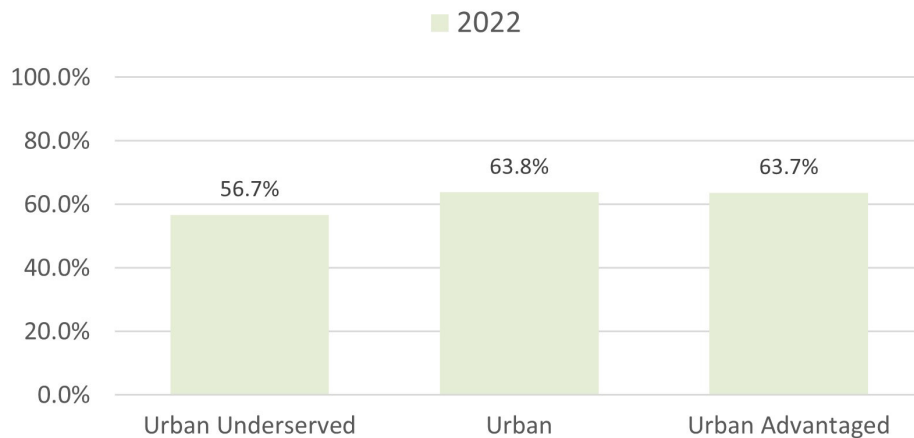
### KEY FINDINGS

- Rural advantaged areas have the highest diabetes A1C control rate at 67.0%.
- Urban underserved areas have the lowest control rate at 56.7%.
- Other notable differences include rural areas (63.1%), urban areas (63.8%), urban advantaged areas (63.7%), and rural underserved areas (64.5%).

## DIABETES A1c CONTROL RATES BY RURAL GEOGRAPHY



## DIABETES A1c CONTROL RATES BY URBAN GEOGRAPHY



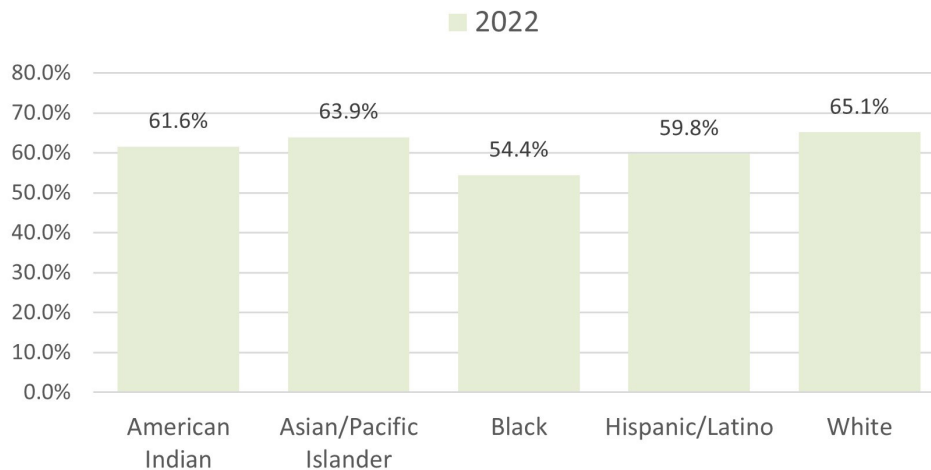
**Implication:** Women in urban underserved areas are less likely to have their diabetes under control compared to those in rural advantaged areas. Targeted diabetes management programs in urban underserved areas could help improve these control rates.

## Racial and Ethnic Disparities

### KEY FINDINGS

- White women had the highest rate of diabetes A1C control at 65.1%.
- Black women had the lowest rate at 54.4%.

## DIABETES A1C CONTROL RATES BY RACE/ETHNICITY



**Implication:** Black women have the lowest rates of diabetes A1c control, highlighting the need for focused interventions to improve diabetes management among Black women.

## Blood Pressure Control

### Background

High blood pressure can cause health problems at any time in life, but during pregnancy, uncontrolled high blood pressure can cause serious problems for both the mother and baby. Women with high blood pressure are at an increased risk of preeclampsia, preterm birth, placental abruption, and need for cesarean birth. High blood pressure during pregnancy can cause extra stress on the heart and kidneys, which can lead to heart disease, kidney disease, and stroke. High blood pressure can also reduce blood flow to the placenta, resulting in the baby not getting enough of the nutrients and oxygen needed to grow and increase the risk of preterm birth.<sup>15</sup> These risks make it critical to detect and control high blood pressure before (and during) pregnancy.

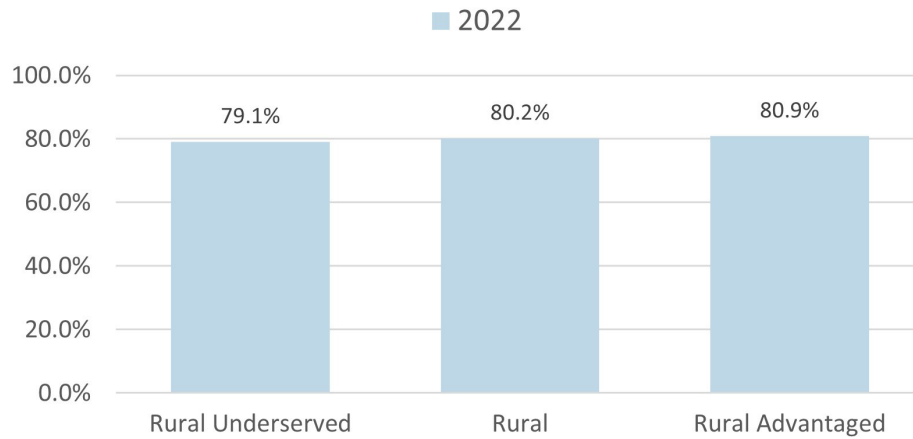
The analysis of the data on health outcomes for women aged 18–44 across different geographic areas and racial/ethnic categories reveals substantial disparities in blood pressure control.

## Rural and Urban Disparities

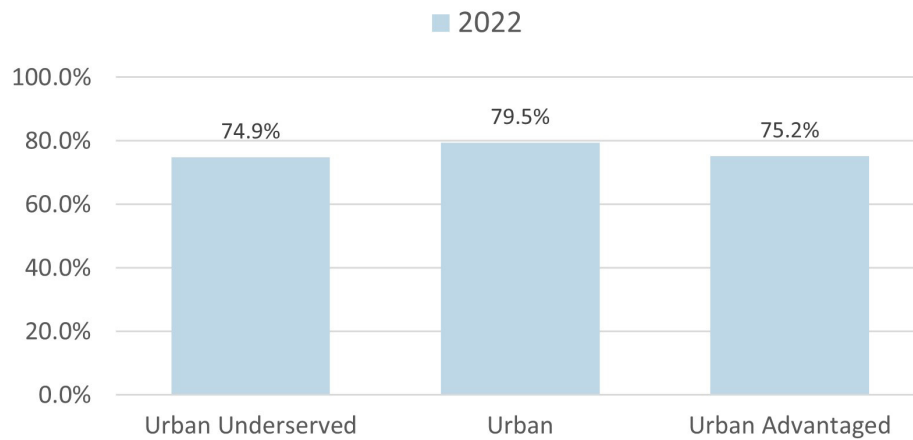
### KEY FINDINGS

- Rural advantaged areas have the highest blood pressure control rate at 80.9%.
- Urban underserved areas have the lowest control rate at 74.9%.
- Urban advantaged areas also had a lower control rate 75.2%.

## BLOOD PRESSURE CONTROL RATES BY RURAL GEOGRAPHY



## BLOOD PRESSURE CONTROL RATES BY URBAN GEOGRAPHY



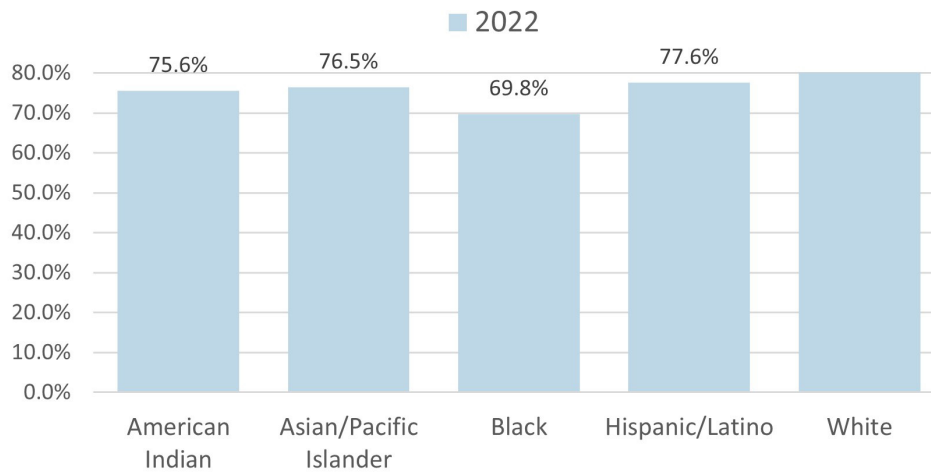
**Implication:** Women in urban underserved and urban advantaged areas are less likely to have their blood pressure under control compared to those in rural advantaged areas. Interventions focused on these urban groups could help improve their blood pressure control rates.

## Racial and Ethnic Disparities

### KEY FINDINGS

- White women had the highest rate of blood pressure control at 80.1%.
- Black women had the lowest rate at 69.8%.
- Other notable differences include Hispanic/Latino women (77.6%), Asian/Pacific Islander women (76.5%), and American Indian/Alaska Native women (75.6%).

## BLOOD PRESSURE CONTROL RATES BY RACE/ETHNICITY



**Implication:** Black women have substantially lower rates of blood pressure control compared to White women and other racial/ethnic groups. This indicates a need for targeted efforts to improve blood pressure management among Black women.

## Depression Screening

### Background

Depression is a serious mental health condition that is associated with worsened maternal and infant outcomes. Pre-pregnancy depression rates in Wisconsin have been increasing, from 10.6% in 2013 to 18% in 2021. Pre-pregnancy depression in Wisconsin was over 22% in 2019 and 2020.<sup>16</sup> Universal depression screening is recommended before, during, and after pregnancy to identify women at risk and help them to get appropriate referrals and treatment.<sup>17</sup>

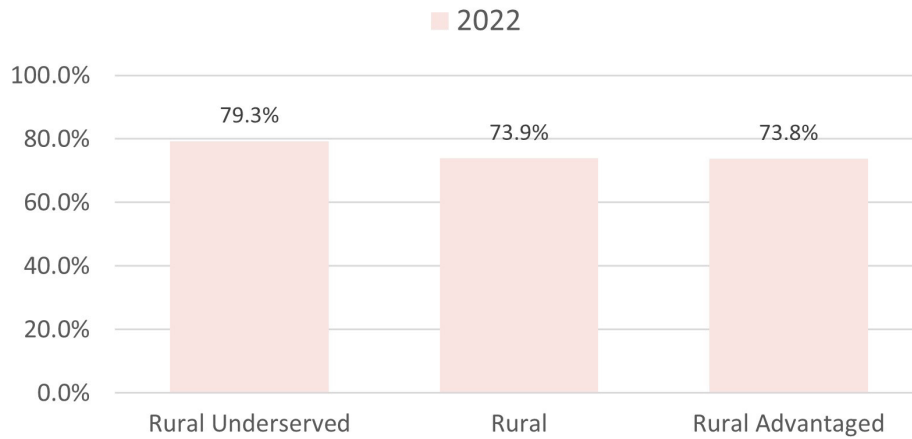
The analysis of health outcomes data for women aged 18–44 across different geographic and racial and ethnic groups reveals substantial disparities in depression screening.

## Rural and Urban Disparities

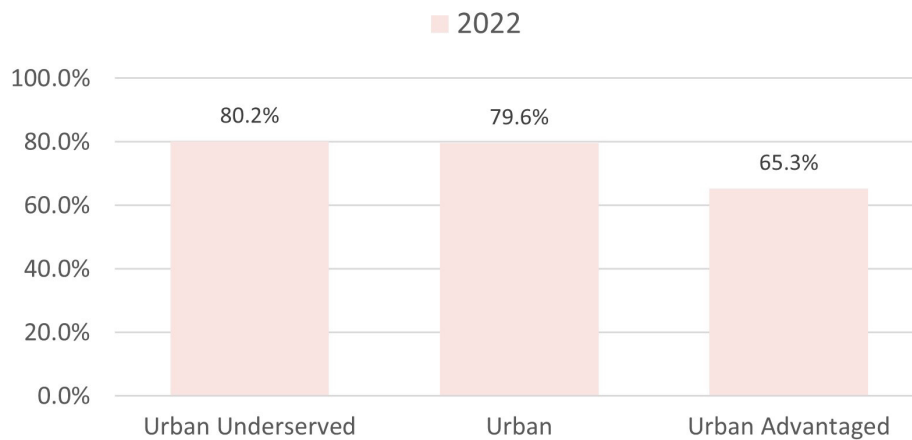
### KEY FINDINGS

- Urban underserved areas have the highest depression screening rate at 80.2%.
- Urban advantaged areas have the lowest screening rate at 65.3%.
- Other notable differences include rural areas (73.9%), rural advantaged areas (73.8%), urban areas (79.6%), and rural underserved areas (79.3%)

## DEPRESSION SCREENING RATES BY RURAL GEOGRAPHY



## DEPRESSION SCREENING RATES BY URBAN GEOGRAPHY



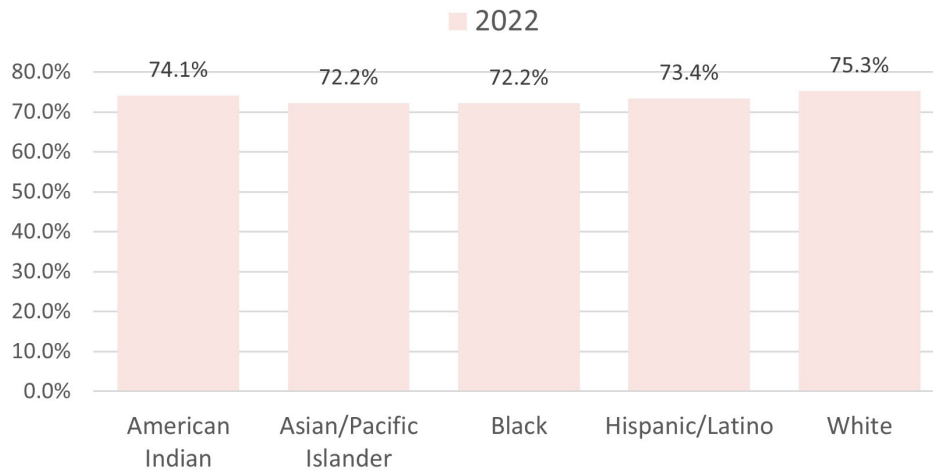
**Implication:** Women in urban advantaged areas are less likely to be screened for depression compared to those in other geographic areas, especially urban underserved areas. Depression screening rates may be higher in underserved areas due to targeted public health initiatives and community health centers focusing on comprehensive care, which includes mental health services. In contrast, lower screening rates in advantaged areas may be due to lower prioritization of mental health issues, higher stigma, and underutilization of mental health services despite better access to healthcare. Increasing screening efforts in urban advantaged areas could help address this disparity.

## Racial and Ethnic Disparities

### KEY FINDINGS

- White women had the highest rate of blood pressure control at 80.1%.
- Black women had the lowest rate at 69.8%.
- Other notable differences include Hispanic/Latino women (77.6%), Asian/Pacific Islander women (76.5%), and American Indian/Alaska Native women (75.6%).

## DEPRESSION SCREENING RATES BY RACE/ETHNICITY



**Implication:** Asian/Pacific Islander and Black women are less likely to be screened for depression compared to White women and other racial/ethnic groups, indicating the need for improved screening practices for these populations.

## Chronic Disease Care for Women of Childbearing Age Summary

The data shows substantial disparities in health outcomes for women aged 18-44 across different geographic areas and racial/ethnic categories. Specifically:

- Urban underserved areas have the lowest diabetes A1c control rates, whereas rural advantaged areas have the highest. Black women have the lowest control rates, whereas White women have the highest.
- Urban underserved and advantaged areas have lower blood pressure control rates compared to rural advantaged areas. Black women have the lowest control rates, while White women have the highest.
- Urban advantaged areas have the lowest depression screening rates, while urban underserved areas have the highest. Asian/Pacific Islander and Black women have the lowest screening rates, while White women have the highest.

# Actionable Insights

By implementing the actionable recommendations below, healthcare providers, policymakers, and community organizations can work towards more equitable health outcomes for women in different geographic areas and address the disparities highlighted in the report.

## Primary Care Utilization

### Enhance Outreach and Education:

- Develop community outreach programs to educate women about the importance of regular primary care visits. Partner with local organizations to disseminate information through workshops, health fairs, and social media campaigns.

### Address Physician Shortages:

- Increase the number of healthcare providers in underserved areas by implementing targeted recruitment and retention strategies. This can enhance access to primary care, reduce patient wait times, and improve overall health outcomes by ensuring that more women receive timely and comprehensive care

### Expand Access to Primary Care:

- Increase the availability of primary care services in underserved areas by establishing more clinics or mobile health units. Collaborate with healthcare providers to extend clinic hours and offer flexible appointment scheduling to accommodate working women and those with childcare responsibilities.

### Implement Community-Based Initiatives:

- Establish community health worker programs to assist women in navigating healthcare systems, scheduling appointments, and addressing barriers to accessing care, such as transportation or language differences.

### Leverage Technology:

- Promote telehealth services to reach women in underserved areas. Provide training for healthcare providers to ensure they can effectively deliver virtual care and educate patients on how to use telehealth platforms.

## Diabetes A1c Control

### Develop Targeted Diabetes Management Programs:

- Implement diabetes education and management programs in urban underserved areas to improve control rates. Focus on culturally tailored interventions that address the specific needs of different racial/

ethnic groups, particularly Black and Hispanic women.

### Increase Screening and Early Intervention:

- Expand screening programs for diabetes and prediabetes in community settings, such as pharmacies and local health departments. Early detection and intervention can prevent the progression of the disease and improve health outcomes.

### Support Self-Management:

- Provide resources and tools for women to manage their diabetes at home, such as glucose monitors and educational materials on diet and exercise. Offer support groups and counseling to help women adhere to treatment plans.

### Enhance Provider Training:

- Train healthcare providers in diabetes management best practices, focusing on the latest guidelines and techniques for improving patient adherence and engagement.

## Blood Pressure Control

### Implement Blood Pressure Monitoring Programs:

- Distribute blood pressure monitors to women in underserved areas and train them on how to use them. Establish community-based monitoring programs where women can regularly check their blood pressure and receive guidance.

### Promote Lifestyle Interventions:

- Encourage healthy lifestyle changes through community programs that offer nutrition counseling, physical activity classes, and smoking cessation support. Highlight the impact of these changes on blood pressure control and overall health.

### Enhance Medication Management:

- Work with healthcare providers to ensure that women have access to affordable medications and understand their treatment plans. Offer medication management programs to help women adhere to their prescriptions and manage side effects.



### **Conduct Community Screenings:**

- Organize regular blood pressure screening events in community centers, schools, and workplaces. Provide immediate feedback and referrals to healthcare providers for those with elevated readings.

## **Depression Screening**

### **Expand Depression Screening Programs:**

- Integrate depression screening into primary care visits and other routine healthcare encounters, such as prenatal and postpartum care. Use validated screening tools and ensure that screenings are conducted in a culturally sensitive manner.

### **Increase Access to Mental Health Services:**

- Address barriers to accessing mental health care by offering services in community settings, expanding telehealth options, and providing financial assistance for low-income women. Collaborate with mental health professionals to ensure a broad range of services are available.

### **Promote Awareness and Reduce Stigma:**

- Launch public awareness campaigns to educate women about the signs of depression and the importance of seeking help. Work to reduce stigma around mental health issues through community education and support groups.

### **Train Healthcare Providers:**

- Provide training for healthcare providers on how to identify and manage depression, particularly in women of childbearing age. Emphasize the importance of regular screening and follow-up care.

### **Create Support Networks:**

- Establish peer support networks and counseling services to provide emotional and social support for women experiencing depression. Encourage the involvement of family members and caregivers in the support process.

# Resources for Taking Action

Data is an important tool to understand health outcomes and care in Wisconsin. However, it is just one component in identifying and addressing health disparities. Some resources for addressing disparities and improving depression screening, blood pressure control, and blood sugar control in diabetes are included below. This is not an exhaustive list but is intended to offer direction for stakeholders across the state.

## Primary Care Utilization

- [Health Center Program](#)
- [Primary Care Development Corporation \(PCDC\)](#)
- [Agency for Healthcare Research and Quality](#)

## Depression Screening

- [What Works for Health: Depression Screening](#)
- [The American College of Obstetricians and Gynecologists: Depression During Pregnancy](#)
- [Moms Mental Health Initiative](#)
- [Equitability of Depression Screening after Implementation of General Adult Screening in Primary Care](#)

## Blood Sugar Control in Diabetes

- [CDC National Diabetes Prevention Program](#)
- [Wisconsin Department of Health Services Chronic Disease Prevention Program: Prediabetes page](#)
- [Wisconsin Department of Health Services Chronic Disease Prevention Program: Diabetes page](#)
- [Toolkit for Improving Chronic Conditions, Hypertension & Diabetes: Care & Outcomes](#)
- [What Works for Health: Diabetes](#)
- [March of Dimes: Preexisting Diabetes](#)
- [The American College of Obstetricians and Gynecologists: Diabetes and Women](#)

## Blood Pressure Control

- [Toolkit for Improving Chronic Conditions, Hypertension & Diabetes: Care & Outcomes](#)
- [What Works for Health: Blood Pressure Control](#)
- [The Community Guide: Blood Pressure Control](#)
- [Quit Connect: A Protocol to Improve Tobacco Quit Line Referrals](#)
- [Wisconsin Tobacco Quit Line](#)
- [ACOG Managing High Blood Pressure](#)

## Questions to Consider for Taking Action

- What other organizations and communities are working on addressing these issues, and how could more collaborative partnerships be formed?
- What barriers exist to accessing quality, affordable healthcare and how can we address those barriers?
- What barriers exist for getting recommended screenings (e.g. location of the facility, office hours, inflexible employment)?
- How could financial barriers be eliminated for accessing care?
- Is communication about the benefits of screening tailored to the population(s) experiencing disparities and available in a variety of formats?
- What factors shape people's access to nutritious food, safe places to exercise, and medications?
- How might past experiences contribute to some communities' lack of trust in healthcare providers?
- How might we encourage the recruitment, training, and retention of a more skilled, culturally responsive, and diverse healthcare workforce?

# Conclusion

This report highlights the critical disparities in healthcare access and outcomes among adult women of childbearing age in Wisconsin, focusing on primary care utilization, diabetes A1c control, blood pressure control, and depression screening. The findings reveal substantial geographic and demographic disparities that underscore the urgent need for targeted interventions.

In 2022, only 65% of insured women in this demographic had a primary care visit, with significant regional variations. Women in urban underserved areas had the lowest rates of primary care visits and diabetes A1c control, indicating significant barriers to accessing primary care. The disparities in blood pressure control and depression screening further highlight the systemic inequities that need to be addressed to improve health outcomes.

To achieve more equitable health outcomes, it is imperative to:

- Enhance access to primary care services through community outreach and the expansion of telehealth.
- Implement targeted diabetes and blood pressure management programs, particularly in underserved urban areas.
- Increase efforts to screen for and address depression, focusing on areas and populations with the lowest screening rates.

By addressing these disparities, stakeholders can foster a healthier Wisconsin for all women, ensuring that the health needs of women of childbearing age are met comprehensively and equitably. Continuous collaboration between healthcare providers, policymakers, community organizations, and other stakeholders is essential to drive these improvements and create sustainable health equity.

This report serves as a call to action for a concerted effort to eliminate health disparities and promote public accountability. With targeted programs and community involvement, we can make significant strides toward improving the health and well-being of women across Wisconsin.

# Methodology

## WHIO Data

The WHIO data is provided by 15 Wisconsin health insurance companies (commercial and Medicare Advantage), a large employer self-funded purchasing coalition, a pharmacy benefits manager company, and the Wisconsin Medicaid program. These organizations submit detailed medical and pharmacy data to the WHIO, along with eligibility records that identify demographic and insurance coverage characteristics of insured people. The WHIO used the claims data to identify people who received services with an indicator diagnosis and used the eligibility data to identify demographic and location based characteristics of these people.

## Data Quality and Validation

Data received by WHIO undergoes multiple data quality checks at each stage of processing. Files are initially reviewed from each WHIO data contributor, with quality checks added in subsequent stages as the data is integrated into a single all payer, person-centric, deidentified database. Results for this report were further examined against available state and national benchmarks, studies, and other results.

## WHIO Data Limitations

The WHIO's data is limited to people in Wisconsin who have insurance coverage, and that are covered by organizations that voluntarily contribute their data to the WHIO. The WHIO data used in this report does not include data for the uninsured population, some portion of self-funded insurance plans, people who are employed by the federal government, or people insured by the Medicare Fee-for-Service health plan option except for Medicare Advantage and supplemental plans in Wisconsin. The WHIO data system currently includes 5.3 million Wisconsinites, about 75% of the population.

## WHIO Measure Descriptions

Evaluation and management visits for women aged 18-44 in General Practice, Internal Medicine, Family Practice, Pediatrics, and Ob/Gyn.

## WCHQ Data

Wisconsin Collaborative for Healthcare Quality (WCHQ) members submitted standardized and recent (2022) clinical data, which was aggregated to provide a statewide snapshot that identified disparities in the depression screening, blood pressure control, and blood sugar

control in diabetes measures. Differences in statewide performance are presented separately for populations defined by race/ethnicity and rural and urban residence. For all WCHQ measures, higher performance is considered better.

## Data Quality and Validation

Data from WCHQ member organizations underwent a rigorous validation process. This consisted of a series of quality checks, including comparing denominators and performance rates with their publicly reported WCHQ measure results and ensuring that all data mappings were complete. Some member-level data was excluded from analysis due to incompleteness or quality issues.

## WCHQ Data Limitations

There are several limitations to the findings of this report. First, some of the population sizes are small. This means that small fluctuations in health outcomes or care could have an inflated impact on the measure results. Second, this report only includes data from health care organizations that are members of WCHQ. Therefore, a subset of individuals throughout the state who are treated in other health systems or who have not recently visited a health system are not included. This particularly impacts patient population groups who receive care through Federally Qualified Health Centers (FQHCs), free & charitable clinics, Indian Health Service clinics, and clinics in northwestern Wisconsin. Lastly, due to the varied methods of data submission, statistical significance testing was not able to be performed on the data in this report.

## WCHQ Measure Descriptions

### Depression Screening in Women

This measure assesses the percentage of women aged 18-44 screened for clinical depression at any time during the measurement period using an age-appropriate standardized depression screening tool.

### Blood Pressure Control in Women

This measure assesses the percentage of women with hypertension (high blood pressure), age 18-44, whose blood pressure was in control during the one-year measurement period.

### Blood Sugar Control in Diabetes in Women

This measure assesses the percentage of women with diabetes, age 18-44, whose A1c blood sugar level was controlled to less than 8.0% within the one-year measurement period.

# Data Tables

## Primary Care Visit Rate (WHIO Data)

Indicator	2022	
	# Eligible	% Met
PAYER		
Commercial	222,023	64.8%
Medicaid	309,682	64.4%
GEOGRAPHY		
Rural Underserved	19,015	66.5%
Rural	74,802	67.1%
Rural Advantaged	49,763	65.9%
Urban Underserved	81,751	63.0%
Urban	186,660	63.7%
Urban Advantaged	118,308	64.8%

## Primary Care Visit Rate (WCHQ Data)

Indicator	2022	
	# Eligible	% Met
RACE/ETHNICITY		
American Indian	719	74.1%
Asian/Pacific Islander	7,136	72.2%
Black	10,936	72.2%
Hispanic/Latino	11,620	73.4%
White	100,497	75.3%
GEOGRAPHY		
Rural Underserved	3,822	79.3%
Rural	14,685	73.9%
Rural Advantaged	12,373	73.8%
Urban Underserved	12,645	80.2%
Urban	52,901	79.6%
Urban Advantaged	36,156	65.3%

## Blood Pressure Control (WCHQ Data)

Indicator	2022	
	# Eligible	% Met
RACE/ETHNICITY		
American Indian	131	75.6%
Asian/Pacific Islander	493	76.5%
Black	2,308	69.8%
Hispanic/Latino	898	77.6%
White	11,604	80.1%
GEOGRAPHY		
Rural Underserved	454	79.1%
Rural	1,600	80.2%
Rural Advantaged	1,323	80.9%
Urban Underserved	2,230	74.9%
Urban	7,066	79.5%
Urban Advantaged	2,853	75.2%

## Blood Sugar Control in Diabetes (WCHQ Data)

Indicator	2022	
	# Eligible	% Met
RACE/ETHNICITY		
American Indian	164	61.6%
Asian/Pacific Islander	599	63.9%
Black	1,515	54.4%
Hispanic/Latino	1,273	59.8%
White	7,427	65.1%
GEOGRAPHY		
Rural Underserved	346	64.5%
Rural	1,283	63.1%
Rural Advantaged	864	67.0%
Urban Underserved	1,663	56.7%
Urban	4,847	63.8%
Urban Advantaged	2,063	63.7%

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