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# COVER THEME Moving toward better health

Encouraging a dialogue about health system reform; finding effective ways to encourage patients to literally get moving; successfully utilizing health care resources—these are all ways to help improve the health of patients in Wisconsin. In this issue of the Wisconsin Medical Journal, we take a closer look at these topics and others that can help ensure we're "moving toward better health."

Cover design by Mary Kay Adams-Edgette.

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

#### **EDITORIAL**

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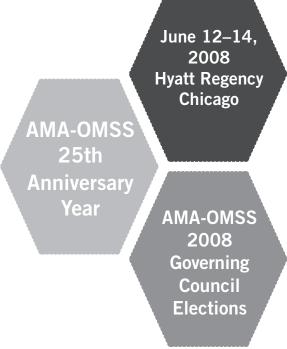
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# Wisconsin first state to screen all newborns for 'bubble boy disease'

The Wisconsin Department of Health and Family Services (DHFS), acting on the recommendation of the Newborn Screening Umbrella Advisory Committee, has approved adding Severe Combined Immune Deficiency (SCID) to the Wisconsin newborn screening panel. With the addition of SCID, Wisconsin now screens approximately 70,000 newborns annually for 48 genetic disorders, including hearing loss (which is not mandated). These tests include all 29 of the core panel of tests recommended by the American College of Medical Genetics Newborn Screening Expert Group in 2006.1

The pilot program to develop an effective and efficient newborn screening test for SCID began 1 year ago as a funding and scientific collaborative effort between the Wisconsin State Laboratory of Hygiene (WSLH) at the University of Wisconsin-Madison, the Children's Hospital of Wisconsin in Milwaukee, and the Jeffrey Modell Foundation. WSLH performs all newborn screening testing in the state and the Jeffrey Modell Foundation focuses on prevention of primary immunodeficiency diseases.

WSLH began reporting SCID results on the newborn screening report form February 18, 2008. The amount of blood collected for newborn screening is sufficient to perform the SCID testing. Physician consultants are available to Wisconsin physicians whose patients receive a "Possible Abnormal SCID (Immunodeficiencies) Report" form. William J. Grossman, MD, PhD, and Jack Routes, MD, are available for consults at the Children's Hospital of Wisconsin in Milwaukee. Contact numbers for Dr Routes and Dr Grossman are 414.907.8511 (pager 1), 414.907.7944 (pager 2), 888.241.3494 (pager 3), or 262.266.6293. The consulting physician at American Family Children's Hospital in Madison is

Christine Seroogy, MD, and she can be reached at 608.217.2454.

As with all disorders screened on the Wisconsin newborn screening panel, the benefits of testing for SCID will be evaluated over time. For more information on the Wisconsin newborn screening program, please visit our Web site at www.slh.wisc.edu/newborn, including the "Health Care Professional's Guide to Newborn Screening."

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# Merging public health

In Wisconsin, there are 92 local health departments of various size and function. Single county departments with limited services cover vast areas in mostly rural Northern Wisconsin. Thirteen separate public health departments serve Milwaukee County, the state's largest urban area. Moderately urban, Outagamie County is served by 5 departments. Some departments have few staff—Florence County has 2.7 employees. Some have many—Milwaukee City Health Department has over 300.

Over the years, several adjacent jurisdictions have combined. Eau Claire City/County Health Department merged more than 40 years ago. More recently, Brown County subsumed Green Bay, Kenosha County subsumed the City of Kenosha, and Rock County took over the care of Beloit. On January 1, 2008, Public Health Madison Dane County (PHMDC) became a unified, city-county health department.

Merged agencies can and do save money, which is often the primary political motivation behind consolidation. One director costs less than 2, unitary phone and IT systems achieve economies of scale, and administrative redundancies are ripe for elimination. But in our experience in Madison Dane County, even greater good comes from integrating operations, realigning resources, and forging common strategies. Here are some recent examples.

- Apparently random cases of hepatitis A reported from Middleton, Oregon, and Madison were linked and the cluster analyzed by a unified infectious disease control team. Previously, confidential case information may or may not have been efficiently passed back and forth between agencies. Responding to the hepatitis outbreak, a gamma globulin/vaccination clinic was promptly organized for an exposed childcare center in one of the municipalities. Interjurisdictional squabbling was avoided regarding which should supply the biologicals, which should provide staff, and if the clinic was even needed.
- Four extremely complex, multi-drug resistant tuberculosis patients, falling ill in rapid succession, received the multi-disciplinary attention they needed individually, while transmission of the often-fatal disease to others was prevented. This was accomplished by an expanded TB team of both city and county nurses who worked effectively together while coordinating with University of Wisconsin physicians, city attorneys and police, Dane County Courts and Department of Human Services and the Wisconsin Department of Health and Family Services. For very complex and serious problems, size, as can be conferred by merger, matters.

# PHMDC has equipped its sanitarians with linked, electronic field devices and trained them in the uniform application of food safety standards for all of Dane County's 3000 food establishments. Local ordinances agreed to by the mayor, county executive, city council members, and county board of supervisors allow us to now assure citizens that soft-serve and ice

cream operations, salad bars, and delis

are regularly inspected and sampled

countywide. The fact that they weren't in the past comes as a surprise to many

people. On a neighborhood level, health assessments and interventions are now carried out relatively unhindered by the patchwork of municipal boundaries. The South Madison Health and Family Center-Harambee on South Park Street, an important PHMDC site of operation, serves the city of Madison, the town of Madison, the city of Fitchburg, and the village of Oregon. Previously, young parents with multiple children in tow who would walk, ride the bus or drive to the center for public health services would be turned away if by mistake they arrived at a day or time that didn't correspond with their

city or county residence. Now all are

welcome, every day.

In addition, the growing collection of public and private health providers on the South Park Street site, most prominently Access Community Health Center and UW Wingra Clinic, spurred on by the recently completed PHMDC South Madison Community Health Assessment, appear to be blossoming into a dynamic "health commons." It is hoped that the health commons will serve as the geographic portal to Madison's "health care Main Street," home to Group Health Cooperative, St. Mary's Hospital, Meriter Hospital, and UW Hospitals and Clinics. HMDC is only 1 of many actors in this grand collaborative process, but its unified and focused presence has been key.

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#### In Remembrance

Editor's note; The following physicians passed away between November 2007 and April 2008.

**William W. Chandler, MD**, 84, of Appleton, Wis; Medical College of Wisconsin, Milwaukee; passed away November 20, 2007.

Ram Das, MD, 70, of Middleton, Wis; Calicut Medical College, Calicut, Kerala; passed away March 8, 2008.

**Clair M. Flanagan, MD**, 92, of Boynton Beach, Fla; University of Wisconsin Medical School, Madison; passed away December 31, 2007

Yoshio Handa, MD, 89, of Madison, Wis; Creighton University School of Medicine, Omaha; passed away January 6, 2008.

**Henrik A. L. Hartmann, MD**, 87, of Madison, Wis; Medisinske Fakultet Universitetet i Oslo, Oslo, Norway; passed away December 28, 2007.

**Theodore L. Hartridge, MD**, 98, of Madison, Wis; University of Pennsylvania School of Medicine, Philadelphia; passed away February 20, 2008.

**John P. Hartwick, MD**, 73, of Jefferson, Wis; Medical College of Wisconsin, Milwaukee; passed away December 10, 2007.

**Frank C. Larson, MD**, of Madison, Wis; passed away December 25, 2007.

**Robert N. Leasum, Jr., MD**, 79, of Osseo, Wis; Jefferson Medical College of Thomas Jefferson University, Philadelphia; passed away January 12, 2008.

**Donald B. Lindorfer, MD**, 80, of Waukesha, Wis; Medical College of Wisconsin, Milwaukee; passed away March 17, 2008.

**Philipp H. Marty, MD**, 83, of Lebanon; University of Wisconsin Medical School, Madison; passed away March 9, 2008.

**Sidney S. Meyers, MD**, 91, of Mequon, Wis; University of Illinois at Chicago College of Medicine, Chicago; passed away November 20, 2007.

**Wolfram E. Nolten, MD**, 73, of Madison, Wis; Med Fak der Ludgwig Maximilians Universität; passed away January 11, 2008.

**Carl J. Saggio, MD**, 65, of Fond Du Lac, Wis; Medical College of Wisconsin, Milwaukee; passed away November 24, 2007.

**Gerhard D. Straus, MD**, 94, Palm Beach, Fla; Medical College of Wisconsin, Milwaukee; passed away January 22, 2008.

**John R. Talbot, MD**, 94, of Lake Placid, NY; University of Wisconsin Medical School, Madison; passed away March 22, 2008.

**Henry M. Waldren, Jr., MD**, 80, of Elkhart Lake, Wis; Medical College of Wisconsin, Milwaukee; passed away March 17, 2008.

# The staff of Asclepius: A new perspective on the symbol of medicine

Kyle Bradford Jones

staff Asclepius (Aesculapius Latin; Figure 1) has been associated with medicine since ancient times. Asclepius, a son of Apollo, was a practitioner of medicine and is 1 of 4 specific gods and goddesses to whom is sworn the original Hippocratic Oath.1 The other element of this symbol, the serpent, was seen by the Greeks as a symbol of healing and renewal due to the continual shedding of skin, and was often worshipped to protect one's health. While the staff is not often associated with other conventions, the serpent also serves as a symbol in the Judeo-Christian tradition, and the meaning is worth looking into as it relates to the health care profession.

Sacred writings shared by both Judaism and Christianity represent serpents not only as healers and saviors, but also as destroyers. The idea of the serpent as a destroyer originated in the Book of Genesis in the Old Testament, as the devil takes the form of the serpent to beguile the first humans, Adam and Eve, into partaking of the forbidden fruit, thereby ending their stay in the idyllic Garden of Eden.<sup>2</sup> The duality of the serpent, however, is possibly best represented by an

account in the Book of Numbers, also from the Old Testament. As many Israelites were dying from a plague of "fiery" poisonous serpents, their leader, the prophet Moses, prayed for help. He was instructed by the Lord to fashion a bronze serpent on a staff, for all of Israel to see. Once an Israelite had been bitten by a serpent, they would be made whole merely by looking upon this bronze serpent. Though some neglected the easy charge, many were saved.3 The serpent has since been associated as a symbol of the expected Messiah, who it was believed would come to save Israel from spiritual and temporal destruction.4

The application of this duality to medicine is unfortunately altogether too real. The majority of doctors, if not all, have seen, either as patient or health care professional, both the "destroyer" and "savior" in medicine. The destroyer often shows itself in a negative health care professional who damages hope in the patient. Sad experience shows us that this characteristic is present in all health care professionals at least some of the time. Often, physicians may not even realize that they are being cold to a patient because they are accustomed to the esteemed position they have held for years. It can be easy to forget what it is like to be a patient, to not know or understand what is wrong with your body, to not know where current or potential problems will lead you in the future, to fear that your sim-

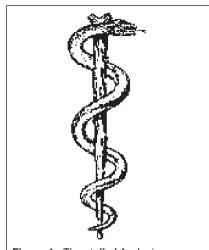


Figure 1. The staff of Asclepius.

ple symptoms hide something more serious than the more likely and lesser diagnosis, to worry about payment for services or prescriptions rendered.

The prestige and regard of the profession should not lead to highminded behavior by its professionals, but this is often the origin of the presence of the destroyer. Unfortunately, the long, difficult years of training distance us from our patients, not just in medical proficiency, but also sometimes in emotion and understanding. In order to be the savior we are trained to be, we do not necessarily need to build up hope in the patient, but simply to build up the patient by showing genuine compassion and concern. Not only is showing this empathy for the patient's condition the right thing to do, but it can in fact improve their health.5,6 It is often said that medicine is an art in addition to a science. The master-

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ing of the proper interaction with patients in order to provide the best care possible is the art, and should be further emphasized by everyone in the profession.

An example from my own life seems to underscore perfectly this duality of the medical serpent and its effect on the well-being of patients. When I was a 16-year old young man, my mother was diagnosed with breast cancer. The diagnosis of cancer, no matter how positive the prognosis, carries with it severe anxiety and fear for any patient, and these feelings were no different for my mother or our family. My mother came into contact with many physicians who were at least partially involved in her care. And some of these physicians were inconsiderate and unfeeling toward her condition.

It is certainly understandable from the physician's perspective to experience this apathy when very similar conditions are seen every day, in numerous patients. However this is no excuse. In attitudes and behavior, the destroyer characteristics of the serpent were on display. The physicians' negativity was infectious, causing my mother to become more fearful, more anxious, and lose some hope for a normal life, even though the cancer was identified early and she was expected to respond well to treatment.

Fortunately, my mother also ex-

perienced the other aspect of the serpent, the physicians who were saviors to her hope, outlook and understanding of her diagnosis, and all that went with it. When these physicians took the time to talk with her and to understand what she was experiencing, the light was back in her eyes and she was able to find the inner strength to deal with her illness. One surgeon in particular showed genuine excitement and support as he ran up numerous flights of stairs in the hospital with a broad smile to report to her that the cancer had not spread to her lymph nodes. Her cancer has been in remission now for many years, and she has been able to serve as a savior to others going through the experience as a volunteer at the cancer clinic where she was treated. Looking at the situation from her perspective, and the positive and negative effect that a physician can have, I decided to become a physician myself. I hope to act as a savior for my patients, in body and spirit, instead of the destroyer.

The symbol of medicine, the staff of Asclepius, is one that has represented healing and renewal for millennia. However, as evident in the Judeo-Christian tradition, it often represents a destroyer in addition to a savior. This is evident every day in medicine, as the physician can act as either emotional and psychological destroyer or savior for their patients. As we be-

come more aware of how the little things—a look, tone of voice, and certainly our actions—can affect our patients, we will come to represent the intended meaning of the serpent—healing and renewal, in body and spirit—and the destroyer will remain a symbol from civilizations past.

**Author's Note:** This manuscript is in no way intended as an advertisement and/or condemnation of any given religious belief or tradition, but is presented merely as a way of looking at the medical profession in a novel way.

**Acknowledgments:** The author would like to thank Robert Fiorentino, MD, for his assistance in reviewing and editing this manuscript.

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# Reexamining the health care system

John J. Frey, III, MD Medical Editor, Wisconsin Medical Journal

ewspapers, television journalists and blogs nationwide have caught up to what many physicians have understood for a very long time: The system in which we work and teach is broken. Instead of being held together with glue and baling wire, the system demands a substantial overhaul and a new direction. Whether through proposals by presidential candidates or in the Wisconsin Legislature, reform will be the major focus of social legislation in the future.

Many health reform writers are citing Winston Churchill who said, "Americans can always be counted on to do the right thing... after they have exhausted all other possibilities." We are exhausting not only the possibilities for health reform, but we are also exhausting our patients, our society, and ourselves.

Health care in Wisconsin is organized very differently from most other parts of the country and, thus, carries with it some new and exciting possibilities. We have many of the elements that are required for improving quality and cost and access. We have wide distribution of electronic health records in the large groups that make up the majority of providers in the state. We have reasonably good distribution of physicians to match the needs of populations of patients. Through the 2 medical schools in Wisconsin, we have resources to train physicians for the state and funds-through the Wisconsin Partnership Fund For a Healthy Future (University of Wisconsin School of Medicine and Public Health) and a Healthier

Wisconsin Partnership Program (Medical College of Wisconsin)—to partner with communities to address major health problems facing the state. We are slowly closing the gap in caring for the uninsured, even as the numbers of uninsured are growing. There is a history in the state of collaboration and cooperationcertainly relative to most other parts of the country. Yet reform feels as stuck here as it does throughout the United States. All these positive aspects of our state are in jeopardy and there are enormous challenges to cost, access, workforce and quality.

During this election Wisconsin Medical Society President Steven Bergin, MD, has chosen to focus on the issue of health system reform. During his inaugural speech in April, Dr Bergin said, "As patient advocates, Wisconsin physicians have a particular stake in finding viable and effective approaches in providing access to coverage, controlling system costs and providing efficient, well-coordinated quality care." He went on to acknowledge that there are no simple solutions, "but if we as physicians are to have any credibility with the patients we serve, we must take up the charge and stay the course."

Together with Dr Bergin, the Wisconsin Medical Journal is seeking to emphasize ideas and approaches to health system reform in our December issue. We hope to include articles that describe new models of care, point to some of the essential economic and organizational challenges for medicine in this state and country, and get all of us

looking forward to a better system for our communities. We encourage anyone who would like to have a manuscript considered for this issue to submit it by August 15, 2008 to wmj@wismed.org.

In addition to the Journal issue on health system reform, the Society is asking many of us to work on defining, from the point of view of Wisconsin physicians, the elements of the system we are trying to create. A survey of 2500 randomly selected Wisconsin physicians is currently being conducted to determine attitudes regarding the basic principles involved in achieving health care reform in Wisconsin. It was developed through a partnership between the Wisconsin Medical Society and the University of Wisconsin School of Medicine and Public Health (UWSMPH), with additional support from the Wisconsin chapter of the American College of Physicians. We strongly encourage everyone who received a copy to complete and return it. Then in June, following the completion of the mailed survey, every physician will have the opportunity to complete an interactive Web site survey utilizing the same format.

Each of us has a point of view that needs to be included. If we continue to argue about "the" correct solution, we will never get to "a" correct solution. Time is running out quickly, and if we don't act, there will be NO solution. Become part of the conversation and by this time next year, hopefully we will be well on our way to the "Right" thing, for Wisconsin at least.

# Minutes in Motion: Motivating a Community to Move

Brenda Rooney, PhD, MPH; Tisha Hooks, PhD, MS; Krystal Baciak; Sarah Havens, BS; Heather Gilles, BS

#### **ABSTRACT**

Introduction: "Minutes in Motion" (MIM) was a community-based exercise challenge designed to recruit a large number of people to increase their physical activity for 6 weeks. We examined participant characteristics that improved the likelihood of success.

Methods: This program challenged community members to engage in 30 minutes of physical activity every day for 6 weeks. Participants were asked to submit the number of minutes they exercised at the halfway point of the challenge and again at the end. Those who participated were eligible for prizes. Participants also were asked to complete voluntary pre- and post-surveys that included questions about usual amount of physical activity, perceived improvement from the exercise, and self-efficacy to exercise.

Results: Of the 3505 community members who signed up for MIM, 78% initially participated and 61% met the challenge goal. The program evaluation was completed by 567 participants. As a result of MIM, 41% of subjects reported they were more active, 51% reported weight loss, 44% had improved endurance, and 51% had improved mood. Fifty-eight percent of subjects exercised more per week at the end of the study than they did before, and self-efficacy to exercise increased in 47% of the subjects. Keeping a log, exercising at work, and wearing a pedometer were related to many of these outcomes.

Conclusions: A physical activity challenge targeted at a community can recruit a large number of people

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to increase their minutes in motion. Outcomes can be enhanced with certain recommended participation elements.

#### INTRODUCTION

The prevalence of obese adults is increasing dramatically in the United States. Results from the Behavior Risk Factor Surveillance System (BRFSS) suggest that obesity (body mass index [BMI] of 30.0 kg/m² or greater) increased by more than 57% among adults between 1991 and 1999. 1,2 BRFSS data from 2005 showed that 61% of US adults and 62% of Wisconsin adults were overweight or obese (BMI of 25.0 kg/m² or greater). According to this survey, 51% of US adults and 43% of Wisconsin adults did not engage in moderate physical activity for 30 minutes or more for 5 or more days per week, nor did they engage in vigorous activity for 20 minutes or more for 3 or more days per week.

In order to slow this rapid increase in obesity, communities need to find creative ways to persuade their members to become more active. They need effective interventions that can be easily applied to a large population at a low cost. Certainly environment and policy play an enormous role in determining the level of physical activity in a community.4 Examples of environmental strategies that promote physical activity include the availability of safe walking and multipurpose trails. Policy interventions include encouraging physical activity through worksites and schools. Large-scale interventions targeted at worksites have been advanced by the Centers for Disease Control and Prevention (CDC).5 The Director's Physical Activity Challenge was a program to encourage 30 minutes of exercise each day for 50 days. This challenge recruited 3740 CDC employees, 79% of whom reached the intervention goal. Participants reported increased energy, weight loss, better sleep, and better body image. Other worksite and mass media approaches have been reviewed and found to be effective.6-8

"Minutes in Motion" (MIM) was designed to challenge community members to be active at least 30 minutes a day for 6 weeks. It was a free program available to all community members and designed as a fun way to increase participants' minutes in motion. Those participants who met the goal were eligible for prizes awarded at the end of the challenge. We report here on personal and participation characteristics that predict significant improvements among a subset of subjects who completed a pre- and post-program evaluation.

#### **METHODS**

The MIM challenge was conducted from April 2, 2007 to May 16, 2007. This was a free program that challenged participants to exercise at least 30 minutes every day for 6 weeks. The program was promoted through the local media as well as by direct mail to major employers in the community. Participants could register by fax, e-mail, or postal mail-either individually or as a team. As an incentive to sign up, the first 1600 registrants received a free pedometer. Throughout the challenge, weekly e-mails were sent to encourage continued participation and offer exercise tips to program participants. Participants were required to submit their times, either individually or as a team, after 3 and 6 weeks. At the end of the challenge, a celebration was organized at an outdoor park, where those who met the goal were eligible for a prize drawing. Attendance at the celebration was not required.

Participants were asked to complete a voluntary electronic survey at the beginning and end of the program. The project evaluation received Institutional Review Board approval; completion of the survey implied consent. Participants were encouraged to include their names on the survey to aid in linking their pre- and post-survey responses; however, they were not required to do so. These surveys included questions regarding current level of activity and perceived improvements in such areas as their usual activity level, weight loss, endurance, and mood. Participants were also asked to rate their self-efficacy regarding exercise at both times. Self-efficacy measures one's belief in his/her ability to become physically active even in the presence of barriers to physical activity or alternative activities. 10 Studies have found that self-efficacy is related to maintaining physical activity in a variety of populations and settings and is a determinant of physical activity.11

For this study, the self-efficacy scale developed by Marcus et al<sup>12</sup> was used. Participants were asked to rate their level of confidence that they could exercise in 5 situations such as when they are too tired, in a bad mood,

or when the weather is bad. The Marcus scale uses a 7-point Likert scale ranging from 1 (not at all confident) to 7 (very confident) on each item, and total scores range from a low of 5 to a high of 35 points.

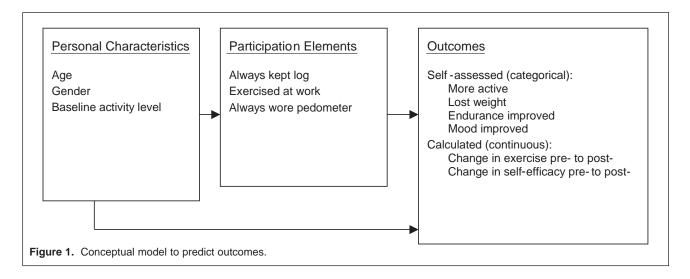
The analysis was conducted to examine how personal characteristics, such as age, sex, and baseline level of activity, as well as participation elements, such as wearing a pedometer or keeping a log, were related to program outcomes (see Figure 1). For the categorical outcomes (all of the self-assessed measures), multiple logistic regression models were developed and odds ratios and confidence limits were calculated to predict improvements over time. Reference groups for each variable were predetermined based on a *priori* hypotheses of odds of least improvement (risk). For the continuous outcomes (pre- to post-calculated changes), models were constructed using a stepwise procedure. Data were analyzed using SAS statistical software, <sup>13</sup> and all *P* values <0.05 were considered significant.

#### **RESULTS**

Initially, 3505 people enrolled in the MIM program. Of that number, 2750 (78.4%) participants submitted some minutes and 2134 (60.8% of the total) met the goal of 30 minutes of daily exercise. A summary of demographics of both total MIM program participants and those who met the goal is provided in Table 1. Middle-aged women were more likely to join the MIM program: 78% of all program participants were women, and 31% were 35-50 years old. In addition, approximately one-third of all MIM participants was under age 18 and participated as part of a family team. Comparing those subjects who completed both a pre- and post-survey with the entire study population showed that the survey participants were more likely to be women and older (*P* values <0.0001).

For the remainder of the results, only the program participants who completed both the pre- and post-survey and whose pre- and post-surveys we were able to match were used (N=567). Survey participants were fairly active even at the beginning of the study; approximately two-thirds were active for 30 minutes or more each day on 5 or more days a week. Seventy-three percent of participants indicated they always kept a daily activity log during the program. Over 60% stated they utilized opportunities to exercise at their work. Finally, 21% of participants indicated they wore a pedometer at all times over the 6-week program.

The first outcome investigated via a multivariate model was a self-assessed measure of an improvement in activity level. Overall, 41% of participants indicated that



	Total	Study
	Participants <sup>a</sup>	Participants <sup>b</sup>
	%	%
Age	e (years)	
Under 18	31.9	0.5
18-34	19.3	23.4
35-50	30.8	47.5
51-64	15.9	26.4
Over 65	2.1	2.1
	Sender	
Men	22.0	9.4
Women	78.0	90.7
Baseline Level of	Activity (≥30 mi	n/day)
1-4 days per week	NA	35.1
5-7 days per week	NA	64.9
Always kept an activity log	NA	72.8
Exercised at work	NA	62.1
Always wore pedometer	NA	21.3

MIM definitely made them more active; 50% indicated they were somewhat more active (Table 2). The odds of a baseline sedentary person (exercising less than 30 minutes, 5 days per week) stating they were definitely more active at the end of the study were 1.72 times higher than for a baseline active person (5 or more days). Also, the odds of stating they were more active at the end of the study were higher when participants indicated they kept a log of their activities (odds ratio [OR]=2.02), utilized opportunities to exercise at work (OR=1.46), or wore a pedometer all the time (OR=1.89). The model revealed no differences across gender or age groups.

A second multivariate model was used to predict subjects' perceived weight loss. Overall, 51% of participants reported they had lost weight through the MIM program. The odds of stating they lost weight were higher when the participant kept a log (OR=1.64) or utilized opportunities to exercise at work (OR=1.53). Additionally, participants age 51-64 years were more likely to notice weight loss than those age 35-50 years (OR=1.63). There was no significant difference in perceived weight loss associated with pedometer use, gender, or among participants age 18-34 and 35-50 years.

A self-assessed measure of improved endurance was also modeled, and the results were very similar to the model for weight loss. Throughout the study, 44% of participants reported improved endurance through the MIM program. The odds of reporting improved endurance were higher when the participant kept a log (OR=2.31) or exercised at work (OR=1.52). In addition, the odds of reporting improved endurance were higher for participants age 51-64 years as compared with the baseline group, age 35-50 (OR=1.87). Again, there was no significant difference in improved endurance associated with pedometer use, gender, or between participants age 18-34 and 35-50.

Lastly, a multivariate model was used to predict an improvement in mood. A total of 51% of the survey respondents reported that their mood improved throughout the MIM program. Participants age 18-34 were more likely to notice an improvement in their mood than participants age 35-50 (OR=2.45). Additionally, women were more likely than men to notice an improvement in their mood during the program (OR=2.37). The odds of a baseline sedentary person reporting improved mood were 1.6 times higher than for an active person at baseline, and the odds of reporting improved mood were

		More ve (41%)		l Weight s (51%)		roved nce (44%)		nproved ood (51%)
Variable	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
			Age	e (years)				
18-34/35-50	1.05	0.67-1.64	1.49	0.97-2.30	1.48	0.96-2.30	2.45 <sup>a</sup>	1.56-3.84
51-64/35-50	1.31	0.86-2.01	1.63 <sup>a</sup>	1.07-2.47	1.87 <sup>a</sup>	1.23-2.86	1.24	0.82-1.88
			G	Sender				
Female/Male	1.59	0.85-3.03	0.57	0.31-1.05	1.67	0.89-3.13	2.37 <sup>a</sup>	1.26-4.47
		Base	eline Level	of Activity Per	Week			
1-4 days/5-7 days	1.72 <sup>a</sup>	1.18-2.51	1.23	0.85-1.77	0.97	0.67-1.41	1.63 <sup>a</sup>	1.12-2.34
			Ke	ept Log				
Yes/No	2.02 <sup>a</sup>	1.32-3.07	1.64 <sup>a</sup>	1.10-2.42	2.31 <sup>a</sup>	1.52-3.50	1.15	0.77-1.71
			Exercis	sed at Work				
Yes/No	1.46ª	1.00-2.11	1.53ª	1.07-2.20	1.52a	1.05-2.19	1.49 <sup>a</sup>	1.04-2.15
			Wore	Pedometer				
Always/Not Always	1.89ª	1.23-2.91	1.34	0.88-2.06	1.36	0.89-2.08	1.28	0.83-1.97

OR=odds ratio. CI=confidence interval.

higher when the participant utilized opportunities to exercise at work (OR=1.49). There was no difference in the perceived improvement in mood associated with keeping a log, pedometer use, or between participants age 35-50 and 51-64.

In addition to the 4 self-assessed outcomes, 2 calculated change outcomes were considered: change in days active and change in self-efficacy. Overall, 58% of participants increased their number of days active per week from pre- to post-survey. Factors found to be significantly related to a change in exercise level were baseline level of activity (*P*<0.0001) and keeping a log (*P*=0.0004). On average, survey participants who were sedentary at baseline increased the number of days per week in which they were active by 2.5 days, while those who were more active at baseline increased this number by 0.3 days. Also, the number of days per week in which they were active for at least 30 minutes increased by an average of 1.6 days for those who kept a log and 1.2 days for those who did not.

Overall, 47% of participants reported an improvement in their self-efficacy scores from pre- to postsurvey. Factors found to be related to a change in selfefficacy included keeping a log (P=0.0892) and wearing a pedometer (P=0.0282). Self-efficacy increased by an average of 1.2 points for those who always kept a log versus 0.3 point for those who did not. Finally, self-efficacy increased by an average of 1.4 points for those who always wore a pedometer versus 0.1 point for those who did not always wear the device.

#### **DISCUSSION**

The rates of obesity and sedentary lifestyle have increased dramatically in the United States and Wisconsin over the past decade. In order to slow the increase in obesity, people need to increase their amount and intensity of activity. Those community efforts that are effective and reach a large audience are likely to slow this trend. The Minutes in Motion program was a unique approach to motivating a large number of community members to become physically active for 6 weeks. Sixty-one percent of those enrolling in the program met the goal of 30 minutes of daily activity over 6 weeks. Among our study participants, over 58% reported an increase in the number of days they exercised per week from pre- to post-survey.

Between 40% and 65% of individuals beginning a new exercise program will drop out within 3 to 6 months. 14,15 While we realize that 6 weeks is not sufficient time for a behavior such as a sedentary lifestyle to become a permanent change, 16 37% of our survey participants stated they planned to increase their level of activity, and 61% planned to maintain their current level of activity over the next 6 months. Our study participants, despite being fairly active at baseline, reported many significant improvements over the 6 weeks. Over 40% reported they were more active or had improved

a Statistically significant.

endurance as a result of their participation. Over 50% reported notable weight loss and improved mood over the 6 weeks.

We set out to determine if certain personal or participation elements would help predict improvements in our subjects. We were encouraged to find that, for the most part, results were fairly similar for men and women and for people of all ages. This is reassuring because a population-based approach such as this would be advantageous only if it were equally beneficial for all demographics. Our more sedentary participants at baseline were more likely to state at the end of the challenge that they were more active, had improved mood, and had a greater improvement in days exercised each week than those participants already active at baseline. This was encouraging because sedentary community members would be most in need of this intervention.

Keeping an exercise log is an easy element to add to an exercise program. Our study found that those people who kept a log all the time felt they were more active as a result of the program and were more likely to report weight loss and improved endurance. They also reported a significantly greater improvement in physical activity from pre- to post-survey. Self-monitoring has been shown to increase effectiveness of other physical activity programs, possibly by promoting the participant's sense of accountability. The log serves as a prompt or reminder and provides feedback of the progress the exerciser has made. Prompting and feedback have been shown to be effective in increasing and maintaining physical activity as well as other positive health behaviors.<sup>7,17</sup>

Since we heavily promoted this program through larger employers in the community, we were encouraged to find that so many participants reported being able to exercise at work, and that those who reported doing so had greater success than those who did not. Participants who reported being able to exercise at work also were more likely to report notable weight loss, improved endurance, improved mood, and being more active. Being allowed to exercise at work provides an additional opportunity to exercise, or perhaps removes a barrier to getting some exercise. Support from coworkers may provide additional accountability or may tap into a preexisting social network. Recommendations on effective community strategies to increase physical activity suggest building or using existing social networks to enhance the effectiveness of interventions.18

Wearing a pedometer has been shown to improve participant awareness, short-term activity level, and self-efficacy.<sup>7,19</sup> In 2003, Rooney et al<sup>7</sup> conducted a

study involving 400 women that was designed to investigate whether wearing a pedometer could make participants more active. They found that goal setting, keeping an exercise log, and wearing a pedometer all the time increased a participant's chance of becoming more active. While the present study was not a pedometer intervention, approximately half of participants received a free pedometer, and 1 in 5 reported wearing it all the time. While we feel that the main benefit of offering the pedometer was increasing overall recruitment, those who wore the pedometer all the time in our study were found to have significant improvements in self-efficacy and were more likely to state that they were more active.

Our study reported on 4 self-reported improvements: being more active, noting weight loss, improved endurance, and improved mood, and on 2 calculated improvements: change in exercise level (days per week) and change in self-efficacy. While several of these appear to be similar constructs, the correlation coefficients between these 6 outcomes ranged from 0.02 to 0.28, with 9 of the 15 coefficients being below 0.2. Relying entirely on self-reported improvements can be suspect; however, we were able to validate 1 of the self-reported improvements: being more active. The calculated improvement in exercise per week based on the difference between pre- and post-survey was 1.55 days higher in those reporting they were more active on post survey (P=0.0001); those who did not indicate they were more active improved 0.93 days on average.

Assuming that our survey respondents represented our overall MIM participants, we were surprised by the level of baseline activity; with nearly two-thirds of those participating in the survey being active at least 5 days a week from the start. This may be because recruitment occurred through many worksites where we might expect people to be less sedentary. Or perhaps the subset of participants who responded to the survey was more likely to be active than the entire group of participants. Despite recruiting fairly active participants, it should be noted that our results adjusted for baseline level of activity and still reported significant improvements for less active individuals.

We didn't gather data on all subjects at enrollment that would help us understand the impact of this study on different subgroups such as those who are sedentary, have a lower education level, may be unemployed, or by ethnic group, nor do we know how well our survey represents the overall participants. We know 1 weakness to our study was that our survey underrepresented some sections of our participant population, such as

those <18 years of age. The survey was completed only by individuals who provided us an e-mail address. It was likely that only 1 person per household completed the survey, though many teams included multiple family members.

Future efforts should focus on reaching unemployed, lower socioeconomic, and higher-risk individuals. As we mentioned above, we promoted this program through a mass mailing to larger employers in the community. There was limited promotion of the program to the general public. Advertisements in local paper, radio, and television, and possible recruitment through other avenues such as churches or community centers would increase recruitment of lower socioeconomic and unemployed individuals. Some additional components could be added to strengthen the impact of the program, such as providing a special log for participants and requiring them to turn these logs in more frequently, or providing a pedometer to all participants and requiring them to also turn in their daily step counts.

Overall, MIM was able to recruit a large number of community members to increase their minutes in motion each day for 6 weeks at a low cost per person. We estimated the overall direct and indirect cost of this project to be about \$18,000, or \$5.15 per participant. We expect the expenses to decrease over time as we gain efficiencies in staff coordination. Our study found that sedentary as well as active individuals benefited from the program. Other communities should consider implementing a program such as this to motivate a large number of people to be more active.

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# Public Views on Determinants of Health, Interventions to Improve Health, and Priorities for Government

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#### **ABSTRACT**

Objective: There is increasing evidence about the importance of factors that impact health beyond health care and individual behavior, yet there is little public and policy discourse about these things in the United States. We surveyed Wisconsin adults to see what they think are the most important factors that affect health. We also examined which interventions they believe would improve health, and whether government should prioritize such interventions.

*Methods:* A phone survey of a random sample of 1459 Wisconsin adults was conducted between September 2006 and February 2007.

Results: The Wisconsin public believes that health practices, access to health care, and health insurance are the most important factors affecting health, and that health insurance is a high government priority. Other broader social and economic determinants of health, such as employment, social support, income, housing, and neighborhood factors are seen as less important to health. Although respondents believe that health practices are important to health, they are less likely to suggest that government prioritize improving individual health practices. Although the public believes the government should prioritize access to health care and health insurance, they are not as likely to support government implementing social or economic policies in order to improve health.

Conclusion: In light of research demonstrating the importance of social and economic determinants of health, and of ongoing public forums meant to raise

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awareness of these determinants of health, it will be important to track whether public opinion of Wisconsin adults changes over time to increase attention to the social and economic determinants of health and related policy initiatives.

#### INTRODUCTION

The last 2 decades have been marked by significant research attention to how multiple factors determine health, particularly in the United States, Canada, the United Kingdom, some European countries, and by the World Health Organization.<sup>1-4</sup> Such research consistently shows that beyond access to medical care and health behaviors, a broad array of social and economic factors contributes strongly to health. Examples of such social and economic factors include income, education, employment, stress, social support, and the neighborhood environment.

Research demonstrates that the social and economic conditions in which people live and work have both direct and indirect effects on health. For example, socioeconomic status (SES), often measured by income, education, and occupation, is one of the strongest and persistent predictors of health in the United States and other countries.5-6 Income affects people's ability to access health care and to adopt healthy behaviors, but it also affects other health risk factors such as stress, access to adequate housing, and access to safe neighborhood environments, each of which have direct effects on health.7 Education level not only indirectly affects health through its impact on income, but also affects people's knowledge about health behaviors, their preference for health behaviors and physical risk, and their ability or opportunity to access and marshal a range of appropriate social and economic resources to make desired changes.4 Employment status and working conditions also affect health through not only physical working conditions (eg, exposure to contaminants, long hours, repetitive motions, heavy physical demands) but

also psychosocial working conditions (eg, stress and amount of control over one's work).<sup>5</sup>

Beyond socioeconomic status, other social and economic factors that have been shown to consistently impact health include stress, social support and social isolation, race/ethnicity, discrimination, religion/spirituality, community safety, neighborhood support and resources, and childhood experiences (eg, abuse, neglect, poverty, poor education quality). These factors demonstrate associations with health status even after controlling for a range of other factors including income, education, and access to health care. Research indicates that many of these social and economic factors have an even stronger effect on the health of people with low socioeconomic status because they are more likely to experience a compounding effect of these factors, and are less likely to have the resources to buffer their effects on health.8

As a result of findings about the influence of social and economic factors on health, many countries have begun to advance social and economic policies to improve health, including significant efforts in the United Kingdom, Sweden, Canada, and the Netherlands. 9-13 Yet in the United States, there is little public discussion of how to improve health by advancing social and economic policy, and few social and economic initiatives aimed at improving health. 14-15

One of the many potential reasons for lack of attention to social and economic determinants of health in the United States is that policymakers and the general public may not view social and economic factors as important determinants of health. Indeed, we know little about what the general public thinks are the most important factors that affect health. Our lack of knowledge in this area is surprising, given the number of public opinion polls conducted in the United States on both general and health-related topics. However, most US public opinion polls regarding health have highlighted what the public thinks about health care issues, 16-17 not what they think about health more generally. Since public opinion can influence policymakers, 18-19 public attitudes about social and economic determinants of health may affect policymakers' willingness and ability to address related policy issues.

The first aim of our study is to examine what the general public thinks are the most important factors affecting health. Although a few studies have examined this question in Canada, Scotland, and Ireland,<sup>20-23</sup> this question has not been addressed in the United States. Our second aim is to examine what types of interventions the public thinks would be most effective at im-

**Table 1.** Demographic Characteristics of the Wisconsin Population Health and Disparities Survey Compared to the Wisconsin Adult Population

	Sample (%)	Wisconsin Adult Population (%)
	Age (years)	
18-44	32	49
45-64	45	34
65-84	20	14
85+	3	3
	Gender	
Female	58	51
Male	42	49
F	Race/ethnicity	
White	91	88
Hispanic	2	4
Black	3	5
Other	5	2
	Education	
Less than high school	5	16
High school graduate	30	34
Some college	28	30
College graduate	37	20
Но	usehold income	
Less than \$20,000	13	19
\$20,000 - \$50,000	39	38
\$50,000 - \$75,000	22	23
\$75,000 - \$100,000	13	11
\$100,000 or more	14	9
	Health Status	
Fair or poor health	14	12

Note: Percents may not add to 100 due to rounding.

proving health, and whether they think the government should make these interventions a priority. Research suggests that addressing early childhood development, educational attainment and quality, and poverty and economic development might be as, or even more, important to health than improving access to health care.<sup>7-8,14, 24-25</sup> Indeed, improving the social and economic determinants of health is one of the 11 health priorities in the Wisconsin 2010 Health Plan. However, the extent to which the public believes these types of social and economic interventions would improve health is unclear, as is the public's level of support for the government making such interventions a priority to improve health.

#### **METHODS**

Data used was from the Wisconsin Population Health and Disparities Study, a phone survey of a random sample of 1459 adults in Wisconsin. The University

Factors that Affect Health	Percent Who Rated 8, 9, or 10	Mean (Standard Deviation)
A person's personal health practices (eg, what they eat, whether they exercise, or whether they smoke)	84.6	8.9 (1.6)
Whether a person has health insurance	75.3	8.3 (2.1)
A person's access to affordable health care	69.8	8.2 (2.0)
How much stress a person has	66.8	8.0 (1.8)
The physical environment, such as the quality of the air and water	63.2	7.8 (2.1)
A person's knowledge about health	60.7	7.7 (1.9)
A person's genetic makeup that is inherited from their parents	55.9	7.5 (2.0)
Whether a person has a job	55.0	7.4 (2.3)
The amount of social support a person has, such as a close circle of friends or family	51.8	7.3 (2.0)
A person's level of income	51.8	7.2 (2.3)
How safe a person's community is	41.9	6.7 (2.3)
The quality of a person's housing	33.2	6.4 (2.2)
A person's childhood experiences	34.0	6.3 (2.4)
A person's level of education	33.7	6.3 (2.4)
Whether a person is religious or spiritual	33.9	5.9 (2.8)
Where a person lives, like in the city or in the country	26.1	5.9 (2.8)
How supportive a person's neighborhood is	24.1	5.7 (2.4)

of Wisconsin Social Science Internal Review Board approved this survey, which was conducted by the University of Wisconsin Survey Center between September 2006 and February 2007 using random-digit dialing (RDD). The survey had a 44% response rate, which is similar to that currently achieved by other RDD surveys. Table 1 shows that the respondents are generally representative of the Wisconsin population ages 18 and older, although they have a slightly higher education level.<sup>26-28</sup>

Respondents were asked their opinions on a range of factors that research demonstrates are associated with health, including demonstrated social and economic factors such as stress, employment, income, education, housing, childhood experiences, social support, religion/spirituality, neighborhood safety, and neighborhood support. They were also asked about health insurance, affordable health care, personal health practices (eg, what people eat, whether people exercise, or whether people smoke), the physical environment (such as the quality of the air and water), and a person's genetic makeup.

In terms of asking people about possible strategies for improving health, we chose strategies that have been discussed as potentially important to improving population health, and that generally coincide with many of the factors we asked about that may affect health. We asked about generic strategies (eg, reducing poverty) rather than particular policies (eg,

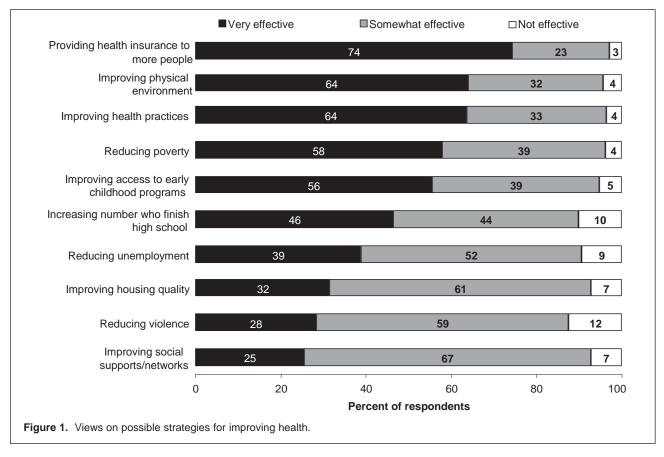
Earned Income Tax Credit) to assess people's general beliefs about these strategies rather than focusing on specific politically-oriented policy options. In terms of social and economic policy strategies, we included improving health practices, reducing poverty, improving access to early childhood programs, increasing the number of people who finish high school, reducing unemployment, improving housing quality, reducing violence, and improving social supports/networks. We also asked about the perceived effectiveness of providing health insurance to more people and improving the physical environment.

#### **RESULTS**

What Factors Affect Health?

Respondents were asked to rate 17 factors that potentially affect people's health on a scale from 0 to 10, where 0 means the factor has no effect on health and 10 means it has a very strong effect. The factors were listed in the same order for each respondent—information about specific ordering of the items is available from the authors. Table 2 summarizes the percentage of respondents rating each factor highly (an 8, 9, or 10) and the mean score for each factor.

Respondents clearly believe that people's health practices (such as what they eat, whether they exercise, or whether they smoke) have the greatest effect on health. Having health insurance and affordable health care were rated the next most important factors affecting health.



A social and economic factor—stress—was ranked next highest, with the physical environment rounding out the top 5 factors considered to have the greatest impact on health. A person's knowledge about health and their genetic makeup were next, followed by many of the other social and economic factors research shows are related to health: employment, social support, income, community safety, housing, childhood experiences, education, and religion/spirituality. The 2 factors respondents thought had the least effect on health were where a person lives (26%) and how supportive a person's neighborhood is (24%).

#### What Strategies Would Improve Health?

Respondents were given a list of 10 possible strategies for improving people's health and asked whether they thought each strategy would: (1) not be effective at improving people's health, (2) be somewhat effective, or (3) be very effective at improving people's health. Figure 1 shows that the highest-rated strategy was providing health insurance to more people, followed by improving the physical environment and improving individual health practices. Four social and economic policy strategies (reducing poverty, improving access to

early childhood development programs, increasing high school graduation rates, and reducing unemployment) were rated in the middle of the list. Strategies least likely to be viewed as very effective included improving housing quality, reducing violence, and improving social supports and social networks.

# Priorities for Government to Address to Improve Health

Respondents who indicated that a particular strategy would be either somewhat or very effective for improving health were then asked how high a priority this strategy should be for the government to address: a low, medium, high, or not something government should address in order to improve health. Figure 2 shows that the list of priorities for government generally is similar to the list of the effectiveness of strategies to improve health, with several notable exceptions. Despite the perceived effectiveness of strategies to improve individual health practices, respondents reported programs to address personal health practices as a lower priority for the government than most other strategies. Similarly, although almost all respondents thought that strategies to improve social supports and social networks would be at least somewhat effec-

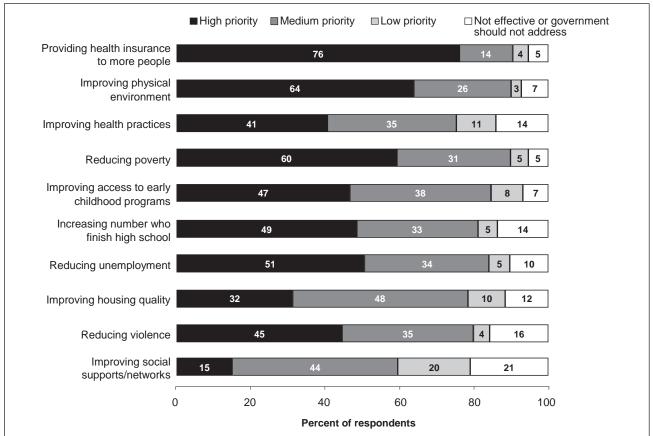


Figure 2. Views on government priorities for improving health. Note: The white category combines both those who reported that the strategy would not be effective for improving health (from Figure 1) with those thinking government should not address this strategy.

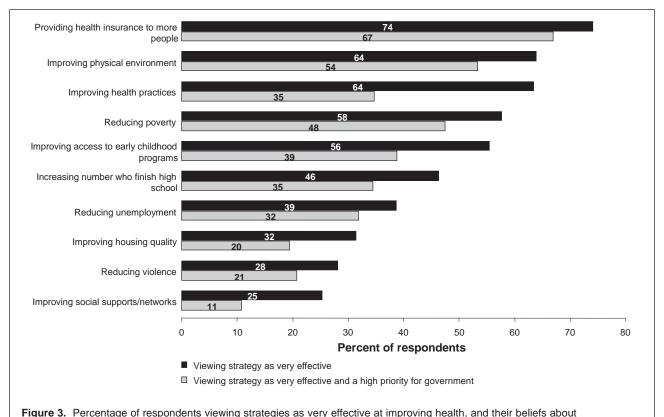
tive, Figure 2 shows that very few respondents (15%) thought that such strategies should be a high government priority. Indeed, 21% of respondents thought that improving social networks would either be ineffective or should not be addressed by government.

Figure 3 superimposes the percentage of people who thought that each strategy would be very effective at improving health (from Figure 1), with their responses about whether the government should make such strategies a high priority. This shows even more clearly that for most issues, people who believe a strategy would be very effective at improving health also think the government should make it a high priority. For example, 74% of all respondents thought that providing health insurance to more people would be very effective at improving health, and almost all of these people also thought this should be a high priority of government. However, when it comes to personal health practices and social relationships, people are less likely to think these issues should be a high government priority, even if they think addressing such issues would be very effective at improving health.

#### **DISCUSSION AND CONCLUSIONS**

This study shows that the general public in Wisconsin views individual health behaviors, access to health care, and health insurance as the most important factors affecting health. They think the government should make health insurance a high priority, which is consistent with other surveys and with current public discourse.<sup>16</sup> Although respondents view individual health practices as important to health, and they report that strategies to improve health practices would be effective at improving health, they are not as likely to believe that government should make this a high priority. This is consistent with research showing that the American public views health behaviors primarily as a matter of personal responsibility.25 Similarly, although social support is recognized as a somewhat important factor affecting health, strategies to improve social support were considered neither as effective nor as great a priority for government in comparison to other strategies.

Wisconsin residents consider the quality of the physical environment to be 1 of the leading factors affecting health. They consider improving the physical environment 1 of the most effective strategies for im-



making such strategies a high government priority.

proving health and also support the government making this a high priority. This is similar to results found in Canadian and Scottish surveys.<sup>20-22</sup>

Although research consistently demonstrates that a range of social and economic factors beyond access to medical care and health behaviors significantly affect health, our results show that most social and economic factors are not seen by the public that way. Similarly, social and economic policy and program interventions are not seen as the most effective ways to improve health. Therefore, it is also not surprising that respondents believe such strategies should not be a high government priority as a means to improve health.

Although political ideology (ie, people's beliefs in a stronger or lesser role of government) certainly plays some role in people's policy opinions, our findings are not solely due to differences in political ideology—many respondents did encourage government intervention in some domains (eg, health insurance and the environment), but not in others (eg, health behaviors and social support). This suggests that if more people believed a range of social and economic factors strongly affect health, there may also be some increased policy support for a governmental role in social and economic

policy to improve health.

Interestingly, there are a number of ongoing national and local initiatives meant to raise people's awareness of the social and economic determinants of health. For example, in Spring 2008, public television aired a documentary series titled "Unnatural Causes: Is Inequality Making Us Sick?" This documentary, along with an organized public impact campaign, aims to improve people's understanding of racial and socioeconomic disparities in health. Similarly, the Robert Wood Johnson Foundation (RWJF) is launching a RWJF Commission to Build a Healthier America, which aims to address socioeconomic disparities in health through the work of a high profile commission. On a state level, the Wisconsin Partnership Program at the University of Wisconsin School of Medicine and Public Health funded a project to identify the most effective interventions for Wisconsin to become the nation's healthiest state with less health disparity, and to monitor the state's progress. As part of this project, the recent Health of Wisconsin Report Card highlights large education disparities in the health of Wisconsin residents as well as disparities by gender, geography, and race/ethnicity.<sup>29</sup> The project aims to make recommendations for the types of inter-

ventions that might improve health and health disparities, including identifying promising policies beyond those involving medical care. At the local level, the City of Milwaukee Health Department is launching a Center for Health Equity to address social and economic determinants of health in the city, state, and nation.

These national, state, and local initiatives demonstrate the growing attention to promote knowledge and address the social and economic determinants of health. Our survey results demonstrate that the Wisconsin public does not currently view social and economic factors as strong determinants of health. It will be important to track changes over time in the public's opinions about social and economic determinants of health, particularly in light of these upcoming national, state, and local initiatives. Moreover, it will be important to further study whether any changes in opinions translate into support for different types of governmental and non-governmental initiatives to address various social and economic disparities in health in Wisconsin. Given multiple demands from the public for policy change in a number of domains, along with difficult fiscal realities, it is unlikely that policymakers will prioritize addressing the social and economic determinants of health unless encouraged to do so by the public or by compelling demonstration of cost effectiveness of specific interventions.

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# Parental Perception of Quality of Hospital Care for Children with Sickle Cell Disease

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#### **ABSTRACT**

*Problem Considered:* Children with sickle cell disease account for 75,000 hospital days annually in the United States, yet little is known about how parents perceive the quality of hospital care these children receive.

Methods: Parents of hospitalized children that had sickle cell disease, cancer, or were admitted to the general pediatric service completed a validated survey assessing the parent-perceived quality of hospital care their children received. The primary outcome was parent-reported quality of care. A chi-square analysis was used to compare the percent of children with low quality care who had sickle cell disease with each control group.

Results: Parents of 112 children completed the survey; 17 children had sickle cell disease, 36 had cancer, and 59 were admitted to the general pediatric service. Parents of children with sickle cell disease were more likely to report low quality care compared to parents of children with cancer (29.4% versus 5.6%, *P*=0.017) and parents of general pediatric patients (29.4% versus 6.8%, *P*=0.011).

Conclusion: Parents of hospitalized children with sickle cell disease perceive their children's care as being of lower quality than parents of children with cancer or children admitted to the general pediatric service.

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#### INTRODUCTION

There are over 18,000 hospitalizations and 75,000 days of hospitalization annually in the United States for children suffering vaso-occlusive crises secondary to sickle cell disease (SCD).1 Despite this large disease burden, only 2 previous studies have evaluated quality of care for hospitalized children with sickle cell disease,2,3 both focusing on process of care measures, with no assessment of parental perception of care quality. Adults with SCD are met with a high level of mistrust by the hospital staff, with health professionals believing that they exaggerate their pain and exhibit significant drug seeking or addictive behaviors.<sup>4,5</sup> While important information can be extracted from these studies, the concerns about addiction and drug seeking may not be as applicable to children with SCD, leaving the SCD community with little understanding of the parent perception of the quality of hospital care that children with SCD receive.

Previous studies evaluating the parent-reported quality of hospital care for children of all diagnoses found that communication between the medical staff and parents and parental involvement/partnership in the child's care were the strongest determinants of high quality hospital care.<sup>6-8</sup> It's been reported that minority children and those with chronic illness receive lower parental-perceived quality of hospital care,<sup>7</sup> making children with SCD a high-risk group for low parent-reported quality of care. We therefore hypothesized that the parents of children with SCD would perceive that their children receive a lower quality of hospital care than the general pediatric population and other children with chronic disease.

#### **METHODS**

Design

The study was a cross-sectional survey of parentreported quality of hospital care for their children. Children <19 years old who were admitted to the

Children's Hospital of Wisconsin between June 2006 and August 2006 and had SCD, cancer, or were admitted to the general pediatric service were eligible for the study. Children with cancer were chosen as a comparison group to evaluate another population of patients with a chronic disease requiring repeat hospitalizations; children admitted to the general pediatric service were chosen as a comparison group in order to represent general pediatric care, and to increase the number of children of similar race as children with SCD.

At the time of discharge, consent was obtained from parents for study participation. Parents were approached by a member of the research team who was scheduled to ensure that discharges for all days would be captured. After giving consent, the parents completed a Picker Inpatient Survey (PIS) evaluating the quality of care their child received during the hospital stay. Parents who did not speak English were excluded. The study was approved by the Institutional Review Board at the Children's Hospital of Wisconsin.

#### Picker Inpatient Survey (PIS)

The PIS is a validated survey used to assess quality of pediatric hospital care from the parent's perspective at over 80 hospitals. 9,10 The survey consists of 52 questions and requires 10 minutes to complete. It is composed of demographic questions, a single question rating the quality of hospital care, and individual item questions designed to evaluate 8 specific quality domains: (1) partnership, (2) physical comfort, (3) coordination of care, (4) information to parents, (5) information to child, (6) confidence and trust, (7) continuity and transition, and (8) overall care. PIS questions regarding emergency department care and intensive care were not included in our study. Due to the young age of many children, the "information to child" domain could not be analyzed. Sample item questions for the 7 domains that were evaluated are shown in Table 1.

#### Outcome: Parental-Perceived Quality of Care

The primary outcome was the parent-reported quality of care the child received during the hospital stay. As has been done in previous work, parent-reported quality of care was determined from the answer to a single question, answered using a 5-point Likert scale (1=poor, 5=excellent). We reported the parent-perceived quality of care in 2 ways: (1) as a mean score (utilizing the mean and standard deviation from the 5 possible Likert scale answers); (2) the Likert scale was dichotomized into low-quality and high-quality care, with responses of "poor," "fair," or "good" indicating

low-quality care and "very good" and "excellent" indicating high-quality care.

#### Predictor Variables

To explore potential reasons for disparities in parentperceived quality of care, we analyzed child/hospitalization characteristics and the parent responses to the item questions in the 8 specific quality domains. These questions were in a variety of formats, with responses requiring anything from a yes/no response to choices from a 4- or 5-point Likert scale. The parent responses to each domain item question were dichotomized as "a problem" or "not a problem." For yes/no questions, an unfavorable response was considered a problem. Similar to previous studies,6,7 responses to questions with more than 2 possible responses were considered a problem if any answer other than 1 of the best 2 was chosen. For example, if either of the lowest 2 responses on a 4-point Likert scale was chosen, this was considered a problem. The percentage of responses that were a problem for each child in each specific domain was that child's percent problem score for that domain. The percent problem scores for each domain were correlated with the quality of care question to determine which specific quality domains were most closely associated with high-quality care.

#### Data Analysis

All surveys were coded with unique identifiers. Survey responses were entered into an SPSS database. Analysis of the parent-perceived quality of hospital care for children with SCD was compared to each of the comparison groups individually, using an independent samples t-test when all 5 possible answers from the Likert scale were analyzed. A chi-square analysis was used to compare the dichotomized quality of care assessments and the percentage of problem scores for the quality domains between the groups. A Pearson's correlation (r) was used to correlate the domain percent problem scores, age, and length of stay with the quality of care assessment.

#### **RESULTS**

A total of 174 children (22 with SCD, 47 with cancer, and 115 on the general pediatric service) was eligible for study participation. Consent for participation was not possible for 49 children (4 with SCD, 7 with cancer, and 38 on the general pediatric service) due to lack of contact with a legal guardian prior to the child leaving the hospital. In addition, there were 13 refusals (1 SCD, 4 cancer, and 8 parents of children on the general pediatric service), leaving 112 (64%) children with

quality-of-care evaluations. The characteristics of the study populations are shown in Table 2. Children on the general pediatric service were younger, while children with cancer had longer lengths of stay than children with SCD. Children with SCD were more likely to be African American.

#### Outcome: Parent-Reported Quality of Care

Children with SCD had significantly lower parentreported quality of hospital care compared to children with cancer and children admitted to the general pediatric service (Table 3). This lower parent-reported quality of care was present when analyzed using the entire 5-point Likert scale and when dichotomized as high versus low quality as described previously.

#### Evaluation of Predictor Variables

There was no significant correlation between parent-perceived quality of care and either length of stay or age. The percentage of problem scores for each of the 7 specific domains of care that were evaluated showed a statistically significant negative correlation with quality of care, with an increased percentage of problem scores being associated with lower parent-perceived quality of care, as measured on the Likert scale, in each domain: discharge planning (r=-0.343), coordination of care (r=-0.374), physical comfort (r=-0.516), confidence and trust (r=-0.518), information to parents (r=-0.582), partnership (r=-0.665), and overall care (r=-0.736).

The average percentage of problem scores across all 7 domains that were evaluated was 23% for children with SCD, 14% for children with cancer, and 15% for children on the general pediatric service, a difference that was not statistically significance (Table 3). However, when the analysis was restricted to percent problem scores from the 2 domains most strongly correlated with parent-perceived quality of care—partnership and overall care—children with SCD had a higher percentage of problem scores (24.5%) compared to children with cancer (11.1%) and those on the general pediatric service (11.5%); however, due to a smaller sample size of children with cancer, only the difference from children on the general pediatric service reached statistical significance (*P*=0.074 and *P*=0.025 respectively).

To further evaluate the 2 domains most highly correlated with parent-perceived quality of care, we analyzed the individual questions comprising those domains. For overall care, the responses were similar between the groups, with questions concerning nurse and doctor availability and courtesy being most highly correlated with parent-perceived quality of care (data not shown).

**Table 1.** Sample Item Questions from the Picker Inpatient Survey

#### Partnership (6 questions total)

Attention paid to your experiences and suggestions in caring for your child

Extent of involvement in making decisions about child's care Child treated differently because of type of insurance Child treated differently because of race/ethnicity

#### Physical comfort (3 questions total)

Everything done to control child's pain Adequacy of pain medication received

#### Coordination of care (4 questions total)

Knowledge of which doctor was in charge of child's care Told who to ask for help if needed Quick response to call button

#### Information to parents (5 questions total)

Doctor/nurse availability to answer your questions or concerns Understandability of responses from doctors/nurses to questions asked

#### Confidence and trust (2 questions total)

Confidence and trust in doctors/nurses caring for your child

#### Continuity and transition (9 questions total)

Adequate time spent discussing home care with physician Told when to see physician for follow-up Taught what needed to know to care for child at home

#### Overall care (6 questions total)

Courtesy and availability of doctors/nurses Hospital policy for visiting or stay with child

For partnership, 2 individual questions showed significant differences among the groups. With regard to parent involvement in the care of their children while hospitalized, 59% of parents of children with SCD would have liked to have been more involved in decisions about their child's care, compared to 31% of parents of children on the general pediatric service and 22% of parents of children with cancer. Secondly, 29% of the parents of children with SCD believed their child was treated differently because of his/her race/ethnicity, compared to 3% of parents of a child with cancer and 3% of parents from the general pediatric service.

As partnership concerns about race were present, and there were obvious racial/ethnic differences between the groups, a subset analysis was performed on African American children. While the number of children is too small for meaningful statistical comparisons, 5 of 16 (31.3%) parents of children with SCD reported low quality care, compared to 0 of 6 (0%) in the cancer

Table 2	Characteristics	of the	Sample	Children
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	Sickle Cell Disease n=17	Cancer n=36	General Pediatric Service n=59
Age in years; median	10.0	9.0	1.0
(IQ range)	(2.25-14.0)	(3.0-15.0)	(0-7.25) <sup>a</sup>
Female (%)	4 (23.5)	9 (25.0)	20 (33.9)
Length of stay in days; median	2.0	4.5	2.0
(IQ range)	(1.5–2.0)	(2.0-7.0)a	(1.0-4.0)
	Race/E	thnicity	
White	0	24 <sup>a</sup>	33 <sup>a</sup>
African American	16	6	16
American Indian/Alaska native	0	2	0
Hispanic	0	3	4
Asian or Pacific Islander	0	0	2
Mixed race	1	0	4
Missing	0	1	0

**Table 3.** Comparison of the Assessment of Hospital Care Quality and Percent Domain Specific Problem Scores Between Children with Sickle Cell Disease, Children with Cancer, and Children Admitted to the General Pediatric Service

	Sickle Cell Disease n=17	Cancer n=36	General Pediatric Service n=59
Quality of hospital care; mean (standard deviation)	3.12 (1.22)	3.67 (0.59) <sup>a</sup>	3.68 (0.66)a
Number (%) of children receiving low quality care, when quality dichotomized <sup>b</sup>	5 (29.4%)	2 (5.6%) <sup>a</sup>	4 (6.8%) <sup>a</sup>
Percent problem scores across all domains	23.1%	14.1%	15.2%
Percent problem scores for partnership and overall care	24.5%	11.1%	11.5% <sup>a</sup>

<sup>&</sup>lt;sup>a</sup> Significantly different from children with sickle cell disease (P<0.05).

<sup>a</sup> Significantly different from children with sickle cell disease (P<0.05)

group, and 2 of 16 (12.5%) for African American children on the general pediatric service.

#### **DISCUSSION**

This first study of the parent-perceived quality of hospital care for children with SCD indicates that children with SCD receive lower parent-reported quality of hospital care than children with cancer or those admitted to the general pediatric service. While the small number of enrolled children makes it impossible to generalize these findings to all children with SCD, or to fully explain the differences between the groups, the disparity is important to document, and hypotheses can be generated about the reasons for the findings.

While the specific reasons for this difference cannot be explained by this study, some things are apparent. Age and length of stay did not appear to explain the differences. As in previous studies, a parental feeling of "partnership" in the child's care was very strongly correlated with parental ratings of care quality.6-8 More than 25% of parents of children with SCD believed that their child was treated differently because of his/ her race, and over 50% of parents of children with SCD would have liked to have been more involved in decisions about their child's care. These findings suggest that greater recognition of the parent as a caregiver for the child, especially during the stress of a hospitalization, can improve parent ratings of care quality, which may serve to diminish the perception that the children are treated differently because of their race. The disparity in parent-reported quality of care is not all due to race, however, as the percentage of African Americans

b Responses of "poor," "fair," or "good" indicate low-quality care; "very good" and "excellent" indicate high-quality care.

reporting low quality care on the general pediatric service and among parents of children with cancer was less than half the proportion of those with children with SCD.

Chronic illness has also been shown to be associated with decreased care quality;7 however parents of children with cancer did not report lower quality care than those on the general pediatric service, and none of the 6 African American children with cancer received low parent-reported quality of care. It may well be that there is something specific to sickle cell disease, especially as a chronic disease primarily affecting African Americans, that affects perception of care quality. One previous study showed that adults with SCD reported lower satisfaction with nursing care than patients with other medical conditions.<sup>11</sup> Previous reports by adults of a lack of trust from their health care professionals and feeling that they are treated differently from those with other conditions may have taken root due to the treatment that children with sickle cell disease receive early in their care. 5 Parents of these children may recognize differential treatment, especially in a hospital setting where children with other chronic illnesses may be in close proximity.

Limitations of this study include the number of missed eligible children and the number of refusals to participate. However, the overall response rate of 64% is higher than other studies assessing hospital care for children. In addition, there were too few African Americans in the comparison groups to adequately address the racial component of this disparity and to more fully understand the relationship between race and evaluations of partnership and other aspects of care. Finally, there were only a small number of children with SCD in the study; however, even with these small numbers, significantly lower parent-reported quality of care was shown, and more studies are needed to further define the reasons for these disparities. Such studies could include interviews with parents who report low quality care to determine when the disparities begin to manifest themselves and how the families would like to be more involved in the care of their children. Additionally, gathering information from the medical staff to determine their comfort in treating children (and the parents of children) with SCD may uncover potential explanations for these findings.

In conclusion, children with SCD receive lower parent-reported quality of hospital care than children with cancer or children on the general pediatric service. Increasing parental involvement in the care these children receive may improve perceived care quality.

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# A Long-term Follow-up of a Single Rural Surgeon's Experience with Laparoscopic Inguinal Hernia Repair

Tim Napier, MD, FACS; Jeremi T. Olson, PA-C; Jennifer Windmiller, BA; Jennifer Treat, MA

#### **ABSTRACT**

Introduction: Inguinal hernia repair is one of the most common surgical procedures performed in the United States, with an estimated 700,000 or more completed annually.

Objective: This study looks at 7 years of laparoscopic totally extra-peritoneal (TEP) inguinal hernia repair at a rural Wisconsin medical center. The goal is to accurately measure recurrence rates and mechanisms of recurrences within a single professional's practice using a follow-up of no less than 2 years. A secondary goal was to record the percentage of patients with short-term and long-term complications.

Method: Patients with laparoscopic TEP inguinal hernia repairs from 1997 through 2004 were seen in follow-up visits ≥2 years after their initial repair. Of a possible 165 patients, 100 (61%) participated, returning for a total of 141 (64%) follow-up exams. Follow-up range was 2-7 years, with a mean of 3.7 years. All repairs were completed using a single technique (TEP) by a single surgeon. Repair variables included mesh thickness, style of mesh to cord accommodation, and fixation technique. Study participants ranged from 16 to 88 years, with an average age of 65.9 years. A wide range of socioeconomic indicators were represented, including education, occupation, and household income. Five participants were female and 95 were male.

Main Outcome Measure: The primary study outcome was the identification of an accurate recurrence rate along with the mechanism of hernia recurrence. Patients

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with long-term groin pain (dysesthesia) and identification of short-term complications were also noted.

Results: Between 2004 and 2007, 100 patients were seen for follow-up. None had symptomatic hernia recurrences. One recurrence was found at exam and confirmed with a herniogram and laparoscopic surgical exploration. Two additional patients, identified by exam and herniograms as having suspected recurrences, are awaiting surgical exploration. In the case of 1 recurrence, the mechanism appears to be partial migration of mesh from the placement area. Long-term groin dysesthesias (moderate or occasional) occurred in 2 patients or 1.4% of repairs. Spermatic cord hematoma (18% of repairs) was the most common short-term complication.

Conclusions: Laparoscopic TEP inguinal hernia repairs are effective and durable in a rural setting. An acceptable recurrence rate (0.7%-2.1%) may be related to mesh placement, completeness of dissection, and the small but real risk of mesh migration or displacement prior to healing fixation. Long-term pain complications are reasonably low.

#### INTRODUCTION

Inguinal hernia repair is one of the most common surgical procedures performed in the United States, with an estimated 700,000 or more completed annually. A number of hernia repair techniques are used, each with pros and cons, resulting in relatively variable hernia recurrence rates due to a variety of factors.

A prospective VA Medical Center study published in April 2004 that compared laparoscopic inguinal hernia repairs with open mesh hernia repairs concluded that laparoscopic repairs had a higher recurrence rate than open hernia repairs. This study had a number of potential weaknesses, including variability of technique between surgeons, the likelihood of residents performing repairs, and the inclusion and variation between

2 laparoscopic repairs (transabdominal preperitoneal [TAPP] and totally extraperitoneal [TEP]). Some long-term studies (>2 years) of hernia recurrence in laparoscopic TEP repairs have involved only 1 surgeon with 1 technique.<sup>2</sup>

Previous studies regarding inguinal hernia recurrences have not specifically identified the nature or mechanism of their recurrences. In most studies, it appears that in laparoscopic repairs, hernia recurrences appear early (within months of the repair) as opposed to open hernia repairs, where recurrences may not happen until years later.<sup>3</sup> A 1996 study by Liem et al identified 3 factors relating to recurrences after laparoscopic TEP repairs: (1) missed indirect hernia, (2) improper mesh placement, and (3) incomplete dissection of cord and surrounding structures.4 These technical problems usually show themselves within a relatively short time post-operative as hernia recurrences. Two additional issues not discussed in the study should also be considered as potential causes for recurrence: (1) migration or displacement of mesh (away from proper placement) and (2) finer (thin) mesh with reduced positional stability.

For over 10 years, the surgeon in this study performed laparoscopic inguinal hernia repairs for single-sided, bilateral, and recurrent inguinal hernias in rural Wisconsin. During that time, no patients returned with a symptomatic recurrence. Laparoscopic hernia repairs were utilized over open repairs for a number of reasons, including favorable results of early studies (ie, reduced recurrences, reduced pain, earlier recovery).<sup>5</sup> A more intuitive factor was the surgeon's belief that an inner patch repair should have a mechanical advantage to an outer patch and that a larger patch could be placed in the pre-peritoneal position as opposed to the open anterior hernia wound. However, when the VA study¹ was published it seemed necessary to assess this practice's data regarding laparoscopic repairs and recurrences.

All of these repairs were completed with 1 technique: TEP. Variables in repairs included size of mesh, mesh thickness, spermatic cord accommodation, and mesh fixation techniques. The repair technique evolved somewhat over time with regard to the listed variables (Figures 1-3). Lower profile fixation methods (reducing the amount of tissue entrapped) were used; most recently fibrin sealant has been used to secure the mesh. This change was an attempt to reduce the number of patients with post-operative dysesthesia from presumed

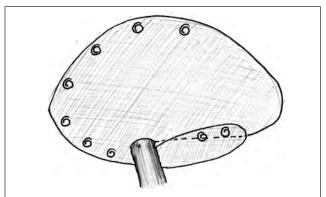
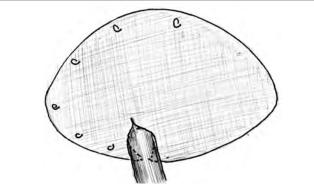
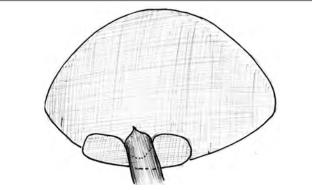


Figure 1. 5 mm Helical Tacks. Lateral Horizontal Slit with overlap.



**Figure 2.** 5 mm Salute Tacks. Vertical Slit in preformed (3-D) mesh.



**Figure 3.** Fibrin Sealant (no tacks). Vertical Slit with underlying mesh.

nerve entrapment via tacks. Currently the Bard 3DMax Mesh in standard sizes is utilized, rather than fashioning the shape and size from a flat piece of (15 cm. x 15 cm.) marlex mesh as had been done in the past. A small incision is made in the mesh to restore the spermatic cord (or round ligament) to its natural anatomic position with respect to the internal inguinal ring. Initially, a lateral-horizontal slit (Figure 1) in the mesh was made

Table 1. Long-term Complications Complication Number of Patients Percent **Complication Type** Mild-rare dysesthesia 8 5.7 Moderate-2 1.4 occasional dysesthesia 2 Hydrocele 1.4 Residual cord hematoma 0.7

Complication Type	Number of Patients	Complication Percent
Spermatic cord hematoma	25	18
Scrotal seroma / hydocele	3	2.1
Umbilical hematoma	2	1.4
Pneumonia	1	0.7
Prostatitis / epididymitis	1	0.7
Abdominal pain and hospital admission	1	0.7
Prolonged discomfort	1	0.7

but now a vertical slit is used (Figure 2). A second small rectangular piece of mesh is used to prevent tissue protrusion below the cord through the vertical slit in the mesh (Figure 3).

#### **METHODS**

This is a retrospective study with long term (≥2 years) follow-up in a patient pool of prior laparoscopic TEP inguinal hernia repairs. Out of a total of 165 eligible patients, 100 patients participated. Eligible patients had undergone laparoscopic inguinal hernia repairs from 1997 through 2004. All repairs were completed with 1 technique (TEP) by 1 surgeon. Variables included mesh type (mesh thickness), style of mesh to cord accommodation, and fixation (Figures 1-3). Follow-up range was 2-7 years, with a mean follow-up of 3.7 years.

Hernia recurrence was initially detected during scheduled examinations. Patients with equivocal findings by exam were recommended for further evaluation by herniography. Four of 6 patients with possible recurrences agreed to this. Laparoscopic exploration for further confirmation and repair was recommended for patients with radiographic findings of recurrence. As part of a patient's follow-up examination, they were asked questions regarding recurrent symptoms of pain, chronic pain at rest, or bulging during strenuous activity.

Postoperative complications were classified as shortand long-term. Short-term complications consisted of post-operative problems lasting no longer than 1 year and were identified by reviewing postoperative care records. Long-term complications were problems lasting longer than a year, and were usually identified through interview at the follow-up exam.

The study was performed at a rural medical center in south central Wisconsin.

#### **RESULTS**

One hundred sixty-five patients who had undergone a total of 220 laparoscopic TEP inguinal hernia repairs over a 7-year period (1997-2004) were eligible for the study. One hundred (61%) of these patients, representing 141 (64%) hernia repairs, participated in the study. None were symptomatic for hernia recurrence. Of the 141 hernia repairs, 6 repairs in 6 different patients were found, upon examination, to have possible recurrences. One patient had a clinically evident hernia recurrence, while the other 5 patients had equivocal exams. Of these 6 patients, 4 consented to radiographic herniograms. The herniograms showed 3 of the patients had the radiographic criteria of hernia recurrence. Only 1 of these 3 patients consented to and underwent laparoscopic exploration, confirmation of hernia recurrence, and repair. One elderly patient with an equivocal exam died (of unrelated causes) before a herniogram or surgery could be completed for confirmation. With only 1 confirmed recurrence, recurrence rate is 0.7%. Hernia recurrence for this patient was identified intraoperatively as a result of displacement of the mesh around the internal inguinal ring, which allowed protrusion of tissue through a previously compromised (dilated) internal ring. In the event that all 3 herniogram suspected recurrences are confirmed with surgery, the long-term recurrence rate would be 2.1%.

Long-term complications (Table 1) included 2 patients (1.4%) with moderate to occasional groin dysesthesia. Eight (5.7%) patients described very mild or rare groin dysesthesias, sometimes only noticed with lifting. The most common short-term complication (Table 2) was that of spermatic cord hematoma, occurring in 25% of patients or 18% of the total repairs. None of the patients with either short- or long-term complications were found to have recurrences.

#### **DISCUSSION**

Overall, the rate of recurrence was within the expected norm. The 1 surgically confirmed recurrence was felt to be secondary to mesh displacement around the internal ring. This probably occurred as a separation at the key-

hole slit of the mesh (which was placed before the surgeon began using a second piece of mesh in that area). In effect, this allowed a recurrent indirect inguinal hernia to occur. (In exploration of the recurrent hernia, the surgeon approached it from an intraperitoneal position to encounter the hernia defect from a field that had not been dissected (Figure 4). This approach allowed better identification of the position and mechanism of the recurrence defect.) Once the nature of recurrence was identified, the recurrent hernia was repaired with a TAPP technique.

Two patients with presumed small (asymptomatic) hernia recurrences noted through herniography are pending surgical exploration. Herniograms are quite helpful, but not solely diagnostic and as such these patients are not officially counted as recurrences until proven surgically.

#### CONCLUSION

Laparoscopic TEP inguinal hernia repairs are effective and durable in a rural setting. An acceptable recurrence rate (0.7%-2.1%) may be related to mesh placement, completeness of dissection, and the small but real risk of mesh migration or displacement prior to healing fixation. Long-term pain complications are reasonably low.

The current development of a database of hernia repair patients to be seen for long-term periodic follow-ups should allow tracking of a relatively accurate recurrence rate for laparoscopic repairs over a short- and long-term period. This approach toward patient care is also consistent with the ever-advancing quality-of-care initiatives coming to general surgery, as well as the rest of medicine.



**Figure 4.** Recurrent indirect inguinal hernia defect viewed laparoscopically.

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# SOME KIDS ARE GROUNDED WHEN THEY'RE CAUGHT WITH A DRINK.

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Underage teens are finding it easier and easier to obtain alcohol—the number one drug of choice for American youth.

What's worse, they're getting it more often from adults, including their own parents, than from strangers. In an American Medical Association (AMA) survey, one in three teens responded that it is easy to obtain alcohol from their own consenting parents.

Some parents believe that underage drinking is a rite of passage. But fatal injuries, car accidents, sexual assaults and contracting sexual diseases are not rites of passage- they are life-altering events. And alcohol causes what may be irreversible damage to a young person's brain, which develops into their 20s.



#### **Dean's Corner**



Robert N. Golden, MD

# An integrated school of medicine and public health—What does it mean?

Robert N. Golden, MD, Dean, University of Wisconsin School of Medicine and Public Health, Vice Chancellor for Medical Affairs, University of Wisconsin-Madison

In 2005, the University of Wisconsin Medical School became the UW School of Medicine and Public Health, a move that signaled the plan to develop a new model that unites public health and medicine. The vision was to create a superior research, education, and community engagement enterprise that integrates biomedical sciences, care of individual patients, and the health of diverse populations.

We are convinced that this new integrated approach, which no other medical school has adopted, is the best way to address the evolving health and health care needs of Wisconsin. We believe that our example will ultimately serve as a national model.

Over the past year we have gone through an extensive, inclusive process to identify exactly what this transformation into an integrated school of medicine and public health will mean to us. The process has involved faculty, staff, community leaders, and both state and national consultants. The result, completed in February, is a "road map" that describes how the transformation will affect our service, education, and research missions.

What follows is a summary of the information contained in the plan.

#### **Guiding Principles**

- We will not establish an independent, freestanding school of public health, and then attempt to build bridges between it and our school.
- We will dismiss preconceived notions about public health and medicine, fields that historically have functioned independently, and will use our new integrated model to solve our most pressing health issues.
- We will increase levels of bilateral interaction with communities, local and state government agencies, and other organizations across the state, as well as with other components of our university.
- We will continue to advance the core aspects of our current strengths.
- We will establish a thoughtful process for setting priorities and using resources.
- We will assess our progress and direction on a regular basis and modify our plans based on those assessments.

#### Criteria for Selecting Priorities, Goals, and Strategies

 Determine Wisconsin's greatest needs as defined by disease bur-

- den, potential for health impact, geography, and other criteria.
- Leverage our strengths and seek opportunities to collaborate.
- Focus primarily on areas and issues that are underserved or neglected, and avoid duplicating successful efforts of others.

# **Transforming Our Service Mission: Engagement**

- As a school within a leading public university, we recognize the central role of service in our institution's purpose, as articulated in the "Wisconsin Idea."
- We will use the term "engagement" to describe the bilateral relationships we will foster.
- Our transformation will expand our engagement with communities and organizations statewide.
- We will push forward with broader population and public health components, seeking direction from community and state organizations. Our Wisconsin Partnership Program's community grants program has already moved us in this direction.

# Transforming Our Educational Programs

 Our health sciences students and trainees will become knowledge-

- able in basic biomedical sciences, clinical sciences, and population health sciences.
- Cross-disciplinary education and "team teaching and team learning" will be expanded and developed.
- Our medical students will receive training in diverse and underserved settings, and our public health graduate students will learn to integrate clinical and biomedical perspectives into their work.
- The school will offer comprehensive and easily accessible training in global health, and will encourage its graduates to become leaders in academic medicine and in public service.

## **Transforming Our Research Mission**

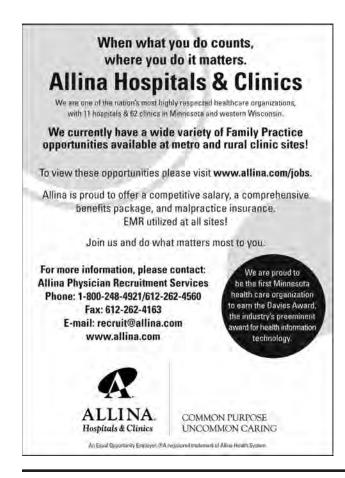
 We will ensure that new knowledge moves from the laboratory bench to the bedside, from the bedside to the community, and

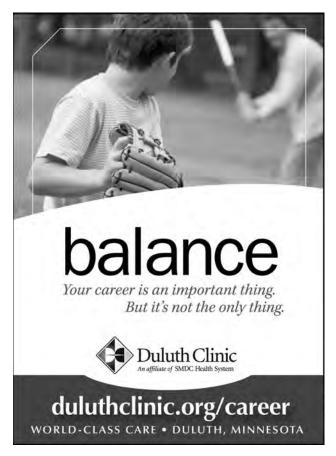
- from the community to the laboratory bench and bedside.
- We will expand our research portfolio, making it strong and vibrant in all areas, with a continuum that spans basic science through Type I translational research and clinical investigations, Type II translational research, as well as population and community based studies.
- We will push to integrate and synthesize knowledge across these areas and focus on research in high-priority areas.
- Basic, clinical, and population health sciences will be connected through a cadre of interdisciplinary faculty.
- Community-based research will be targeted as an area of emphasis and, whenever possible, linked to basic and clinical sciences.
- Training opportunities in public health research will be developed with an emphasis on its interface with clinical and basic sciences.

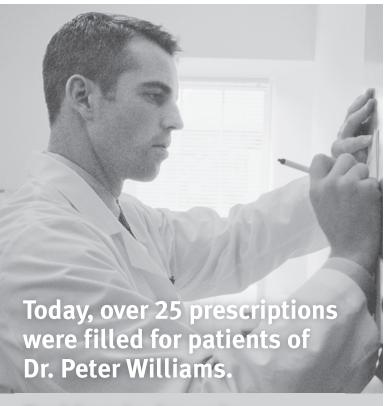
### Launching Our Transformation

- A Transformation Executive Operations Committee will develop a timeline for setting goals and strategies, create mechanisms for monitoring progress, and provide periodic reviews of goals and strategies.
- A Transformation External Advisory Board will provide review and guidance, and facilitate external relations and resource development.
- We will create the position of Associate Dean for Public Health.
- A Research Advisory Committee will begin scanning the environment in preparation for its report on research priorities integrating basic, clinical, and population health science approaches.

For more information, I invite you to visit www.med.wisc.edu/about/transformation.php.







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# MetaStar to begin new Medicare contract

Jay Gold, MD, JD, MPH; Kay Simmons, MA

uring the past few years, this column has featured articles on a number of projects and activities on which MetaStar and its partners have been working. Those activities were all part of the Medicare Quality Improvement Organization (QIO) contract with the Centers for Medicare & Medicaid Services (CMS), known as the 8th Statement of Work.

Over the course of that contract, MetaStar and other QIOs employed the following 4 strategies to help providers transform the care they deliver:

- (1) measuring and reporting performance to identify opportunities for improvement and to track progress;
- (2) adopting and using information technologies such as electronic medical records, medication barcodes, and computerized physician order entry;
- (3) redesigning care processes; and
- (4) changing organizational culture.

These strategies were employed to achieve improvement in various clinical measures, including heart care, surgical infection prevention,

Doctor Gold is senior vice president and principal clinical coordinator for MetaStar, Inc. Ms Simmons is vice president of communications. This material was prepared by MetaStar, Inc., the Quality Improvement Organization for Wisconsin, under a contract with the Centers for Medicare & Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy.

Table 1. MetaStar 9th Statement of Work Themes and Measures

### Prevention (10 Measures) (National and Sub-national)

Core work (national):

Mammography

Colorectal cancer screening

Influenza immunization

Pneumoccocal immunization

Examples of detailed measures include:

Percent of targeted participant practices recruited

Percent received post recruitment education

Percent recruited that electronically reported quality data to CMS & QIO

Relative improvement on the above core topics

Chronic kidney disease (sub-national)

Screening for nephropathy

ACE/ARB therapy to prevent progression

AV fistula rate (new dialysis patients) from targeted population claims

Focused disparities (sub-national)

Using "Every Diabetic Counts" to improve rates on:

HbA1C

Lipid examination rates

Eye exam rates

### Patient Safety (14 Measures) (National)

MRSA-infection rate

MRSA-transmission rate

Pressure ulcers-nursing homes

Pressure ulcers-hospitals

Physical restraints-nursing homes

SCIP-infection (1,2,3,4,6,7)

SCIP-cardiology

SCIP VLE (1,2)

### Care Coordination (3 Measures) (Sub-national)

Global re-hospitalization rate

Patient assessment of hospital discharge performance

Physician visit post-discharge

### **Beneficiary Protection (4 Measures) (National)**

Timely completion of case review

Beneficiary satisfaction with complaint process

Completion of satisfaction survey

Percent of QIA completion

MRSA=Methicillin-resistant Staphylococcus aureus

SCIP=Surgical Care Improvement Project

pressure ulcers, pneumonia, pain, and drug safety. MetaStar worked in settings that included hospitals, physician offices, nursing homes, and home health agencies. In addition, MetaStar conducted statutorily required medical case reviews of beneficiary quality of care com-

plaints and beneficiary appeals of certain provider notices.

Due in large part to the efforts of MetaStar's partners and collaborators, there was improvement in all of the measures of the 8th Statement of Work. MetaStar was able to achieve the highest level (Excellent Pass) in the contract evaluation process in 6 of 8 areas; the remaining 2 were in the second highest level (Full Pass) of the evaluation process. As a result MetaStar receiving an automatic contract renewal, for which we extend sincerest thanks to everyone who partnered with us and worked diligently to ensure the right care for every person every time.

On August 1, 2008, MetaStar will begin work on its new 3-year contract—the 9th Statement of Work. This contract will be structured somewhat differently from previous contracts: there is a national component, which will be carried out by all QIOs, and

there is also a sub-national component, for which the work will be awarded on a competitive basis in a limited number of states.

The statement of work is divided into 4 themes: Prevention, Patient Safety, Care Coordination, and Beneficiary Protection. Each of these 4 themes has topics or components on which the QIO and partnering health care professionals and stakeholder organizations are to focus. Within the components are 31 quality measures that will be used to track and assess progress in the 4 themes (Table 1). MetaStar will continue to collaborate with physicians, hospital and nursing home staff, physi-

cian office staff, and health care stakeholder organizations to carry out the work of this new contract.

As of this writing, we at MetaStar know we will be doing work on all of the national topics-Prevention, Patient Safety, Beneficiary Protection-but are awaiting final decisions from CMS on the sub-national competitive proposal submissions. It is anticipated that all contract awards will be final in early summer. As the new work begins, this column will bring you updates and information on the projects and activities of this contract, with emphasis on topics of particular interest to the medical community.





Molly J. McCarragher, JD

# Social Security: Take the money at 62 or wait?

Molly J. McCarragher, JD

If you are eligible for Social Security, you may begin receiving reduced benefits as early as age 62, no matter when you reach full retirement age, according to the Social Security Administration.

Should you begin taking Social Security at 62? Or wait until you reach full retirement age? Or wait a little longer to take advantage of delayed retirement credits?

From an actuarial viewpoint, whether you start taking benefits early, late or right on time, you can expect to receive about the same amount over your lifetime. From a personal viewpoint, only you can decide when the time is right.

### 66 is the New 65

The "normal" or full retirement age—the age at which full Social Security benefits are available—is increasing due to longer life expectancies. Full retirement age is 66 for those born between 1943 and 1954, and then rises incrementally to 67 for those born in 1960 or later.

The trade-off for taking benefits earlier is that the monthly payments will be lower—permanently. Let's say you were born in 1946,

Ms. McCarragher is a relationship manager with SVA Wealth Management, Inc., Registered Investment Advisor, an affiliate of Suby, Von Haden & Associates, S.C. For more information contact Wisconsin Medical Society Insurance and Financial Services, Inc. toll free at 866.442.3810.

and your full retirement benefit, available at your full retirement age of 66, is \$1000 a month. If you begin taking benefits at age 62, your monthly payment is permanently reduced to \$750 a month. Conversely, if you wait until age 70 to apply for benefits, you will receive a "delayed retirement credit" that permanently increases your monthly benefit to \$1320. There is no increase in benefits for delaying Social Security past age 70.

### **Questions to Consider**

No one can calculate the exact date when he or she will break even. Neither can anyone predict the future of Social Security. Consider the following questions when weighing your decision.

### How healthy are you?

If you enjoy good health and have a family history of longevity, you might be wise to delay Social Security until you reach full retirement age or later. If your spouse survives you, your survivor can drop his or her benefit and assume your higher monthly benefits for the remainder of his or her life.

## How much longer do you plan to work?

If you continue to earn income between 62 and full retirement age, Social Security will deduct \$1 from your benefits for every \$2 you earn above the annual limit (\$13,560 for

2008). For example, if you are eligible for a monthly benefit of \$110,0 and you earn \$20,000 in 2008, your monthly benefit will be reduced to \$832. Once you reach full retirement age, you can take the full benefit with no earnings limit.

### What benefits will your spouse receive?

Your spouse is eligible for Social Security benefits equal to one-half of your full retirement amount at his or her full retirement age, even if he or she has never worked under Social Security. If your spouse begins taking benefits at age 62, the monthly benefit is permanently reduced. Should you delay taking Social Security until after your full retirement age, your spouse will not receive delayed retirement credits.

# How will your spouse's earnings affect your benefits?

Your spouse's earnings do not affect your benefits or those of your other beneficiaries. If your spouse qualifies for Social Security, he or she will receive benefits under his or her own work record or a combination of benefits that equals the spouse benefit, whichever is higher.

At full retirement age, your spouse may choose between taking his or her own benefit or the spouse's benefit. Your spouse could take the spouse's benefit now, then switch to his or her own benefits later, thus taking advantage of delayed retirement credits.

# What if I die before my spouse reaches retirement age?

Your surviving spouse can receive survivor benefits (reduced for age) as early as age 60, assuming you qualify for Social Security. However, benefits received before age 62 may permanently reduce the amount of full retirement benefits available later. If the surviving spouse remarries, he or she does not qualify for survivor benefits.

## How do divorced spouses fare in Social Security?

If you were married for at least 10 years and your former spouse does not re-marry, he or she will receive the same survivor benefits as your widow or widower. The benefits

paid to your former spouse (or multiple former spouses, providing each marriage lasted at least 10 years) do not reduce the amount paid to your other survivors.

## When should I apply for Social Security benefits?

Apply about 3 months before you wish to begin receiving benefits.

### What about Medicare?

You are eligible for Medicare at age 65, regardless of your full retirement age for Social Security. Register for Medicare benefits about 3 months before you turn 65 by going to www.medicare.gov or by calling 800.633.4227. If you are already receiving Social Security benefits when you turn 65, your

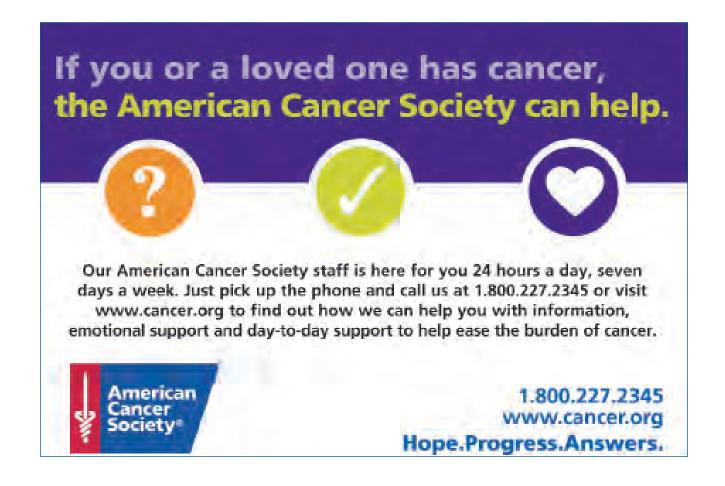
Medicare Hospital Benefits will start automatically.

### Where can I learn more?

The Social Security Web site, www. socialsecurity.gov, is a goldmine of information about retirement, disability, and survivor benefits. For more information, contact your local Social Security office or call 800.722.1213 weekdays between 8 a.m. and 8 p.m., Central Time.

### Conclusion

If you're approaching retirement age, Social Security is one of many decisions you will need to make. Consult your financial advisor to help you make the right choice for you and your family.



# 2008 House of Delegates Action on Resolutions and Board Reports

Editor's Note: To read the complete text of resolutions and amendments, visit the members-only section of our Web site: www.wisconsinmedicalsociety.org.

Resolution 1 directed the Wisconsin Medical Society to appoint a "task group" to determine all the currently known ways physicians can reduce their daily contributions to the excessive costs of medical care. It also asks this "task group" to recommend an affordable action plan for the Wisconsin Medical Society to advise and regularly remind physicians of these ways and that this report be presented to the House of Delegates in 2009 for action. It further asks that the Wisconsin Medical Society request that the American Medical Association complete a similar study and develop an action plan at the national level. Action: Referred to Board of Directors.

Resolution 2 directed the Wisconsin Medical Society to support legislation that will place the Injured Patients and Families Compensation Fund on an actuarially sound footing, including capping payouts from the Fund. It further requests that the Wisconsin Medical Society also support legislation that would make participation in the Fund voluntary and would allow physicians to choose liability insurance that will best serve their needs. *Action: Not Adopted.* 

**Resolution 3** directed the Wisconsin Medical Society to seek the repeal of the nursing home bed tax. *Action: Not Adopted.* 

Resolution 4 directed the Wisconsin Medical Society to recommend that the American Medical Association evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is "sufficient" evidence of health care disparities for these couples and children because of their exclusion from civil marriage. Action: Adopted as Amended:

RESOLVED, That our American Medical Association delegation request that the AMA evaluate existing data concerning same-sex couples and their dependent children and determine whether there is sufficient evidence of health care

disparities for these couples and children because of their exclusion from civil marriage.

Resolution 5 directs the Wisconsin Medical Society to support the Joint Principles of the Patient-Centered Medical Home as a guideline for Wisconsin and all states to improve the health of its citizens. It further requests that the Society encourage Wisconsin and all states to implement and fund pilot programs to demonstrate the quality, safety, value and effectiveness of the patent-centered medical home; and, that the Society forward a resolution to the American Medical Association in support of the Joint Principles of the Patient-Centered Medical Home. *Action: Adopted as Amended:* 

RESOLVED, That the Wisconsin Medical Society support the Joint Principles of the Patient-Centered Medical Home as developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association as guidelines for Wisconsin and all states to improve the health of its citizens, and be it further

RESOLVED, That the Wisconsin Medical Society encourage Wisconsin and all states to implement and fund pilot programs to demonstrate the quality, safety, value, <u>payment mechanisms</u> and effectiveness of the patient-centered medical home, and be it further

RESOLVED, That the Wisconsin Medical Society put forward a resolution to the American Medical Association in support of the Joint Principles of the Patient-Centered Medical Home and to encourage national payors to implement and fund pilot programs to demonstrate the quality, safety, value, payment mechanisms and effectiveness of the patient-centered medical home.

### Principles (2/07)

Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice—the personal physician leads a team of individuals at the prac-

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tice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation—the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (eg, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (eg, family, public and private community based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
  - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
    - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through sys-

tems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

<u>Payment</u> appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Resolution 6 directed the Wisconsin Medical Society to support the State of Wisconsin having a fully funded and staffed State Medical Examining Board (MEB) to be able to effectively perform its duty of oversight of physician practice and investigation of complaints against physicians in a timely manner to protect the health of the people of Wisconsin. It further requests that the Society ask the Department of Regulation and Licensing to (1) evaluate the current funding and staffing



level of the State MEB with regards to its ability to perform its duty of oversight of physician practice and investigation of complaints against physicians in a timely manner, and (2) ask the legislature to evaluate the feasibility of the State MEB returning to an independent board. *Action: Referred to Board of Directors.* 

Resolution 7 directed the Wisconsin Medical Society to help educate our physicians and our patients through journal articles, public service announcements, etc. about the necessity, especially in certain areas, to test for radon and the importance of remediating high levels. *Action: Adopted.* 

Resolution 8 directed the Wisconsin Medical Society to amend its Constitution and Bylaws such that the composition of the Nominating Committee is such that each District appoints 2 members to the Nominating Committee and the Specialty sections appoint 2 members, for a total of 18 voting members. It also requests that the members of the Nominating Committee be provided a list of persons that have held the open position over the previous 10 years along with their District or Specialty section designation such that the Nominating Committee can consider the representation of all parts of the state over time for that position in its deliberations. It further directed that the Wisconsin Medical Society Board of Directors establish an open process for information sharing about the candidates on the Wisconsin Medical Society members-only Web site and convene an open forum that all Districts could participate in via teleconference or personal attendance during which candidates for President-elect could be interviewed before the Nominating Committee meeting. Action: Adopted as Amended.

RESOLVED, That the Wisconsin Medical Society amend its Constitution and Bylaws to such that the composition of the Nominating Committee such that each District appoints 2 members to the Nominating Committee and the Specialty sections appoint 2 members, for a total of 18 voting members; and be it further

RESOLVED, That the members of the Nominating Committee be provided a list of persons that have held the open position over the previous 10 years along with their District or Specialty section designation such that the

Nominating Committee can consider the representation of all parts of the state over time for that position in its deliberations; and be it further

RESOLVED, That the Wisconsin Medical Society Board establish an open process for information sharing about the candidates on the members-only Web site and convene an open forum that all Districts could participate in via teleconference or personal attendance during which candidates for President-elect could be interviewed before the Nominating Committee meeting.; and be it further

RESOLVED, That the Nominating Committee develop criteria that ensures a fair, standardized and transparent process for all candidates.

**Resolution 9** directed the House of Delegates of the Wisconsin Medical Society to direct the Board of Directors to suspend changes to its membership pending additional evaluation and report to this House in 2009. *Action: Not Adopted.* 

Resolution 10 directed the officers and nominees for elected office of the Wisconsin Medical Society to disclose on an annual basis any and all affiliations, both past and present, with insurance companies, liability insurance companies, managed care organizations and government health care programs. It further directs that the above disclosures will be published in the Wisconsin Medical Journal prior to elections. Action: Adopted as Amended.

RESOLVED, That the Board members, officers and nominees for elected office of the Wisconsin Medical Society disclose on an annual basis any and all present affiliations, both past and present, with insurance companies, liability insurance companies, managed care organizations, industry and government health care programs; and be it further

RESOLVED, That the officers, directors, and nominees for elected office of the Wisconsin Medical Society disclose on an annual basis all significant affiliations. Disclosure will be modeled on the requirements of the ACCME and consistent with state and federal law.

The definition of significant affiliations includes all financial or leadership relationships that may be reasonably anticipated to have a material effect on issues considered, policies developed, or

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activities undertaken by the Wisconsin Medical Society.

Financial relationships include compensation, contracts, honoraria, stock ownership representing more than 10% of any one corporation's holdings, or other remuneration or consideration.

Leadership relationships include service as an officer, director, or trustee of an organization.

Disclosure will include all current relationships and all relationships during the preceding 5 years. As appropriate, the officer, director, or candidate should report significant affiliations of immediate family members. Immediate family members are defined as a spouse, parent, or child.

RESOLVED, That the above disclosures will be published in the *Wisconsin Medical Journal* and on the members-only section of the Wisconsin Medical Society Web site prior to elections.

**Resolution 11** directed the Wisconsin Medical Society to request that the WisMedPAC Board of Directors review its policy on political endorsements, research what other respected organizations such as the American Medical Association PAC have done and consider adopting strategies for lobbying that do not include formal political endorsements. Action: Adopted.

Resolution 12 directed the Wisconsin Medical Society to change the mission statement of the Society to reflect this changing environment and directs that the new mission statement read: The mission of the Wisconsin Medical Society is to facilitate the achievement of a healthiest Wisconsin through advocacy for healthy choices by all (individuals, families, communities and policy mak-

ers), universal access to safe and cost-effective health services, highest levels of physician professionalism and optimal conditions for the practice of medicine. Action: Referred to Board of Directors.

Resolution 13 directed the Wisconsin Medical Society to adopt the policy, per the Governance Task Force Informational Briefing, Page 6, that a two-thirds (2/3) supermajority vote be required for passage of contentious public policy resolutions, with

the Wisconsin Medical Society Speaker identifying contentious public resolutions.

Action: Board Report CC: Governance Task Force Recommendations: Two Thirds Vote for Public Policy Adopted in Lieu of Resolution 13:

**Board Report CC:** Governance Task Force Recommendations: Two Thirds Vote for Public Policy recommended that 2007 Board Report C: Governance Task Force (GTF) recommendation on a two-thirds vote for public policy resolutions not be adopted.

Late Resolution 14 directed the Wisconsin Medical Society to establish a very strong expectation that every member will make an annual contribution to WISMedPAC or WISMedDirect. It further directed the Wisconsin Medical Society Board of Directors to take leadership by first creating an expectation that every Wisconsin Medical Society Board member will make a \$500 annual contribution to WISMedPAC or WISMedDirect. It also directs the Society to remind and inform members regularly in all Wisconsin Medical Society publications, and to send annual solicitation letters with optional amounts listed as \$100, \$250, \$500, Other. Finally, it directs that feedback be given for each contribution in the form of an appreciation letter with lists of contributors and the amount of the contributions sent to county medical societies. Action: Adopted as Amended.

RESOLVED, That Wisconsin Medical Society will establish a very strong expectation that every member will make an annual contribution to WISMedPAC and/or WISMedDirect; and be it further and that members be reminded and informed regularly of this expectation of the value of contributing in WMS publications; and be it further

RESOLVED, That the Board of Directors take leadership by first creating an expectation that every Board member will make an \$500 annual contribution to WISMedPAC and/or WISMedDirect; be it further

RESOLVED, That members be reminded and informed regularly in all WMS publications, and be it further

RESOLVED, That the annual solicitation letters be sent with optional amounts listed as \_\_\_\_ \$100 \_\_\_\_ \$250 \_\_\_\_ \$500 \_\_\_\_ Other; and be it further

RESOLVED, That feedback be given for each contribution in the form of an appreciation letter



with lists of contributors and the amount of the contributions be sent to county medical societies.

Late Resolution 15 directed the Wisconsin Medical Society to change the wording of ABO-004. Action: Adopted as Amended.

RESOLVED, That the Wisconsin Medical Society hereby change the wording of its current policy on abortion ABO-004 to read:

Abortion as a Medical Procedure and Providing Abortion-Related Information: The Wisconsin Medical Society: (1) supports enactment of appropriate legislation that would acknowledge the right of a physician to perform and to practice this medical procedure as he/she might perform any other medical procedure or to refuse to perform an abortion according to the dictates of his/ her training, experience and conscience; (2) supports the development of guidelines that ensure that abortions be performed only under proper medical circumstances with adequate provisions for safeguarding the health of the patient; and (3) although abortion is a morally contentious issue, it is a legal medical procedure and physicians should be allowed expected to advise their patients of all the available options, in the event of an unwanted or unplanned pregnancy.

Late Resolution 16 directed the Wisconsin Medical Society to oppose any legislation that would dictate how medical and surgical procedures should be performed, especially if said legislation prohibits consideration of the health and well-being of the mother in cases of pregnancy termination. Action: Referred to Board of Directors.

Late Resolution 17 directed the Wisconsin Medical Society to support legislation providing immunity from prosecution under controlled substance-related statutes. *Action: Referred to Board of Directors.* 

Late Resolution 18 directed the Wisconsin Medical Society to work with our legislators to ensure that the State of Wisconsin create and fund a central database where pharmacists would be required to check the history of previously-dispensed controlled substances before dispensing, that the database also be available to providers who write for controlled substances and that the database is networked to adjacent state databases. *Action: Adopted As Amended.* 

RESOLVED, That the Wisconsin Medical Society suggest to our state and work with our legislators to ensure that the State of Wisconsin creates and funds a central database where pharmacists would be required to check the history of previously dispensed controlled substances before dispensing controlled substances, that the database also be available to providers prescribers who write for controlled substances, and that the database is be networked with the databases of adjacent states.

Late Resolution 19 directed Wisconsin's government to restore reimbursement for graduate medical education (GME) to previous levels. Action: Original Language Substituted and Adopted.

RESOLVED, That the Wisconsin government restore the reimbursement for graduate medical education (GME) to the same level as it would have been had the State not instituted reductions in the GME reimbursement to the teaching hospitals in the first place.

Late Resolution 20 directed that the Wisconsin Medical Society convey to Wisconsin's Congress, its strong recommendation for increased funding for the Food and Drug Administration to allow it to meet its mission and that the Wisconsin Medical Journal be encouraged to inform physicians about the prevalence and implications of counterfeit pharmaceuticals. It further requested that physicians be informed that when experiencing an unexpected or suboptimal response to treatment, the physicians be encouraged to ask their patients to show them their medications and report where they purchased them, so that they might be able to counsel their patients regarding the risks of purchasing lower cost pharmaceuticals that could be counterfeit and therefore unsafe or ineffective. Action: Adopted.

Late Resolution 21 directed physicians to advocate for legislation that aims to increase health care access security for all in Wisconsin. It also directs the Wisconsin Medical Society to research and implement new approaches to increase physician participation in health care access policy-making in Wisconsin. *Action: Adopted as Amended:* 

RESOLVED, That in line with the AMA Declaration of Professional Responsibility and the ethical principles of beneficence and justice, the Wisconsin Medical Society encourage physi-

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cians to should advocate for legislation that aims to secure increased health care access security for all in Wisconsin.

RESOLVED, That the Wisconsin Medical Society will research and implement new approaches to increase physician participation in health care access policy-making in Wisconsin.

Resolution 22 directed the Wisconsin Medical Society to publicly commend Drs. James Thomson and Jungying Yu for their meritorious work in the field of induced Phuripotent Stem Cell research and to formulate an official position encouraging policies that support further research and use of iPS cells in lieu of ES cells. Action: Adopted as Amended:

RESOLVED, That the Wisconsin Medical Society publicly commend Drs. James Thomson and Jungying Yu for their meritorious work in the field of induced Pluripotent Stem Cell research; and be it further

RESOLVED, That the Wisconsin Medical Society supports further research and use of iPS cells (induced pluripotent stem cells).

**Board Report A:** 2007 House of Delegates Resolution 4: Nursing Home Bed Tax. *Action: Adopted.* 

**Board Report A:** 2007 House of Delegates Late Resolution 33: HIV Testing. *Action: Adopted.* 

**Board Report A:** 2007 House of Delegates Board Report A: Standard Benefit Plan. Action: *Adopted as Amended:*\*

Transplants (Determined to be medically necessary) Heart, Heart/Lung, Kidney, Lung, Liver, Pancreas, Bone Marrow (as stated in the policy) (up to a separate lifetime maximum benefit of \$500,000; Prior approval required)

Wisconsin

Kidney Transplants and Dialysis Treatments (up to \$30,000 \$75,000 per year; Prior approval required)

Society

(added to bottom of Standard Benefit

Plan grid)Above listed monetary limits

shall be reviewed on a biannual basis and updated to reflect current economic realities.

\*Standard Benefit Plan in its entirety is located on the Society's Web site at: http://www.wiscon sinmedicalsociety.org/initiatives

**Board Report AA:** 2006 House of Delegates Resolution 4: Nursing Homes Play An Important Role In The Care of Our Patients and Should Not Be Systematically Closed. *Action: Adopted.* 

**Board Report B: 2007** House of Delegates 2006 Resolution 9: Improving Nutritional Value of Beverages Available In Primary School/ SCH-003: School Food and Nutrition Programs. *Action: Adopted as Amended:* 

That the Wisconsin Medical Society encourage schools to embrace and fully implement policies that strive to create and foster healthier school environments. These policies should promote increased physical activity, healthier eating both during and after school, and educational methods that inspire and develop lifelong health habits; and

That the Wisconsin Medical Society actively provide information and resources to physicians and others on healthy school programs and initiatives; and

That the Wisconsin Medical Society encourages supports schools' provision of healthy snacks and nutritious meals and encourages the Department of Public Instruction to continue its educational and monitoring programs that ensure effective wellness policies and implementation of such policies within Wisconsin to enhance school food and nutrition programs.

**Board Report B:** 2007 House of Delegates Resolution 17: Restriction of Cell Phone Use While Driving. *Action: Adopted Substitute Resolved.* 

RESOLVED, That the Wisconsin Medical Society recommends work to: 1) prohibit the use of cell phone (hands on or hands off or built-in) by anyone driving while on a learner's permit or graduated driver's license (GDL): and prohibiting the use of hands on cell phones use, including text messaging, by all vehicle operators drivers while driving.

RESOLVED, Due to evidence demonstrating that cognitive ability is temporarily impaired by any use of cell phone, hand held or hand free, while driving, Wisconsin Medical Society dis-

Medical



In his inaugural speech, Wisconsin Medical Society President Steven C. Bergin, MD, (who is pictured above being congratulated by the Society's Immediate Past President Clarence C. Chou, MD) urged his colleagues to get involved politically to make health insurance available for everybody. "We must shed our professional cocoon and awaken from our political hibernation," said Dr Bergin, an OB/GYN from Stevens Point. "We need to mount a vigorous sustained grass roots campaign engaging and dialoguing with local, state, and national legislative representatives. We should not off-handedly dismiss proposals just because they depart from the status quo." Doctor Bergin's presidential theme focuses on ways to improve health care quality, controlling costs, and increasing access to healthcare. To read the full text of his inaugural speech, visit wisconsinmedicalsociety.org/publications\_and\_media/press\_releases/inaugural.

courages the use of cell phones, including text messaging, by all vehicle operators while driving

**Board Report B:** 2007 House of Delegates Resolution 15: Zostavax. *Action: Adopted.* 

**Board Report B:** 2007 House of Delegates Resolution 16: Raise Driving Age In Wisconsin To Eighteen. *Action: Adopted.* 

**Board Report B:** 2007 House of Delegates Resolution 22: Action On Strategic Priority, Patient-Centered Care. *Action: Adopted.* 

**Board Report B:** 2007 House of Delegates Resolution 29: Embryonic Stem Cells. *Action: Adopted.* 

**Board Report B:** 2007 House of Delegates Substitute Resolution Adopted In Lieu of 2007 Resolution 12: Physician Education About End of Life and Pain Issues. Action: Adopted.

**Board Report B:** 2006 House of Delegates Resolution 11: Population Medicine. *Action: Adopted.* 

**Board Report BB:** 2007 House of Delegates Resolution 16: Raise Driving Age In Wisconsin To Eighteen. *Action: Adopted.* 

**Board Report BB:** Screening Brief Intervention, and Referral To Treatment (SBIRT). *Action: Adopted.* 

Board Report C: 2008 Budget. Action: Adopted.

**Board Report C:** 2007 Resolution 26: Aims/Metrics of Governance Task Force Recommendations. *Action: Adopted.* 

2007 Board Report C: 2006 Late Resolution 14: Creation of Ethical Conduct Policy and Procedure. Action: Adopted.

**Board Report C:** Bylaws Revision Chapter IV Section 1 and 2: Board of Directors. *Action: Not Adopted.* 

**Board Report CC:** Strategic Policy Panel. *Action: Adopted.* 

**Board Report C:** Bylaws Revision (Minus Chapter IV, Section 1 and 2). *Action: Adopted.* 

### Chapter I: Membership

Section 1. Eligibility

Every physician who holds a license to practice medicine and surgery in Wisconsin, every medical student who is enrolled in an LCME accredited medical school in Wisconsin, and every physician who is serving in an ACGME or AOA approved training program in, or outside of, Wisconsin shall be eligible for membership. Members will conduct themselves in a manner that is not in conflict with the purposes for which the Wisconsin Medical Society, Inc. (Society) is organized and operating.

### Section 2. Application

Applications for membership shall be submitted to the county society of the county in which a significant portion of the physician's practice is located. That county society shall accept or reject a request for membership as soon as possible. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification. If the physician's county society is inactive or unable to act on the application within sixty (60) days, the application shall be submitted directly to the state society for action.

Section 3. Membership Classifications Members, as defined in this section except for Affiliate members, shall have all the rights and privileges of the Society.

A. Regular. Regular members consist of all members in good standing who do not fit into Categories B and C:

- (1) Physician—Full-time. A member in good standing with a full-time practice devoted to approximately all direct patient contact.
- (2) Physician—Part-time. A member in good standing with a part-time practice devoted to approximately all direct patient contact.
- (3) Dual Physician. A member in good standing with a full-time combined practice responsibility (approximately 50% or less direct patient contact plus educational, public health, and/or research responsibilities).
- (4) Resident/Fellow. Resident/
  fellow members consist of
  those members who are enrolled in ACGME or AOA
  approved training programs
  in, or outside of, Wisconsin
  who hold a license to practice medicine and surgery in
  who are licensed as required
  by the state of Wisconsin, or
  the state in which the training program is located.
- (5) Young Physician. First to fourth year post residency with a full-time practice devoted to approximately 100% direct patient contact.
- (6) Student. Student members consist of those members who are enrolled in an LCME accredited medical school in Wisconsin

**Board Report CC:** Proposed Bylaws Revision. *Action: Adopted.* 

### Chapter I: Membership

Section 3. Membership Classifications Members, as defined in this section except for Affiliate members, shall have all the rights and privileges of the Society.

A. Regular. Regular members consist of all members in good standing who do not fit into Categories B and C:

- (1) Physician—Full-time. A member in good standing with a full-time practice devoted to approximately all direct patient contact.
- (2) Physician—Part-time. A member in good standing with a part-time practice devoted to approximately all direct patient contact.
- (3) Dual Physician. A member in good standing with a full-time combined practice responsibility (approximately 50% or less direct patient contact plus educational, public health, and/or research responsibilities).
- (4) Resident/Fellow. Resident/fellow members consist of those members who are enrolled in training programs in, or outside of, Wisconsin who are licensed as required by the state of Wisconsin, or the state in which the training program is located.
- (5) Young Physician. First to fourth year post residency with a full-time practice devoted to approximately 100% direct patient contact.
- (6) Student. Student members consist of those members who are enrolled in an LCME accredited medical school in Wisconsin.

Editor's Note: Society members are encouraged to submit ideas year round. While most Wisconsin Medical Society policy changes are determined annually by the House of Delegates, the Society reminds all members that ideas, proposals and resolutions can be submitted at any time through the Society's member communication form found on the next page. Items submitted are referred to strategic councils for further study, and recommendations will be considered at a future Board of Directors meeting.

### **Member Communication Form**

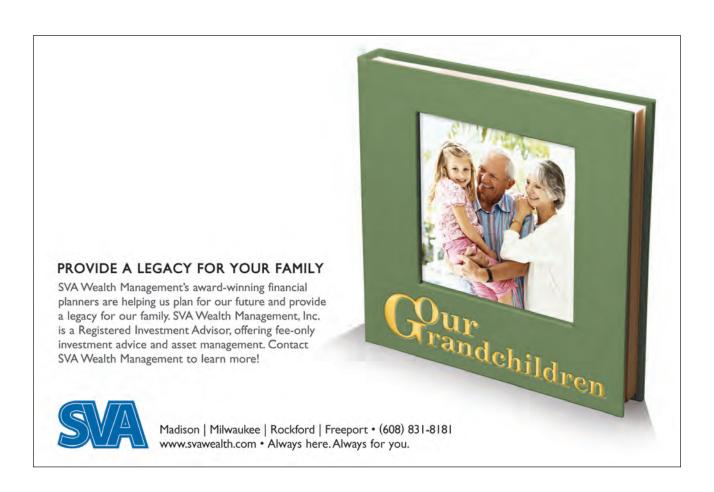
Member Name:	Da	te:	
I can be contacted at:			
□ E-mail Address:			
□ Phone:			
□ Mailing Address:			
Statement of Request, Question, Concern, Idea or Proposal			
Additional Details or Supporting Rationale			

### Special Note on Communications for Board of Directors or House of Delegates

If you are proposing a specific *policy action* for consideration at a Board of Directors quarterly meeting, or a *resolution* for the House of Delegates annual April meeting, please state **in your own words** the key points that the policy action or resolution should include.

If your request, question, concern, idea or proposal is confidential and you would like to communicate with a staff member directly, please contact Karen Carney at 608.442.3772 or e-mail karenc@wismed.org, or Merry Earll at 608.442.3766 or e-mail merrye@wismed.org.









### Wisconsin Medical Society presents these exciting trips in fall 2008

### CROATIA & VENETIAN TREASURES

Sept 19 - 27, Oct 3 - 11 \*\$1,299

Sophisticated Opatija on the Croatian Riviera is redolent of the splendor of a bygone era, and Lido di Jesolo, Italy, a beautiful resort on the blue Adriatic coastline, is a superb base from which to explore the culturally rich and scenic Veneto.

### ENCHANTING IRELAND Sept 19 - 27 \*\$1,499

Magnificent landscapes greet you at every turn as you explore the Emerald Isle. Stay in Killarney, a delightful town surrounded by idyllic lakes and mountains, and Kilkenny, one of Ireland's loveliest medieval cities.

### BEST OF THE ITALIAN RIVIERA & TUSCANY

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Montecatini, ideally situated in the heart of Italy is surrounded by the exquisite beauty of the Tuscan landscape, and the seaside resort of San Remo basks in the wonderful climate of the sun-drenched Italian Riviera.

Special Airfare Programs are available from Milwaukee and Madison (Other departure cities are available upon request)

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From the medieval roofs of Salzburg to the soaring mountain peaks of the Alps, Switzerland and Austria offer a kaleidoscope of inspiring delights to discover.

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Prices are for the LAND ONLY PROGRAM and are per person, double occupancy (plus taxes). The Land Only Program includes first-class hotel accommodations, daily breakfast, Go Next welcome gathering and much more! For additional information and a color brochure contact:



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#### PHYSICIAN—PRIMARY CARE

For more information about Community Care, contact Alice at 414.231.4131, or visit our Web site at www.communitycareinc.org.

For consideration, submit your CV by fax to 414.342.9306, by e-mail to alice.wilde@communitycareinc.org, or mail to:

Community Care Organization Att: Human Resources 3220 W. Vliet St. • Milwaukee, WI 53208 At Community Care we are all about helping older adults with disabilities and frail elders stay in their homes as safely and independently as possible for as long as possible. Through the hard work, collaboration and caring commitment of our skilled staff we have helped thousands of underserved individuals avoid nursing home placement.

As a Primary Care Physician in our innovative, community-based managed care programs you can make a real difference and you will enjoy...

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- collaborating with a quality-minded interdisciplinary team of Nurses, Social Workers, PTs, OTs, Behavioral Health Specialists, PharmD
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### **Classified Ads**

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**CHILTON** WISCONSIN-Our group is seeking BC/BP emergency physician or FP/IM physician with 2 years ED or 1500 hours experience, to join our practice. Outstanding compensation, benefits, and retirement package with a distributed ownership structure. Opportunity to explore medical information systems, preventive and occupational health, as well as traditional clinical leadership roles. The city of Chilton is located on the outskirts of Lake Winnebago. Please direct inquiries or CVs to Mary Schwei, Infinity HealthCare, Inc. 111 E. Wisconsin Ave, Milwaukee, WI 53202, phone 888.442.3883, fax 414.290.6781, e-mail mschwei@infinityhealthcare.

LAKE GENEVA—Part time opening for an MD or DO one morning per week at Lake Geneva medical weight loss clinic. OR, act as supervising physician for PA at the clinic. Call 813.961.9415, Richard or Gail or e-mail rjachimek@tampabay. rr.com. For more information visit www.medicalweightlossllc.com.

Advertise in the Official Publication of the Wisconsin Medical Society—Call Heidi Beich, Slack Attack Communications, 5113 Monona Drive, PO Box 6096, Madison, WI 53716; phone 608.222.7630; fax 608.222.0262; e-mail heidi@slackattack.com.

### **Classified Ads**

AMERY. WISCONSIN—Chief Medical Officer, Amery Regional Medical Center. This CMO position serves as a senior officer and member of the senior management team of the Amery Regional Medical Center (ARMC) and actively participates in ARMC policy development, strategic planning, governance process, and resource allocation. The CMO maintains a proportional clinical practice and is primary liaison with the ARMC-based physicians, advanced practice providers, and outreach/specialty physicians. This full-time position involves 2 days/ week of administrative CMO duties, call responsibilities, and 2 days/week of clinical practice at the ARMC. Qualified candidates must be BC'd in Family Medicine or Internal Medicine, have at least 3 years current clinical practice experience, and have a consensus-oriented, bridge-building leadership style. Previous CMO experience is preferred. For consideration, please e-mail your CV and cover letter to sandy.j.lachman@ healthpartners.com or apply on-line at www.healthpartners.jobs. For more information, contact Sandy Lachman at 800.472.4695 ext 2. Visit these Web sites: www.healthpartners.com, www.amerymedicalcenter.org, www.amerywisconsin.org. EOE

SENSIA HEALTHCARE is an established and growing Milwaukee-based Preventive and Occupational Medicine Program with an opening for a full-time or part-time physician. All primary care specialties are encouraged to apply. Hours are from 8 A.M. to 5 P.M. Monday through Friday. We offer a competitive salary and benefit package with NO oncall, NO pager, NO weekends, and NO holidays. Interested parties send CV to jkanter@sensiahealthcare.com or fax to 414.359.9401, Attn: Jennifer.

INTERNAL MEDICINE—The Medical College of Wisconsin is seeking highly motivated BC/BE Internists to join our primary care practice. Our mission is to provide patient-centered, state-of-the-art, cost-effective patient services in our on-campus and nearby clinics. Responsibilities include clinical practice in primary care with an opportunity to

teach medical students and residents. Base salary with incentive compensation and excellent benefits. Wisconsin medical license required prior to start. Mail cover letter and CV to Mark Lodes, MD, Director or Deborah Fears, Administrator, Primary Care Initiative, Medical College of Wisconsin, 9200 W Wisconsin Ave, Milwaukee, WI 53226; phone 414.805.5589; fax 414.805.5544. An Equal Opportunity Affirmative Action Employer M/F/D/V.

MILWAUKEE-Family Medicine-The Medical College of Wisconsin is seeking a highly motivated physician to join our Walk-In Clinic practice on a fulltime or part-time basis. The practice is open weekdays from 12:30 P.M. - 8 P.M. and weekends from 8:30 A.M. - 4 P.M. The clinic is open to all ages, and provides acute medical care to the community. Applicants should have an interest and expertise in the acute care of both children and adults; additional expertise in office-based procedures is recommended. Board eligibility or certification required. Wisconsin medical license and MCW credentialing required prior to start. Mail or fax cover letter and CV to Mark W. Lodes, MD, Executive Director, Primary Care Initiative, Medical College of Wisconsin, 9200 W. Wisconsin Ave, Milwaukee, WI 53226. 414.805.5672, fax 414.805.5544.

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