


December 2008 • Volume 107 • Issue 8

**Wisconsin
Medical**

Journal

Official publication of the Wisconsin Medical Society

A photograph of a middle-aged man with glasses, wearing a dark suit jacket, a white shirt, and a red tie. He is smiling slightly and looking towards the camera. He is standing in front of the Wisconsin State Capitol building, which is visible in the background. The building has a large dome and classical architectural features. The sky is a clear blue.

Condition Critical:
Now is the time
for health system reform

A health plan tailored to our specific needs?



Her agent said “Go with WPS.”

She had a question. Her agent had the answer. WPS Health Insurance — the company that’s been insuring the health of Wisconsin physicians and their employees for more than 60 years. Because when you need more than a “one-size-fits-all” health plan, WPS is clearly the way to go.

Call the Wisconsin Medical Society today for a no obligation quote. Ask us about exclusive benefits for Society members! **1-866-442-3810**.

Affordable premiums | Flexible plan designs
Comprehensive provider networks

WPS
HEALTH INSURANCE®

Insuring **Wisconsin's** Health Since 1946



Wisconsin **Medical Society**
Insurance & Financial Services, Inc.

www.wisconsinmedicalsociety.org

2009 Wisconsin Medical Society Educational Programs

The Wisconsin Medical Society is committed to providing high quality, reasonably priced education that meets the needs of our members.

In 2009, Society educators will focus on topics that affect nearly every medical practice including Medicare, Medicaid, Evaluation and Management coding, and medical records. From teleconferences to full-day seminars, you and your staff can select educational offerings based on your learning style, skill level, budget and time.

Midwest Coding and Practice Management Symposium

The 2009 symposium is scheduled October 18 - 20 at the Kalahari Resort in the Wisconsin Dells. You can choose from a variety of break-out sessions to customize your learning experience.

Face-to-Face Education

Face-to-face education remains the optimal learning experience for many of our members and their staffs. Seminars and workshops will be scheduled at local hotels and conference centers throughout the state.

"Lunch and Learn" Teleconferences

Society teleconferences are a great way to keep up-to-date on emerging issues. Just grab your sack lunch and dial in. For one low price, the entire office can participate.

On-site Education

The Society will bring customized coding and billing education to you at a time and place most convenient for your group. Call the Education Department at 608.442.3820 and ask for one of our educators. They will be happy to help you identify and discuss your needs and provide special pricing.

Visit www.wisconsinmedicalsociety.org/education for a complete listing of upcoming programs and registration information. Physicians receive CME credit for participating and continuing education units are available for staff.



Wisconsin Medical Society
Your Doctor. Your Health.

wisconsin medical society foundation 2009
fundraising dinner and silent auction

how medicine solves crime

CSI:
CRIME SCENE INVESTIGATION



madison

4.16.09

monona terrace convention center

Wisconsin Medical Journal

Official publication of the Wisconsin Medical Society



COVER THEME Condition Critical: Now is the time for health system reform

As the 155th president of the Wisconsin Medical Society, Steven C. Bergin, MD, has worked to highlight the need for health system reform and the critical condition of our current system. With the recent elections and a wave of change on its way to Washington D.C., it is clear that now is the time for health system reform. This issue of the Wisconsin Medical Journal showcases different perspectives on health system reform and areas that need reform now.

Cover photo by Greg Anderson.
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.

FOCUS ON . . . HEALTH SYSTEM REFORM

- The time is critical.....357
Steven C. Bergin, MD
- Your patients are waiting... for your leadership.....360
Tim Bartholow, MD
- The ailing health care system:
SOAP note for physician leadership.....363
Donna Friedsam, MPH; Richard Rieselbach, MD, MACP
- Is there a doctor in the 'home'?.....367
Jeff Grossman, MD

ORIGINAL CONTRIBUTIONS

- Short Report: Factors that Affect Specialty Choice and
Career Plans of Wisconsin's Medical Students.....369
*Kjersti E. Knox, BA; Anne Getzin, BA; Alison Bergum, MPA;
Patrick McBride, MD, MPH; Richard Rieselbach, MD, MACP;
Donna Friedsam, MPH*
- Navigating the Health Care System:
A View from the Urban Medically Underserved374
*Elizabeth Bade, MD; Jennifer Evertsen, MS;
Sabrina Smiley, MPH; Indrani Banerjee, BS*
- Collaboration Saves Time380
Philip A. Bain, MD, FACP

Volume 107 • Issue 8

YOUR PROFESSION

Proceedings from the Quality and Safety Forum, Part I382

Dean's Corner

Partnerships are most effective tool for eliminating disparities391
Jonathan I. Ravdin, MD

YOUR PRACTICE

From the Office of the General Counsel

The Americans with Disabilities Amendment Act—Are you ready for the changes?.....393
Michelle Leiker, JD

Follow your retirement plan.....395
Christopher P. Thomas

MetaStar Matters

Advancing outpatient prevention: A new MetaStar project.....396
Jay A. Gold, MD, JD, MPH

Erratum368

Instructions to Authors389

2008 Index to Articles.....397

Classifieds399

The *Wisconsin Medical Journal* (the *Journal*) (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic, or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Journal* nor the Wisconsin Medical Society take responsibility. The *Journal* is indexed in Index Medicus, Hospital Literature Index, and Cambridge Scientific Abstracts.

Send manuscripts to the Wisconsin Medical Journal, 330 E Lakeside St, Madison, WI 53715. Instructions to authors are available at the Wisconsin Medical Society Web site: www.wisconsinmedicalsociety.org, call 866.442.3800, or e-mail wmj@wismed.org.

MEDICAL EDITOR

John J. Frey, III, MD

EDITORIAL BOARD

John J. Frey, III, MD
Philip F. Giampietro, MD
Janet C. Gilbert, MD
Mahendr S. Kochar, MD, MACP
Kathleen R. Maginot, MD
Joseph J. Mazza, MD
Thomas C. Meyer, MD
Richard H. Reynertson, MD
Sarina B. Schrage, MD
Peter Sigmann, MD
Geoffrey R. Swain, MD
Darold A. Treffert, MD

Statistical Consultant

Robert Greenlee, PhD

Evidence-Based Medicine Consultant

David A. Feldstein, MD

STAFF

Kendi Parvin
Communications Director
Kristin Knipschild
Associate Editor
Rachel Berens-VanHeest
Editorial Consultant
Mary Kay Adams-Edgette
Layout and Design
Mary Oleson
Administrative Assistant

ADVERTISING

For a media kit, please call Heidi Koch, Slack Attack Advertising, 608.222.7630.

SUBSCRIPTION RATES

Members, \$12.50 per year (included in membership dues); non-members, \$89. Current year single copies, \$12 each. Previous years single copies, when available, \$10 each.

Periodical postage paid in Madison, Wis, and additional mailing offices

Published monthly except January, March, June, and October.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918. Address all correspondence to the *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701. Street address: 330 E Lakeside St, Madison, WI 53715; e-mail: WMJ@wismed.org

POSTMASTER

Send address changes to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

ISSN 1098-1861

Established 1903

SOCIETY OFFICIALS

Steven C. Bergin, MD, *President*
Robert J. Jaeger, MD, FACOG, *President-Elect*
Clarence P. Chou, MD, *Immediate Past President*
Susan L. Turney, MD, *Executive Vice President/CEO*
John W. Hartman, MD, *Treasurer*
Kevin T. Flaherty, MD, *Speaker*
Charles J. Rainey, MD, JD, *Vice Speaker*

BOARD OF DIRECTORS

George M. Lange, MD, FACR, *Chair*
Kevin A. Jessen, MD, *Vice Chair*

District 1

Mark E. DeCheck, MD
Barbara A. Hummel, MD
Lowell H. Keppel, MD
Mahendr S. Kochar, MD
Kesavan Kutty, MD
George M. Lange, MD
Edith A. McFadden, MD
David C. Olson, MD
Rosanna Ranieri, MD
Sri V. Vasudevan, MD

District 2

Jay A. Gold, MD, JD
Norman M. Jensen, MD
Susan K. Kinast-Porter, MD
Martha (Molli) Rolli, MD
Tosha B. Wetterneck, MD
Kurt Wilhelm, II, MD

District 3

Eric A. Gundersen, MD
David M. Hoffmann, MD

District 4

Andrew J. Braun, MD
Richard A. Dart, MD
Mary Jo Freeman, MD
William E. Raduege, MD

District 5

Terry L. Hankey, MD
Kevin A. Jessen, MD
Karen L. Meyer, MD

District 6

John W. Hartman, MD
Bruce M. Neal, MD
Jennifer Philbin, MD

District 7

Arne T. Lagus, MD
Daniel R. Sherry, MD

District 8

David M. Saarinen, MD
Medical Schools Section
Yolanda T. Becker, MD

Young Physicians Section

Andrea Hillerud, MD

Resident Fellow Section

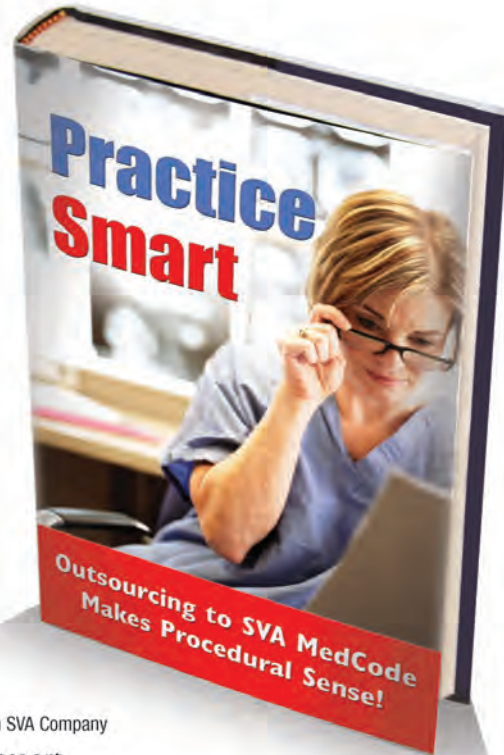
Claudia L. Reardon, MD

Medical Student Section

Matthew W. Buelow,
Medical College of Wisconsin
Amanda Herzog, UW School of
Medicine and Public Health

PRACTICE SMART

Avoid costly billing delays and backlogs created by position vacancies, system conversions, employee leave or seasonal workflow. Get timely, accurate reimbursement for services by outsourcing your medical coding to SVA MedCode Specialists. Our Certified Professional Coders are available for short- or long-term assignments, at your place of service or ours. Contact Catherine Smith, RN, CDMS, CPC at SVA MedCode Specialists, LLC, (800) 279-2616 or visit www.sva.com to learn more.



SVA MEDCODE SPECIALISTS, LLC An SVA Company
 Madison | Milwaukee | Neenah | Rockford | Freeport
 Always here. Always for you. • www.sva.com

2130

Physician Opportunities

available in North Central Wisconsin and Upper Michigan

- | | |
|--|----------------------------|
| Cardiologist | Medical Oncologist |
| Dermatologist | Neurologist |
| Electrophysiologist | Neurosurgeon |
| Emergency Medicine | NPs and PAs |
| Endocrinologist | Ob/Gyn |
| Family Practice—with
and without OB | Orthopaedic Spine Surgeon |
| Gastroenterologist | Orthopaedic Trauma Surgeon |
| General Surgeon | Otolaryngologist |
| Hospitalist | Psychiatrist, Inpatient |
| Internal Medicine | Psychiatrist, Outpatient |
| Med/Peds | Pulmonologist |

Contact Dawn Decker, Physician Recruitment Manager, for further information!
 3000 Westhill Drive, Suite 305, Wausau, WI 54401 • dawnd@aspirus.org
 800-792-8728 • 715-847-2742 fax • www.aspirus.org



Well-rounded.

Join a team of 100 physicians in a growing, integrated 21-multi-specialty clinic and a 162-bed, JCAHO, acute care hospital. We provide quality care to 150,000 people in a 60 mile service region.

OPPORTUNITIES

- Dermatology
- Internal Medicine
- Psychiatry
- Family Medicine
- Med/Hem Oncology
- Pulmonology
- Gastroenterology
- Otolaryngology
- Radiology
- Hospitalist
- Neurology

The Brainerd area in central Minnesota offers lakes, trails, golf courses, an excellent educational system, fine dining, distinct shopping and arts all just minutes from home.

Contact: Nancy Juntunen, 218-454-5800
 or nancy.juntunen@sjmcmn.org

www.sjmcmn.org | www.explorebrainerdlakes.com AA/EOE



Steven C. Bergin, MD

The time is critical

Steven C. Bergin, MD, President, Wisconsin Medical Society

Our patient is arousable but becoming increasingly more incoherent. Cries of despair punctuate the surrounding silence. The periodic facial contortions associated with guttural moans and groans express chronic internal pain. The eyes reveal fear, anxiety, and anguish. The skin is cold and clammy, and the body is limp and flaccid. The blood pressure is slowly dropping, and the pulse is thready and weak. The breathing is shallow and labored.

Yes, our patient's chronic illness for over half a century has taken a turn for the worse. The lack of coordinated care has led to multi-system failure. Incremental managements to date have failed to produce a quality outcome. No immediate prospect for a cure is on the horizon. Unfortunately, our patient's status has been downgraded to *critical*.

I believe this hypothetical patient reflects the current state of our health care system. Amazingly, it has proven to be quite resilient—even in the face of multiple health system failures: coverage, access, cost, and quality.

With the housing and financial markets' collapse and with all economic indicators confirming domestic and global recession, the question arises, "How much time does our health care system

"By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people."

—President Harry S. Truman, in a 1945 speech to Congress

have before it codes and cannot be resuscitated?"

Although the nation's current economic plight has garnered non-stop media coverage, the inextricably linked consequences affecting the health care system and ultimately the health of the nation have been, at best, glossed over. With the continued loss of jobs and employer-based health insurance, the ranks of the uninsured and underinsured have swelled. (In Wisconsin, over 27,000 jobs have been lost.¹) Millions of Americans will go without medical care because they cannot afford it—while others will avoid care because they are mired in medical debt. Incredibly, 20% of the group forgoing care—both insured and uninsured—is comprised of work-

ing-age Americans.² Everyone talks about mortgage foreclosure, but no one is addressing the ever-increasing rate of personal bankruptcy—with unpaid medical bills accounting for about 50% of the total.³

There are many factors responsible for skyrocketing health care costs. For example, unpaid medical bills—free care—translate into physicians and hospitals charging higher fees to cover the lost operating revenue. This cost shifting is like a hidden tax: insurers pass it on to the insured by restricting benefits, increasing deductibles, and raising premiums. The federal government is by no means blameless in this area and must shoulder its fair share of responsibility. And yes, the unrealistically low reimbursement rates to physicians—primary care physicians specifically—

Dr Bergin is an OB/GYN in Stevens Point, Wis and president of the Wisconsin Medical Society.

have contributed to the unintended consequence.

Powerful supply forces that exist in our health care system also contribute to the problem. Physicians and hospitals can create and satisfy demand. Large costs are involved in treating acute events that result from lack of attention in preventing and treating chronic health problems. Pharmaceutical company direct-to-consumer advertising has fueled patient demand and expectations from physicians. But physicians, hospitals, and the pharmaceutical industry should not be held totally accountable. Americans' unrealistic expectations drive the use and overuse of expensive new technologies and treatment even where the application has minimal chance of a successful outcome. We have a society that pretends death is optional.

Following the birth and death of the Clinton Health Security Act, there have been only incremental attempts to deal with health care reform. In short, the measures passed—Health Insurance Portability and Accountability Act, State Children's Health Insurance Program, and the Medicare Modernization Act have lessened the burden for some Americans but haven't come close to solving the vexing issues of cost, access, coverage, and quality. Given there were no new health care initiatives during the last 4 years of the Bush Administration, can we expect the new administration will offer a new direction in an attempt to reform an extremely complex system?

I believe the answer is an unequivocal yes. The pressure is on, as Congressional forces are quietly marshalling support for existing and developing initiatives. Senators Kennedy, Baucus, Wyden, and others are prominent among those looking to broker a political solution.

During the recent campaign, President-elect Obama's underlying theme was "America needs change," and he said that if elected he would be the instrument of that change. On December 11, former Senator/Majority Leader Tom Daschle (D-SD) was announced as the new secretary of the Department of Health and Human Services (DHHS). In the announcement, President-elect Obama said Daschle would not only be responsible for implementing a health care reform plan, but that he would also be the architect of the plan.

This announcement immediately raised several pertinent questions.

1. Does Senator Daschle's appointment as DHHS Secretary truly represent a change in health care reform policy?
2. Will we see a retooling of the failed Clinton Health Security Act?
3. What is Senator Daschle's philosophy now regarding health care reform?
4. Does he hold to the rigid ideology of the past or has he taken a more pragmatic view as to how to effectively pursue meaningful change?
5. What type of framework will he create for the US health system?

Answers to these provocative questions and a definite insight into Senator Daschle's current thinking on the health care reform issue can be found in his recently published book *Critical—What We Can Do About the Health-Care Crisis*.⁴ When the book was released, President-elect Obama said "Senator Daschle brings fresh thinking to this problem," and "his Federal Reserve for Health concept holds great promise for bridging this intellectual chasm and, at long last, giving this nation the health care it deserves."

Senator Daschle's text highlights the current health care crisis and supports his perspective with tragic real-life examples of how the health care system has failed ordinary Americans. He traces the long, arduous history of attempted health care reform and points out mistakes made and lessons learned.

Rather than finger pointing and placing blame, he offers his vision for a reformed health care system and provides a blueprint that includes his key concept of a Federal Health Board (Board). (Daschle, 169-180) He proposes creating a Federal Health Board and charging it with developing the health care system framework, as well as the operational details. Its functions would include the following:

- Set the rules for the expanded Federal Employees Health Benefit Program
- Promote high-value medical care by recommending coverage of drugs and procedures backed by evidence based medicine
- Align incentives with high quality care—ie, pay-for performance based on adherence to evidence-based guidelines
- Play a role in rationalizing our health care infrastructure—ie, resource distribution based on geographical need

The Board would be quasi-governmental—an independent board insulated from political pressure and yet accountable to elected officials and the American people. "This would make it capable of making truly complex decisions inherent in promoting health system performance. It also would give it the flexibility to make tough changes that have eluded Congress in the past." (Daschle, 169)

The Board's Governors would be chosen based on knowledge and expertise in health care and would

be representative of health care stakeholders. Terms would be for 10 years—the President would appoint, and the Senate would confirm. Continuity would be established and conflicts of interest would be minimized.

Enforcement of policies would be outside the purview of the Board, as it would not be created to be a regulatory agency. However, recommendations would have teeth as federal programs would be required to abide by them. In effect, this covers one-third of the American population. The hope is that the Board's recommendations would spill over into the private sector and would be adopted there as well.

The following quotes from Senator Daschle's text support the notion that he is not a partisan ideologue and has embraced a more centrist viewpoint regarding health care reform.

- “We must stay focused on pragmatic solutions such as a Federal Health Board and reject rigid ideology.”(Daschle, 198)
- “I have strong views on what an ideal system would look like. But I'm not willing to sacrifice worthy improvements on the altar of perfection.”²
- “The tortuous history of health care reform in the last century illuminates our current predicament, offering lessons we shouldn't ignore if we want to finally fix our broken system.” (Daschle, 45)

There are undoubtedly many cynics out there who, having read Senator Daschle's book, are not convinced as to what his true intentions may be. But that is the beauty of being a US citizen where we can question, disagree, and participate openly in the forthcoming national debate.

References

1. Boulton G. Health insurance after layoff. Unemployed should seek alternatives to COBRA if young and relatively healthy. *Milwaukee Journal Sentinel*. December 6, 2008. <http://www.jsonline.com/business/35635084.html>. Accessed December 11, 2008.
2. Kaiser Foundation. Medical debt and access to health care. <http://www.kff.org/uninsured/upload/Medicaid-Debt-and-Access-to-Health-Care-Report.pdf>. Accessed December 18, 2008.
3. Lambrew JM, Podesta JD, Shaw TL. Change in challenging times: a plan for extending and improving health coverage. *Health Affairs*. 2005. <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.119v1>. Accessed December 18, 2008.
4. Daschle T, Greenberger SS, Lambrew JM. *Critical—What We Can Do about the Health-Care Crisis*. New York, NY: Thomas Dune Books; 2008.

You can take care of your patients. We'll take care of your practice.

Medical Billing solutions you can rely on.

To have a successful practice takes more than just attending to the health of your patients; it's also managing the health of your business. Beyond simply generating statements, Schenck Health Service Solutions' medical billing team handles all aspects of patient billing, from charge submission to collecting for unpaid services. We'll help your hard work get paid sooner, so you can concentrate on taking care of your patients. To learn more, visit www.schencksolutions.com/medbill or call Tim Welch or Kathy Algiers at 800-236-2246.



schencksolutions.com

Fairview Health Services

Opportunities in Minnesota to fit your life

Fairview seeks family medicine physicians to join us in Minnesota. Whether your focus is work-life balance or participating in clinical quality initiatives, we have an opportunity that is right for you.

- Choose inpatient/outpatient practice or outpatient-only practices.
- Enjoy 4-day workweeks and optional OB.
- Experience exceptional practice support including accessible specialist consultations and onsite lab and radiology.
- Work and live in vibrant and growing communities. We offer urban, suburban and rural practice opportunities to meet your and your families' needs.
- Enjoy an initial income guarantee with productivity component and a fantastic benefit package, including malpractice insurance.

Shape your practice to fit your life as a part of our nationally recognized, patient-centered, evidence-based care team.

Visit fairview.org/physicians to explore our current opportunities, then apply online, call 800-842-6469 or e-mail recruit1@fairview.org.

Sorry, no J1 opportunities.

fairview.org/physicians
TTY 612-672-7300
EEO/AA Employer





Tim Bartholow, MD

Your patients are waiting... for your leadership

Tim Bartholow, MD

Senior Vice President of Member Services,
Policy Planning and Physician Professional Development,
Wisconsin Medical Society

Until October of 2008, I practiced family medicine for 16 years in a semi-rural community. I watched diabetic patients decide between rent, hamburger, or insulin. I took care of a healthy farming couple, both 55 years old, whose insurance cost \$900 per month with a \$15,000 deductible. In the event of an illness, they planned to sell a tractor to cover that deductible. When patients and other citizens sometimes need health care but can't afford it, I—along with other physicians—am indignant that in what is still the richest nation in the world, where we spend 16.3% of our Gross Domestic Product (GDP) on health care, citizens are unable to see their doctor.¹

In November 2008, I joined the staff at the Wisconsin Medical Society because I feel so strongly that reform is needed and physicians need to take part in this reform.

Ultimately, the United States spends more than France, Germany, and others, spend on health care.² The problem isn't that we spend too little, the problem is how we

steward our resources. While many physicians feel agitated by payers (insurance companies) and purchasers (employers) forcing rules on us, as the only ones who can actually practice medicine, we physicians need to ask ourselves how we can provide leadership for reform and improvement.

First, let's look at our practices and examine if we are as efficient as we can be. Various manufacturers have embraced "Lean" production or similar thinking, eliminating waste using methods of continuous improvement. The Lean process identifies what each working team needs to achieve, agrees on "standard work," and then seeks to eliminate wait time and walking time for each worker. These investigations require teams to earnestly and honestly work together, knowing each team member is safe and able to report errors and opportunities. And surely, we physicians would make safe environments by *purposeful example*.

Using Lean, a Toyota executive recalled improving capacity at 1 clinic facility by 41%, while spending 63% more on primary care, 27% less on emergency department care, and 6% less on inpatient hospitalization. In this example, the manufacturer optimized "presenteeism" with a "get it done" expression of the much-touted patient-centered medical home.

Second, let's focus on chronic care. Healthy citizens are the work-

ers who drive our economy, and right now, we need everyone. For those with chronic disease, we need to manage these conditions doggedly or accept the predictable consequence of work loss and more cost. Primary care doctors can see a patient 2-3 times weekly for a year for the same cost to the system of a single hospital admission. Frequent visits to primary care doctors can also help stabilize chronic conditions.

Consider diabetes, an epidemic in Wisconsin and the nation.³ Treatment for diabetes costs 2.3 times more than treatment of the general population.⁴ Also worrisome is that in 2005, 47% of new diabetes cases were in 45 to 59-year-old patients, now the most common age range for onset of diabetes.⁵ If the primary care doctor, their certified diabetic educator, and their nutritionist can see these patients frequently, these health care professionals can leverage the patient's readiness to change and can encourage more stable patient health and reduced costs.

This cooperation can be replicated for other chronic illnesses like asthma, anticoagulation, and congestive heart failure with doctors working in concert with other health care professionals. Patients benefit from ready access to their doctor. Perhaps payers could more fully reward clinics that are willing to be open late or early and who maintain same day appointment

Author Affiliation: Wisconsin Medical Society, Madison, Wis.

Corresponding Author: Tim Bartholow, MD, Senior Vice President of Member Services, Policy Planning and Physician Professional Development, Wisconsin Medical Society, 300 E Lakeside St., Madison, WI 53715; phone 608.442.3800; fax 608.442.3802; e-mail tim.bartholow@wismed.org.

availability, each of which result in avoiding repeated lab work, emergency department, or urgent care. For Medicare seniors and Medicaid recipients with chronic disease, Medicare and Medicaid as payers no longer cover the cost of primary care doctors to deliver that chronic care management—and this calculation is before further predicted cuts. This insufficient payment endangers the social contract we have made with our seniors, a growing cohort with the entry of baby boomers, many of whom struggle with chronic illness.

Third, we must assess our use of technology. Innovation is responsible for two-thirds of health care spending growth. While we value important innovations, many of us can identify some innovations that are not worth their cost.⁶ The “value proposition for the patient” needs to be assessed before a technology is paid for by purchasers.

US Senator Max Baucus, D-MT, introduced legislation for such a “Comparative Effectiveness Institute.”⁷ For each new technology or mandate added to Medicaid, Medicare, or insurance, the price of coverage becomes just a little higher, which means companies or the tax payers are just a little less able to afford it, and a few more people consequently do not have coverage. There are now 47 million of 300 million citizens who do not have insurance, and in the current economic climate we expect this will get worse.⁸ What's more, because doctors can recommend drugs and devices best suited to patients without the assistance of media, why not consider severely limiting direct-to-consumer advertising?

Finally, each individual citizen has a role. If we only eat what we need, eat many colors of vegetables, and minimize “the whites” (bread, rice, potatoes, and pasta), we reduce

our risk of diabetes. Exercise is also important and a delay of diabetes onset is shown for those who will commit as little as 30 minutes of walking 5 times per week.

For school children, including those on free and reduced meal status, we must evaluate and do something about the nutritional message being sent when schools serve French toast sticks with syrup and Pop-Tarts® with icing. How do we suppose these emerging adolescents, with this nutritional imprinting, will nourish themselves as adults?

In yet another individual citizen role, if I am your coworker using company health care, what is my duty to you when health care is so expensive? If I ignore advice to stabilize a chronic condition like diabetes, if I smoke, or if I drink to excess, then the predictable cost of the clinic and hospital care that I need will be reflected in next year's insurance premium to my workplace. So, if I am not responsible with my health, my coworkers will help pay for it. Because health care is a significant amount of the national economy—and of workers' total benefits—these improvements in individual health ultimately help your coworkers as well as the national economy. With health care costing what it does, the problem is no longer separate from other economic issues. And because poor health can jeopardize our nation, exercise and proper diet should now be regarded as our individual *civic duty*.

So that's how this humble country doc sees it. Be efficient, avoid predictable illness of chronic disease by paying for primary care to make it happen, be more selective with innovations, and hold ourselves and our coworkers accountable for a crucial role in staying healthy. Most of this gets back to what our grandmothers once told us. When you look at the big

picture, relaying that message beyond grandma's wing, the nation needs to buy more health and less health care, expecting better outcomes for our significant collective investment.

As physicians, what will our legacy be when we are all gone years from now? Will we have provided for the common good and the security of health care, including the real opportunity to access health care—or not? Will we, as physicians, have only complained about a system too complicated for powerless people like ourselves to have made any lasting change? *Or will we lead—in our practices, our hospitals, our communities, and in our state and national legislative bodies?* Doctors, your public awaits your answer.

References

1. Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2007-2017. <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>. Accessed December 12, 2008.
2. Organisation for Economic Co-operation and Development. OECD in Figures 2008. <http://ocde.p4.siteinternet.com/publications/doifiles/012008061P1T002.xls>. Accessed December 12, 2008.
3. Centers for Disease Control and Prevention. Annual Number (in Thousands) of New Cases of Diagnosed Diabetes Among Adults Aged 18-79 Years, United States, 1980-2005. <http://www.cdc.gov/diabetes/statistics/incidence/fig1.htm>. Accessed December 12, 2008.
4. Centers for Disease Control and Prevention. National Diabetes Fact Sheet, 2007. http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf. Accessed December 12, 2008.
5. Centers for Disease Control and Prevention. Distribution of Age at Diagnosis of Diabetes among Adult Incident Cases Aged 18-79 Years, United States, 2005. <http://www.cdc.gov/diabetes/statistics/age/fig1.htm>. Accessed December 12, 2008.


6. Ginsburg, PB. Robert Wood Johnson Foundation. High and rising health care costs: Demystifying US health care spending. <http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf>. Accessed December 12, 2008.
7. Amendment to title XI of the Social Security Act, S 3408, 110th Cong, 2nd Sess (2008).
8. DeNavas-Walt C, Proctor BD, Smith J. US Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Current Population Reports, P60-233. Washington, DC: US Government Printing Office, 2007.
9. Bernanke, BS. Challenges for Health-Care Reform. Remarks at the Senate Finance Committee Health Reform Summit, Washington, DC, June 16, 2008. <http://finance.senate.gov/healthsummit2008/Statements/Chairman%20Bernanke's%20Remarks.pdf>. Accessed December 12, 2008.

Know a special doctor that goes the extra mile for your community?

Send in your nomination for the **2009 Physician Citizen of the Year Award**

The Physician Citizen of the Year Award is presented annually by the Wisconsin Medical Society to a physician who volunteers time, talents, and expertise to help others through cultural, civic, or charitable efforts and events. Please tell us about a physician you think is worthy of this award. To nominate a physician, visit www.wisconsinmedicalsociety.org/for_patients/physician_of_the_year.

Deadline is January 15, 2009.



Remedy
Medical Services

Comprehensive physician staffing solutions

3587 Gateway Drive, Suite 110
Eau Claire, Wisconsin 54701


Emergency/Primary Care Physicians
Consider employment with us ...

Remedy Medical Services, S.C. is one of the fastest-growing physician-owned companies in Wisconsin. We offer:

- Full or part-time openings
- Hospitalist, ER and clinic
- \$190k minimum annual FT salary
- Malpractice and tail paid
- Average 6-10 shifts per month FT
- ACLS/ATLS required

To learn more, or start the application process, give us a call or visit us online.

888-732-6409
www.remedymedicalservices.com
E-mail: fedelem@remedymedicalservices.com



Alexandria Clinic, P.A.

Employment Opportunities:
ENT • Dermatology
Family Practice • Hospitalist • Urology

The Alexandria Clinic, P.A. is an independent, physician-owned, multi-specialty group practice. We are located two hours west of the Twin Cities on I-94 in the heart of the Central Lakes. Alexandria offers year-round recreation for the whole family!

We are home to a service area approaching 100,000 people and over 1,000 growing businesses. We're easy to get to and hard to leave!

Attractive compensation and benefits package with shareholder and partnership opportunities.

For more information, please contact:
Alexandria Clinic, P.A.
Attn: Tim Hunt, Administrator
610 30th Avenue West, Alexandria, MN 56308
Phone: 320.763.2540 Fax: 320.763.5749
E-mail: thunt@alexclinic.com
Visit our Web site at www.alexclinic.com

The ailing health care system: SOAP note for physician leadership

Donna Friedsam, MPH; Richard Rieselbach, MD, MACP

Health care reform. The oft-used phrase has launched endless political debates and stimulated volumes of literature. Yet physicians, immersed and busy in the daily provision of care for their patients, often remain on the periphery of the health care reform dialogue. Now, timing and recent research in Wisconsin and elsewhere demand that physicians take time to visit with the current ailing patient—our health care delivery system.

Subjective—Objective

Here's what we know: as much as 40% of system costs are attributable to poor quality—overuse, underuse, misuse, duplication, inefficiency, or poor communication.¹ Preventable medical errors result in as many as 98,000 US hospital deaths each year.² In Wisconsin, about half a million residents still lack health insurance coverage,³ and costs continue to substantially outpace overall economic growth and the growth in real wages. The state and nation face a shortage⁴ and a maldistribution⁵⁻⁶ of primary care

physicians, and this imbalance continues to grow as medical students increasingly choose other specialties over primary care.⁸

Only about half of US adults receive recommended preventive and chronic care.⁹ Medical practice shows unwarranted variation in cost, supply, and volume, while higher spending does not produce better quality, access, survival rates, or health outcomes.¹⁰⁻¹¹ Meanwhile, half of the US population spends little or nothing on health care, while 5% of the population spends almost half of the total amount, and 20% of users account for 80% of costs, generally for serious chronic and acute conditions.¹²⁻¹³

Cost, access, and quality are inter-dependent; 3 legs of the stool that requires balance. Lack of insurance coverage results in uncompensated care, delayed care, and inappropriate entry points, all of which contribute to higher costs and higher prices. System fragmentation underlies the poor overall performance in quality and cost: patients navigate across multiple providers and care settings, with poor communication and lack of clear accountability. Payment systems reward high-cost, intensive medical intervention over often-higher-value primary care, including preventive services and the management of chronic illness. Providers grapple further with inadequate payment from Medicare and Medicaid, along with costs for underinsured and uninsured

patients, shifting these costs onto commercial insurance.

Assessment

Health care experts and opinion leaders,¹⁴ along with a range of national expert, industry, and advocacy panels, have endorsed several goals:

- **Universal Insurance**—This may be achieved in various ways through employer-based, other market, and government mechanisms.
- **Payment Reform**—Reform by bundling of services, episodes of care, and pay-for-performance incentives.
- **Measurement and Reporting**—Reporting based on benchmarks, standard for price, and quality.
- **Patient Centered Medical Homes**—Homes to provide round-the-clock, accessible, and coordinated care; preventive, primary, and specialty care with focused disease management.

The US Department of Health and Human Services (DHHS) is currently promoting reforms based on its Four Cornerstones¹⁵ for health care improvement:

- **Interoperable Health Information Technology**
 - **Measure and Publish Quality Information**
 - **Measure and Publish Price Information**
 - **Promote Quality and Efficiency of Care with Payment Incentives**
- Significant change will require legislative and regulatory action to support broad-based payment

Author Affiliations: Population Health Institute, University of Wisconsin School of Medicine and Public Health, Madison, Wis (Friedsam); Department of Medicine, University of Wisconsin School of Medicine and Public Health, Madison, Wis (Rieselbach).

Corresponding Author: Richard Rieselbach, University of Wisconsin School of Medicine and Public Health, 760 WARF Building, 610 Walnut St, Madison, WI 53726; phone 608.263.4881; fax 608.262.6404; e-mail rer@medicine.wisc.edu.

reform, achieve coverage and access goals, and promote standards for data collection and reporting across providers and systems. The public and private sectors, while awaiting such legislative action, are moving forward with health system transformation through local initiatives.

The Wisconsin Department of Health Services (DHS), through its Medicaid program, and the Department of Employee Trust Funds, through the state employee health plan, are testing a range of quality and cost-containment innovations intended for application in the wider market. These include advancement of electronic health records, collection and public reporting of quality and cost data, pay-for-performance, and provider/plan tiering mechanisms.

Several Wisconsin groups are advancing the agenda of quality and value-purchasing. These include the nationally recognized¹⁶ Wisconsin Collaborative on Healthcare Quality, the emerging Wisconsin Health Information Organization, and the Wisconsin Hospital Association's Checkpoint and PricePoint initiatives. These efforts, together with the Wisconsin Medical Society and MetaStar, have been designated by DHHS Secretary Mike Leavitt as the nation's second Chartered Value Exchange.¹⁷

Governor Doyle's broader health care reform strategy relies on coverage expansions through BadgerCare, with potential purchasing reforms through his BadgerChoice proposal. BadgerChoice is a virtual purchasing pool designed to make insurance more affordable for the nearly 800,000 Wisconsin residents insured through small businesses. It is intended to allow employees to choose from several private plans, priced within a new community rating system, giving employ-

ees the opportunity to apply their employer's contribution toward the coverage they select.

As well, the BadgerCare Plus program, through expanding coverage to childless adults, will have latitude not otherwise available in Medicaid and State Children's Health Insurance Program (SCHIP) entitlement programs, to begin experimenting with value-based insurance design (VBID). VBID tailors the benefit package and copays to the evidence base of specific services for targeted groups, targeted interventions, or individual patients, measuring value by clinical and economic benefit. Such an enterprise will rely on the data from mandatory health needs assessment and health risk appraisals, as well as regularly submitted claims and utilization data.

Plan—What's the Right Course of Treatment?

Despite these significant efforts, a broad range of perspectives remain on how to shape reform, and a lack of consensus remains on how to achieve the overall goals. This is particularly true with regard to mechanisms for reducing the numbers of uninsured and for controlling costs and prices.

Numerous studies report opinions on health care reform among the public¹⁸⁻¹⁹ and across health care-related professional sectors.²⁰ The Commonwealth Fund recently reported the results of a national survey, finding that 82% of Americans think US health care should be fundamentally changed or completely rebuilt.²¹

Yet opinions vary about the role of government. A majority (56%) of registered voters say the main goal of efforts to reform the health care system should be to make sure everyone is covered by health insur-

ance, compared with 41% who say the main goal should be to make insurance more available and affordable in the private marketplace, even if some people remain uninsured.

Even where the goals may be shared, opinions vary about the specifics. The Kaiser poll reports that nearly 6 in 10 (59%) voters say that the costs of sick and healthy people alike should be shared over an entire group within an insurance pool, while about one-third (32%) say that healthier people should not be asked to pay more to subsidize sicker people.²²

A 2005 survey of US health care experts—representing academia, health care industry, business, insurance, government, labor, and consumer advocacy—found that a majority support policies to build on Medicaid to achieve coverage goals.²⁰ At the same time, only slightly more than half felt that Medicaid and SCHIP had been successful in meeting their overall goals. And only 39% of business-sector respondents reported believing these programs have been successful.

The Towers Perrin 2008 Employer Survey reports similar perspective from among the 500 corporate leaders responding; 71% favor retaining the employment-based system for pre-Medicare coverage, while 84% oppose an exclusively government-based health care system.²³ These survey responses also demonstrate a lack of consensus around the impact of the current health system on the competitiveness of US businesses, with many respondents valuing the current system of voluntary employment-based health coverage.

The literature also reports disparate opinions among physicians.²⁴⁻³¹ Physicians report increasing disgruntlement with the health

care system.³² Since 2001, surveys have found more than 70% of physicians believe that fundamental changes are needed in the US health care system.²⁴

The Wisconsin Medical Society recently fielded a survey of Wisconsin physicians to measure their attitudes and opinions across a range of major health care reform elements. The clear message is ambiguity: Wisconsin physicians have a wide range of preferences, with few points of consensus on direction for reform in health care financing and delivery (A. Getzen; K. Knox; R. Rieselbach, MD, MACP; A. Bergum, MPA; D. Friedsam, MPH; unpublished data, 2008).

How, then, can Wisconsin physicians best care for the ailing patient? Today's best practice for patient care has a new essential element: physician leadership to assure that health care reform best serves our patients. Such leadership will require a more unified physician voice in advocating for appropriate health care reform. It's time to gather with physician colleagues, review the facts of the case, agree on the solutions we need to attain, and forge a consensus on the treatment plan to get there.

References

1. Lawrence D. Bridging the Quality Chasm. *Institute of Medicine, Building a Better Delivery System*. Washington, DC: National Academy Press; 2005: 99-101.
2. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Institute of Medicine. Washington, DC: National Academy Press; 2000.
3. Wisconsin Department of Health and Family Services. Wisconsin health insurance coverage, 2006. <http://dhs.wisconsin.gov/stats/pdf/fhs06ins.pdf>. Accessed December 12, 2008.
4. Council on Graduate Medical Education. Physician Workforce Policy Guidelines for the United States, 2000-2020. Sixteenth Report. 2005.
5. US Government Accounting Office. Physician supply increased in metropolitan and nonmetropolitan areas but geographic disparities persisted. GAO-04-124, October 2003. <http://www.gao.gov/new.items/d04124.pdf>. Accessed December 12, 2008.
6. Goodman DC, Fisher ES. Physician workforce crisis? wrong diagnosis, wrong prescription. *N Engl J Med*. 2008;358:1658.
7. University of Wisconsin School of Medicine and Public Health. Medical Student Post-Graduate plans, 2003-2008. 2008.
8. Medical College of Wisconsin. Medical Student Post-Graduate Plans, 2004-2008. 2008.
9. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348:2635-2645.
10. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. part 1: the content, quality, and accessibility of care. *Ann Intern Med*. 2003;138:273-287.
11. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. part 2: health outcomes and satisfaction with care. *Ann Intern Med*. 2003;138:288-298.
12. Stanton MW, Rutherford MK. The High Concentration of US Health Care Expenditures. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 19. AHRQ Pub. No. 06-0060.
13. Conwell LJ, Cohen JW. Characteristics of people with high medical expenses in the US civilian noninstitutionalized population, 2002. Statistical Brief #73. March 2005. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st73/stat73.pdf. Accessed December 12, 2008.
14. Shea KK, Shih A, Davis K. *Commonwealth Fund Commission on a High Performance Health System. Data Brief: Health Care Opinion Leaders' Views on Health Care Delivery System Reform*. New York: The Commonwealth Fund; April 2008.
15. HHS.gov, Value-Driven Health Care. <http://www.dhhs.gov/valuedriven/fourcornerstones/index.html>. Accessed December 12, 2008.
16. Greer AL. *Embracing Accountability: Physician Leadership, Public Reporting, and Teamwork in the Wisconsin Collaborative for Healthcare Quality*. New York: The Commonwealth Fund; June 2008.
17. HHS secretary awards health leaders with special distinction for improving quality and value of health care [news release]. February 1, 2008. <http://www.hhs.gov/news/press/2008pres/02/20080201a.html>. Accessed December 12, 2008.
18. Schoen C, How SKH, Weinbaum I, Craig Jr JE, Davis K. *Public Views on Shaping the Future of the US Health System*. New York: The Commonwealth Fund; August 2006.
19. Robert SA, Booske BC, Rigby E, Rohan AM. Public views on determinants of health, interventions to improve health, and priorities for government. *WMJ*. 2008;107(3):124-130.
20. The Commonwealth Fund. health care opinion leaders: Medicaid should be improved and expanded to cover more low-income Americans. 2005. http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=303134. Accessed December 12, 2008.
21. How SKH, Shih A, Lau J, Schoen C. *Public Views on US Health System Organization: A Call for New Directions*. New York: The Commonwealth Fund; August 2008.

Call for Reviewers

22. Kaiser Health Tracking Poll, Issue 8, June 2008. <http://www.kff.org/kaiserpolls/upload/7784.pdf>. Accessed December 12, 2008.
23. Towers Perrin. Employer health care cost survey. 2008. http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2008/200801/hccs_2008.pdf. Accessed December 12, 2008.
24. Blendon RJ, Schoen C, Donelan K, et al. Physicians' views on quality of care: a five-country comparison. *Health Aff.* 2001;20:233-243.
25. Carroll AE, Ackerman RT. Support for national health insurance among US physicians: 5 years later. *Ann Intern Med.* 2008;148:566-567.
26. McCormick D, Himmelstein DU, Woolhandler S, Bor DH. Single-payer national health insurance. physicians' views. *Arch Intern Med.* 2004;164:300-304.
27. Ackermann RT, Carroll AE. Support for national health insurance among US physicians: a national survey. *Ann Intern Med.* 2003;139:795-801.
28. Shearer S, Toedt M. Family physicians' observations of their practice, well being, and health care in the United States. *J Fam Pract.* 2001;50:751-756.
29. Foster HW, Ling WY, Werner EM, Osterweis M. Women medical students tend to favor health care reform. *Minority Health Today.* July 2000.
30. Physicians' Congress for Health Care Reform. Colorado physicians' congress health systems reform matrix questionnaire results briefing paper. 2007.
31. Savage S, Sobelson G, Smith B, Jones P, Monahan J. Opinions of New Hampshire doctors contrast with presidential candidate plans for healthcare reform. December 2007. http://www.nhms.org/topics/12-14-2007_a.pdf. Accessed December 12, 2008.
32. Taylor H, Leitman R. Attitudes toward the United States' health care system: long-term trends. *Health Care News.* 2002;2:1.

The *Wisconsin Medical Journal* is seeking reviewers to add to our list of highly qualified reviewers for manuscripts. We need contributions from reviewers who can be objective, insightful, and respond in a timely manner. Manuscript review is an important collegial act and is essential to the integrity of the *Journal*.

Reviewers receive manuscripts electronically and are asked to review and return the manuscript with comments within 4 weeks. All reviews can be returned on-line.

Interested physicians should e-mail wmj@wismed.org with their name, e-mail address, speciality, at least 3 areas of expertise or interest, their current and previous practice location, and how often in 12 months they would be willing to serve as reviewers.

Is there a doctor in the ‘home’?

Jeff Grossman, MD

Because of my job, I’m frequently asked by friends and colleagues to recommend a physician. Without much trouble, I can name an exceptional doctor in any one of more than a hundred sub-specialties, depending on the problem at hand. But ask me to find a general internist or family physician, and I’ve got a problem. Our large, multi-specialty group has a shortage of these doctors, most of whose practices do not accept new patients.

Yet primary care physicians are central to solving the quality, cost, and access problems creating a “crisis” in American health care. General internists, general pediatricians and family physicians provide preventive care, diagnosis and therapy for many of the acute and chronic illnesses that affect us. They also provide a “medical home”, a place for care, comfort, and counsel over the course of our lives. These are the people we call our personal physicians, on whom we rely, especially as we age, for integration of our care in an increasingly complex health care system.

It is alarming that fewer medical students and young physicians are choosing careers as primary care physicians, since they are cru-

cial to building and maintaining the “medical home.” Shortages are predicted in internal medicine and family medicine; a recent report in *Health Affairs* estimated that by 2025 there will be a 29% increase in workload compared with a 2% increase in the workforce. For those of us who try to recruit and retain these physicians, predictions are unnecessary; today’s reality tells the story.

Steven Schroeder, MD, of the

much lower incomes than their subspecialty colleagues, but no less school debt. To deliver excellent care, they must provide many services for which there is no reimbursement, while facing an increasing amount of administrative work that detracts from patient care. They often deal with an aging population with increasingly chronic and complex diseases and bear most of the burden for the implementation of electronic health records. With

We need to make dramatic investments to create health care organizations that support a real “medical home” under whose roof our citizens can find the efficient, effective, timely, equitable, safe, and patient-centered care called for by the Institute of Medicine.

Robert Wood Johnson Foundation, was prescient when he wrote in the *New England Journal of Medicine* 15 years ago: “Strangely neglected in the current debate over reform is any acknowledgment that a major cause of both these problems [sic, cost and access] is the uniquely skewed distribution of our physician work force among specialties.” At that time, he noted the decreasing popularity of generalist careers, and contrasted our relative paucity of generalists with their greater abundance in Europe.

The shortage has several causes. Primary care physicians often have

the same training, they can choose hospital-based inpatient care over an ambulatory practice and enjoy a more controlled work schedule and better compensation. Finally, they will probably tell you they feel undervalued by the public and their subspecialty colleagues.

While the media and professional journals are full of descriptions of the primary care “problem,” primary care physicians are voting with their feet, and health care organizations have an immediate dilemma that profoundly affects our ability to care for our patients.

What is the answer? Most of us

Author Affiliation: Department of Pulmonary and Critical Care Medicine, UW Health, Madison, Wis.

Corresponding Author: Jeff Grossman, MD, 600 Highland Ave, Madison, WI 53792-0001; phone 608.263.7203; e-mail je.grossman@hosp.wis.edu.

think we cannot effectively address this national problem on a local basis. The federal government and large payers must take the initiative to change payment mechanisms for primary care. Several public and private agencies are now supporting experiments to reward the practice of primary care. Such trials are worthy precursors of evidence-based policy and action, but are they enough to create the change that is needed?

I think not. The pipeline to a physician career begins in the first year of medical school (or even earlier) and ends 7 or 8 years later. That's a long time to wait for a renaissance of primary care. Moreover, a renaissance is not apt to occur in response to a bit of tinkering here and there with the current reimbursement system. We need change far more substantive

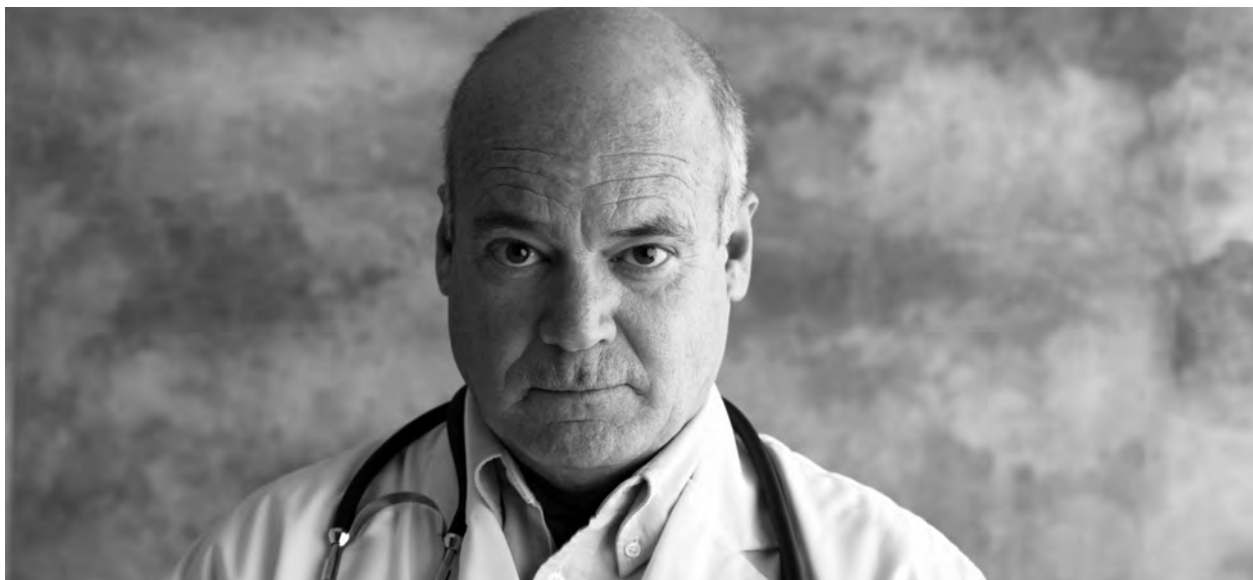
and rapid, and better reimbursement is only part of the answer. We need to make dramatic investments to create health care organizations that support a real "medical home" under whose roof our citizens can find the efficient, effective, timely, equitable, safe, and patient-centered care called for by the Institute of Medicine. Having so well defined the goals, we must now create the environment in which they can be realized.

Many people of great intelligence and good will are focused on this problem, but action has been scarce. We are now standing on a "burning platform" in primary care. Perhaps ironically, this sense of urgency to make things right for patients and physicians leaves me more optimistic than I've ever been that out of the current "crisis," we will create a better system of care.

ERRATUM

The article "Medicaid win in Congress shows power of physician voice," (*WMJ*. 2008;107[5]:265) by Sridhar Vasudevan, MD, was incorrectly titled. It should have been titled "Medicare win in Congress shows power of physician voice."

The on-line version of this article has been corrected. *Journal* staff apologize for the error.



"Talking to smokers...I don't have the time."

When you make the time to talk to your patients about smoking, you save lives. **Help them stop.**

University of Wisconsin Center for Tobacco Research and Intervention

www.ctri.wisc.edu

Short Report: Factors that Affect Specialty Choice and Career Plans of Wisconsin's Medical Students

Kjersti E. Knox, BA; Anne Getzin, BA; Alison Bergum, MPA; Patrick McBride, MD, MPH; Richard Rieselbach, MD, MACP; Donna Friedsam, MPH

ABSTRACT

Objective: To identify factors that influence specialty choice among Wisconsin medical students and provide insight into approaches to encourage more students to pursue careers in primary care.

Methods: The importance of several factors in medical student career choice was surveyed using a Web survey convenience sample of all Wisconsin medical students. Students intending to pursue a career in primary care and in other specialties were compared.

Results: Respondents, regardless of specialty choice or gender, identified a similar group of factors as highly influential, and similar group of factors as non-influential in their decision-making. However, significantly more primary care students than other specialty students considered interest in underserved populations, relationships with patients, scope of practice, and role models important in their career choice. Significantly more primary care students than other specialty students responded that salary and competitiveness were "not at all" important. A greater number of other specialty students than primary care students stated that interest in scope of practice, role models, and training years were "not at all" important. Debt-related factors were reported as "not at all" important by nearly one-third of respondents.

Conclusions: Although primary care and other specialty students report making their career plans based on the impact of similar factors, significant differences between primary care and other specialty students were reported in key areas. These results validate many previously reported

factors, and indicate that salary and years of training may have been overemphasized in understanding student career choice. The results of this survey may be useful for Wisconsin medical schools in order to sustain, support, and foster student interest in primary care.

INTRODUCTION

Current trends, including potential expansions in health insurance coverage and the aging population, are fueling decades-long concerns about a physician shortage in the United States. A shortage of primary care physicians further limits access to care, a growing problem as some states expand insurance coverage.¹ In 2005, the Council on Graduate Medical Education anticipated a shortage of 85,000-96,000 physicians by 2020.² Others argue against a need to increase the overall physician supply, instead calling for proportionately more primary care physicians relative to other specialists and better geographic distribution of primary care physicians.³

The number of United States medical students applying to family medicine residencies decreased 42% from 1996 to 2002.⁴ University of Wisconsin School of Medicine and Public Health statistics show a 14% decline in graduates matching into family medicine, internal medicine, and pediatrics, and a 36% decline in family medicine alone between 2003 and 2008.⁵ While overall match rates in primary care for the Medical College of Wisconsin have remained steady, match rates into family medicine declined 49% between 2004 and 2008.⁶

Wisconsin's 2 medical schools, despite acknowledging these concerns and conducting programs to promote primary care choices, currently produce a workforce that does not meet Wisconsin's health care needs, and will be less able to do so under current trends.⁷

This survey measures factors that influence specialty choice among a convenience sample of Wisconsin medical students. Findings provide insights for approaches to encourage more students to pursue careers in primary care.

Author Affiliations: University of Wisconsin School of Medicine and Public Health, Madison, Wis (Knox, Getzin, McBride, Rieselbach); University of Wisconsin School of Medicine and Public Health, UW Population Health Institute, Madison, Wis (Bergum, Friedsam); Wisconsin Medical Society (Rieselbach).

Corresponding Author: Kjersti E. Knox, BA, University of Wisconsin School of Medicine and Public Health, 760 WARF Building, 610 Walnut St, Madison, WI 53726; phone 608.263.4881; fax 608.262.6404; e-mail knox2@wisc.edu.

METHODS

All Wisconsin medical students with active e-mail addresses—those attending the University of Wisconsin School of Medicine and Public Health or the Medical College of Wisconsin—were invited to participate in a survey by the Associate Deans of Student Affairs at each school and were sent 2 e-mail reminders. Students were able to access the survey via a secure Web link embedded in the e-mail text. Replies were anonymous. The survey, hosted by the University of Wisconsin Survey Center, was available from May 12 to June 2, 2008. The response rate was 21% (304/1480) (respondents completed at least 1 question). The University of Wisconsin School of Medicine and Public Health Institutional Review Board approved this survey.

Surveys queried students on their intent to pursue a career in a primary care specialty, factors influencing their career plans, interest in health care reform, and basic demographic information (gender and age). For the purposes of this project, primary care specialties include family medicine, general internal medicine, and general pediatrics. Respondents rated their opinions on factors affecting career choice using a 5-point Likert scale with options ranging from “not at all” to “extremely.” Each question also provided an opt-out answer of “don’t know.” Students rated factors that literature has previously identified as influential in specialty choice: interest in working with underserved populations or in underserved communities, relationship with patients, research opportunities, breadth or scope of practice, salary or pay scale, experiences with physician role models, competitiveness, feedback or attitudes of physician instructors, schedule or workload, prestige, location of available jobs, and years required for training.

Data analysis was performed with SPSS statistical software version 16.0. The analysis focused on understanding the differences between students who report knowing or having chosen their planned specialty and those who do not yet know. Specialty choice (primary care versus other specialty) and the corresponding influencing factors were compared and analyzed by gender and age. Statistical significance of differences between groups was measured using chi-squared and Fisher’s exact tests with $P \leq .05$ considered significant.

RESULTS

Students who reported knowing what specialty they plan to pursue represented 61% ($n=184$) of all student respondents ($n=304$). Relatively more of these students were older respondents (74% of ≥ 26 year olds compared to 47% of < 26 year olds) with nearly identical rates of males and females. Students who plan to pursue a career

in a primary care specialty constituted 41% of all students who identified a specialty choice. Approximately two-thirds of respondents selecting primary care were female (66%).

Respondents identified similar factors as highly influential in their decision-making regardless of specialty choice or gender (Table 1). The 5 factors most frequently considered “extremely” or “quite” important did not differ among age groups (< 26 years old compared with > 26). Prestige is the only factor that was rated significantly different among different age groups; more younger students (21%) rated prestige as “extremely” or “quite” important than older students (6%, $P < .01$). Significantly more females than males rated interest in underserved ($P < .01$) and relationship with patients ($P < .05$) as “extremely” or “quite” important. A larger portion of male respondents rated salary ($P < .01$) and competitiveness ($P < .05$) as “extremely” or “quite” important.

Significantly more primary care students considered interest in underserved ($P < .01$), relationships with patients ($P < .01$), scope of practice ($P < .01$), and role models ($P < .05$) to be “extremely” or “quite” important in their career choice than other specialty students. Significantly more other specialty students than primary care students considered research ($P < .01$), salary ($P < .01$), and competitiveness ($P < .05$) “extremely” or “quite” important (Table 2). Upon limiting analysis to only “extremely” important responses, significant differences were also seen in the number of students who considered relationships with patients ($P < .01$), interest in underserved ($P < .01$), workload schedule ($P < .05$), and job location ($P < .05$) “extremely” important.

Upon controlling for gender, male and female respondents showed similar significance levels for each of the variables. However, primary care males reported significantly more influence of role models and significantly less influence of competitiveness than other specialty males ($P < .05$) whereas no such difference was observed between primary and other specialty females. Furthermore, primary care females reported significantly more influence of job location than other specialty females ($P < .05$) whereas no such difference was observed between primary and other specialty males. The influence of instructor attitudes did not differ significantly across any of the demographic categories.

Differences between primary care and other specialty student opinions were driven by the extremes (“extremely” or “not at all”) as well as the spectrum of student opinion for many factors. Primary care students were significantly more likely to consider interest in underserved “extremely” important than other specialty students, whereas other specialty students were signifi-

Table 1. The 5 Leading Factors Most Frequently Rated “Extremely” or “Quite” Important in Interest or Choice of Medical Specialty Among Students Who Report Knowing What Specialty They Plan to Pursue

Factors	Specialty		Gender	
	Primary Care Specialties	Other Specialties	Female	Male
Relationship with patients	1	2	1	2
Breadth or scope of practice	2	1	2	1
Experiences with physician role models	3	3	3	3
Feedback or attitudes of physician instructors	5	4	4	4
Interest in working with underserved populations or in underserved communities	4	—	5	—
Schedule or workload	—	5	—	5

Note: n=178 surveyed for specialty, n=184 surveyed for gender.

Table 2. Factors Rated “Extremely” or “Quite” Important in Interest or Choice of Medical Specialty Among Students Who Report Knowing What Specialty They Plan to Pursue: Comparing Students Pursuing Primary Care and Other Specialties

Factors	Primary Care	Other Specialties	Significance
Interest in working with underserved populations or in underserved communities	66%	28%	*
Relationship with patients	97%	61%	*
Research opportunities	6%	27%	+ a
Breadth or scope of practice	90%	71%	*
Salary or pay scale	4%	22%	+ a
Experiences with physician role models	74%	59%	**
Competitiveness	10%	23%	**
Feedback or attitudes of physician instructors	62%	50%	
Schedule or workload	37%	47%	
Prestige	7%	16%	
Location of available jobs	34%	28%	
Years required for training	19%	13%	

Note: n=178, with n=73 for primary care and n=105 for other specialties.

* $P \leq .01$

** $P \leq .05$

^a P calculated using Fisher’s exact test; all other P values were calculated using Chi-squared test.

cantly more likely to consider interest in underserved “not at all” important (Figure 1). Four out of 5 primary care students also reported relationships with patients as “extremely” important, whereas other specialty student opinion was more evenly distributed among the 5 response options (Figure 2).

Respondents identified similar non-influential factors in their decision-making regardless of specialty choice or gender (Table 3). Significantly more primary care students than other specialty students responded that salary (44% versus 21%, $P < .01$) and competitiveness (51% versus 35%, $P < .05$) were “not at all” important. However, a greater number of other specialty students than primary care students stated that interest in scope of practice (7% versus 0%, $P < .05$), role models (10% versus 0%, $P < .01$), and training years (39% versus 22%, $P < .01$) was “not at all” important.

DISCUSSION

Although primary care and other specialty students

report making their career plans based on the impact of similar factors (relationship with patients, breadth or scope of practice, experiences with physician role models, and feedback or attitudes of physician instructors), significant differences between primary care and other specialty students were reported in some key areas. Significantly more students who plan to pursue primary care careers than students who plan to pursue careers in other specialties reported an interest in working with underserved populations or in underserved communities. Examining results showed that the results of this survey were not greatly biased by gender.

Other studies have identified controllable lifestyle, breadth of knowledge, role models, desire to provide comprehensive care, patient contact, perceived levels of prestige and intellectual content, concerns about mastery of a broad content area, and interest in diverse patients as influential factors in students’ decisions to

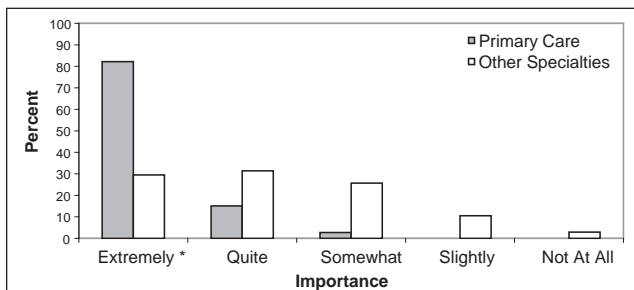


Figure 1. Interest in underserved rated by importance in choice of medical specialty among students who report knowing what specialty they plan to pursue, comparing students pursuing primary care and other specialties.

* $P < .01$

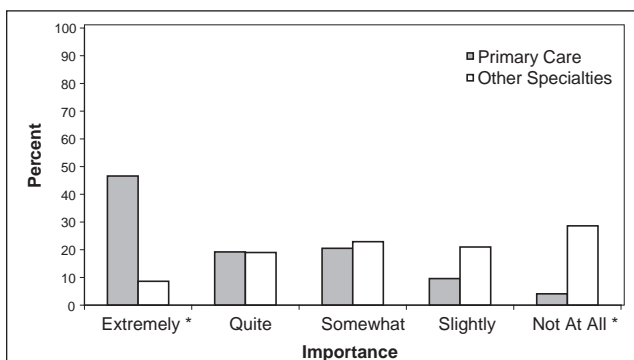


Figure 2. Relationship with patients rated by importance in choice of medical specialty among students who report knowing what specialty they plan to pursue, comparing students pursuing primary care and other specialties.

* $P < .01$

pursue primary care.⁸⁻¹⁴ The literature, however, shows mixed results on the degree to which debt influences student career choice.¹⁵⁻¹⁸ Although this survey did not inquire directly about debt concerns, a large number of respondents report that debt-related factors are “not at all” important (30% said salary and pay scale “not” important; 32% said years required for training “not at all” important). From this, it appears that salary and years of training may be overemphasized in importance in student career choice. In contrast, experiences with role models were identified as “extremely” or “quite” important for students across the board, regardless of age, gender, or career choice in this survey, emphasizing the importance of the roles of physician mentors and instructors in influencing student career plans.

This Web survey has important limitations. The response rate of this convenience sample was 21% (304/1480) and may be due to the timing of the survey, which was open during final examinations, graduation, and for 2 weeks after finals. Survey respondents disproportionately represented the University of Wisconsin (UW), which may have been due to the survey being

sent by students at UW and therefore more knowledge of the survey on the campus. The low response rate (~10%) at the Medical College of Wisconsin (MCW) did not yield enough data from MCW students to make strong statistical comparisons between the 2 schools. In addition, the year of the student’s education was not obtained, making it unclear whether the results were weighted toward a certain stage of academic or professional development. The views of non-responders therefore may not be similar to respondents or generalizable to all United States medical students. Definitions of terms found in the survey were not provided and may have been subject to varying interpretation among respondents. Previously published literature on factors that affect medical student career choice has identified “controllable lifestyle” as a major factor influencing students’ plans, but this was not a construct directly probed in this survey.

Previous studies have shown that medical students often have an initial interest in primary care and working with the underserved, but these interests decline during their medical education.¹⁹⁻²⁰ Some medical schools promote international health electives and longitudinal, intensive experiences with underserved communities as effective strategies for maintaining and cultivating student interest in primary care and underserved populations.²⁰⁻²³ The current survey’s results support this notion, with 47% of students planning a career in primary care identifying working with the underserved as “extremely” important in their career choice.

A lot has been written about the need to reallocate Medicare’s graduate medical education support toward primary care residencies. Beyond this, the Institute of Medicine’s 1996 warning appears to hold true: “unless medical students and residents encounter enthusiastic role models, mentors, and teaching methods that support prerequisite skills ... market driven changes are likely to be short-lived and may eventually give rise to dissatisfied and demoralized physicians who resent not being able to practice medicine as they choose or were trained.”²⁴ Indeed, 10 years later, survey results showed that primary care residents had significantly lower levels of satisfaction with career choice, lower feelings of competence and excitement, and higher levels of inferiority and fatigue compared to other specialty residents.²⁵

Wisconsin’s medical schools need to nurture interest in primary care disciplines among medical students to meet the expanding needs among Wisconsin’s residents and its health care system. The results of this survey indicate working with the underserved, relationships with patients, mentoring, and the scope of practice may

Table 3. The 5 Leading Factors Most Frequently Rated “Not At All” Important in Interest or Choice of Medical Specialty Among Students Who Report Knowing What Specialty They Plan to Pursue

Factors	Primary Care Specialties	Other Specialties	Female	Male
Research opportunities	1	1	1	1
Competitiveness	2	4	4	2
Salary or pay scale	3	—	—	4
Prestige	3	3	3	3
Location of available jobs	5	5	5	—
Years required for training	—	2	2	5

Note: n=178 surveyed for specialty, n=184 surveyed for gender.

be important to students planning careers in primary care, while research, competitiveness, pay, prestige, and location of jobs may be less influential for these students. These data may be useful for Wisconsin medical schools in order to sustain, support, and foster student interest in primary care.

Acknowledgments/Funding/Support: The authors acknowledge Ceri Jenkins, Chad Kniss and Lindsay Griffin for their help with this survey, the Medical College of Wisconsin Office of Student Affairs for provision of data, and the University of Wisconsin School of Medicine and Public Health, Wisconsin Medical Society, and Wisconsin Chapter of American College of Physicians for financial support.

Financial Disclosures: Shapiro Grant.

REFERENCES

- Steinbrook R. Health care reform in Massachusetts—expanding coverage, escalating costs. *N Engl J Med.* 2008;358:2757-2760.
- Council on Graduate Medical Education. *Physician Workforce Policy Guidelines for the United States, 2000-2020.* Sixteenth Report. 2005.
- Goodman DC, Fisher ES. Physician workforce crisis? wrong diagnosis, wrong prescription. *N Engl J Med.* 2008;358:1658.
- Dorsey ER, Jarjoura D, Rutecki GW. Influence of controllable lifestyle on recent trends in specialty choice by US medical students. *JAMA.* 2003;290:1173-1178.
- University of Wisconsin School of Medicine and Public Health. Medical Student Post-Graduate Plans, 2003-2008. 2008.
- Medical College of Wisconsin. Medical Student Post-Graduate Plans, 2004-2008. 2008.
- Wisconsin Hospital Association. *Wisconsin's Health Care Workforce Report 2008.* 2008.
- Rosenthal MP, Diamond JJ, Rabinowitz HK, et al. Influence of income, hours worked, and loan repayment on medical students' decision to pursue a primary care career. *JAMA.* 1994;271:914-917.
- Mutha S, Takayama JI, O'Neil EH. Insights into medical students' career choices based on third- and fourth-year students' focus-group discussions. *Acad Med.* 1997;72:635-640.
- Kassebaum DG, Szenas PL. Factors influencing the specialty choices of 1993 medical school graduates. *Acad Med.* 1994;69:163-170.
- Osborn EH. Factors influencing students' choices of primary care or other specialties. *Acad Med.* 1993;69:572-574.
- Fincher RM, Lewis LA, Jackson TW. Why students choose a primary care or nonprimary care career. the specialty choice study group. *Am J Med.* 1994;97:410-417.
- Newton DA, Grayson MS, Thompson LF. The variable influence of lifestyle and income on medical students' career specialty choices: data from two US medical schools, 1998-2004. *Acad Med.* 2005;80:809-814.
- Dorsey ER, Jarjoura D, Rutecki GW. The influence of controllable lifestyle and sex on the specialty choices of graduating US medical students, 1996-2003. *Acad Med.* 2005;80:791-796.
- Kahn MJ, Markert RJ, Lopez FA, Specter S, Randall H, Krane NK. Is medical student choice of a primary care residency influenced by debt? *MedGenMed.* 2006;8:18.
- Rosenblatt RA, Andrilla CH. The impact of US medical students' debt on their choice of primary care careers: an analysis of data from the 2002 medical school graduation questionnaire. *Acad Med.* 2005;80:815-819.
- Lawson SR, Hoban JD, Mazmanian PE. Understanding primary care residency choices: a test of selected variables in the Bland-Meurer model. *Acad Med.* 2004;79:S36-S39.
- Zinn WM, Sullivan AM, Zotov N, et al. The effect of medical education on primary care orientation: results of two national surveys of students' and residents' perspectives. *Acad Med.* 2001;76:355-365.
- Schafer S, Shore W, French L, Tovar J, Hughes S, Hearst N. Rejecting family practice: why medical students switch to other specialties. *Fam Med.* 2000;32:320-325.
- Ko M, Edelstein RA, Heslin KC, et al. Impact of the University of California, Los Angeles/Charles R. Drew University medical education program on medical students' intentions to practice in underserved areas. *Acad Med.* 2005;80:803-808.
- Ramsey AH, Haq C, Gjerde CL, Rothenberg D. Career influence of an international health experience during medical school. *Fam Med.* 2004;36:412-416.
- Smith JK, Weaver DB. Capturing medical students' idealism. *Ann Fam Med.* 2006;4:S32-S37; discussion S58-S60.
- Thompson MJ, Huntington MK, Hunt DD, Pinsky LE, Brodie JJ. Educational effects of international health electives on US and Canadian medical students and residents: a literature review. *Acad Med.* 2003;78:342-347.
- Institute of Medicine. *Primary care: America's health in a new era.* 1996.
- Girard DE, Choi D, Dickey J, Dickerson D, Bloom JD. A comparison study of career satisfaction and emotional states between primary care and specialty residents. *Med Educ.* 2006;40:79-86.

Navigating the Health Care System: A View from the Urban Medically Underserved

Elizabeth Bade, MD; Jennifer Evertsen, MS; Sabrina Smiley, MPH; Indrani Banerjee, BS

ABSTRACT

Objective: The purpose of this project was to discover areas identified by minority and underserved patients that lead to dissatisfaction with the health care system and specific areas identified as barriers to health.

Methods: Six focus groups (n=25) were conducted, with participants including mostly poor African-American adults with and without a primary care home, in addition to 1 group of community dwelling mentally ill patients, and 1 group of case managers for community dwelling mentally ill patients who navigate the health care system for their clients. Qualitative analysis by 3 authors identified themes emerging from the focus groups.

Results: The following themes were identified: (1) difficulty with insurance, including coverage, accessibility, stability, and choices; (2) socioeconomic, more than racial, barriers to care; (3) a misunderstanding or lack of information about the health care system and a lack of health literacy; and (4) lack of personal accountability for health and health care.

Discussion: Patients with access to a primary care home seemed more satisfied with the health care system. An increase in health literacy education and simplification of insurance policies and procedures could increase satisfaction and possibly improve outcomes for underserved patients. Providing preventive care and improving patient accountability for personal health may also improve satisfaction and outcomes.

Author Affiliations: Aurora Family Care Center, Milwaukee, Wis (Bade); Center for Urban Population Health, Milwaukee, Wis (Evertsen); University of Wisconsin Population Health, Madison, Wis (Smiley); University of Wisconsin-Madison, Madison, Wis (Banerjee).

Corresponding Author: Elizabeth Bade, MD, Aurora UW Medical Group, Clinical Assistant Professor of Family Medicine, Aurora Family Care Center, 1020 N 12th St, Suite 202, Milwaukee, WI 53233; phone 414.219.5940; fax 414.219.5960; e-mail liz.bade@aurora.org.

INTRODUCTION

In recent years, health care disparities of minority patients have been well documented. The 2002 Institute of Medicine report on health care disparities reviewed over 100 studies of health outcomes focusing on quality of health care for various minority populations.¹ This report concluded that not only decreased access to care affects health outcomes, but also—even when controlling for variables such as income, access, and socioeconomic status—people of color have less interventions and overall poorer health outcomes than white Americans.¹ It is not easy, however, to differentiate the multiple factors that likely contribute to the differences in health outcomes for minority patients, including genetic factors, access to care, socioeconomic factors, and physician bias and prejudice (conscious or unconscious). Specifically in Milwaukee, there are multiple markers of disparities, including a significant difference in AIDS incidence by race.² Only by finding the causes of disparities can Wisconsin achieve its goal of ending health disparities by 2010.³

Academic health centers have traditionally had a large population of underserved patients, providing a unique opportunity to assess needs and address disparities when they are found. Yet much of the available research to date has focused on proving that disparities exist; limited research asks the important question of *why* they exist.⁴ To address the reasons health care disparities exist, and therefore try to find solutions for these disparities, it is important to ask the people most affected by them. Focus groups are a useful tool for evaluating perceptions of health care disparities and patients' experiences in the health care system.⁵⁻⁶ Focus groups may be especially well suited for minority populations since they provide a non-judgmental outlet for people to voice opinions and frustrations in a peer-group setting.⁵

For this study, focus groups mainly consisted of patients from a primary care clinic in urban Milwaukee, Wis, but also included members of the surrounding

community, and case workers for the mentally ill. The goal was to explore the perceptions and experiences within a specific group of medically underserved individuals. Specific objectives included exploring perceptions about personal health, experiences within the health care system including feelings of being treated unfairly, comfort levels with physicians, and barriers to appropriate health care.

The Family Care Center (FCC), located in urban Milwaukee, serves a primarily African American population (80%). The majority of patients are women (61%). The clinic serves a medically underserved population with 47% possessing Title 19 insurance, 12.9% Medicare, and 21.3% commercial insurance. In 1999, the ZIP code that includes the FCC had a median household income of \$13,140 compared to \$45,901 in the metro area, with 47% of residents below poverty level and only 67.8% of those graduated high school (versus 84.5% in the metro area).⁷ Moreover, according to the US Census Bureau, the area qualifies as a Health Professional Shortage Area (HPSA).⁸

METHODS

Six focus groups were conducted in the fall of 2007, with 4 groups consisting of patients from the FCC. Demographics from the focus group can be found in Table 1. Patients belonging to an ethnic minority group who had public health insurance and were over the age of 18 were eligible. The patient's physician invited the patient to participate during a regular clinic visit. Recruitment took place for a period of 3 months. If a patient was interested, he or she provided a name and phone number and was called later by a member of the research team to set up an appropriate meeting time. Additional participants were recruited from a local church and the neighborhood outside the clinic. One focus group consisted only of community dwelling mentally ill patients who were also patients at FCC. These participants were recommended by their physician and/or case manager and were personally invited. The final group consisted of case managers who navigate the health care system for mentally ill clients. The focus groups were asked the same questions (Table 2), but the questions were modified slightly for the case managers so the responses given were about the participants' experiences with their clients instead of their personal experiences in the health care system.

Approval for the focus groups was obtained from the Aurora Health Care Institutional Review Board. Each participant completed a concise demographic survey and was assigned a pseudonym to mask his or her identity

during the discussion. Demographic data was collected on the 25 participants who were community dwelling and/or patients; however, demographic data was not collected from case managers since their clients were the subjects being assessed. Participants received an incentive of \$25 for their participation. An African American moderator facilitated all but 1 of the focus group discussions, while 2 interviewers who were white and Asian Indian observed participants and recorded notes. One group was facilitated by a white moderator. All interviewers have a background in qualitative research, and none are employees of the FCC.

The focus groups were audio taped and transcribed. Three researchers independently read, searched, and compared themes to reach a consensus. An expert consultant then coded the transcripts with the identified themes using Ethnograph v5.0 software.

RESULTS

Of the 25 non-case worker participants, 96% were African American, 52% had a chronic illness, and 78% were unemployed.

The following themes were identified from the transcripts: (1) difficulty with insurance, including coverage, accessibility, stability, and choices; (2) socioeconomic and racial factors; (3) misunderstanding of the health care system and a lack of health literacy; (4) lack of personal accountability for health and health care. A summary of supporting comments from the questions is found below, and supporting quotes are in Table 3.

Present State of Health

Participants noted that jobs, insurance, "the system," stress, and unhealthy lifestyle (including exercise and diet) affected their present state of health. The most frequently noted factor was family history. Even when probed by the moderator during 1 discussion whether unhealthy lifestyle contributed to their present state of health, participants said that family history was still the key contributor to overall health. In contrast, the group of case managers noted that affordable and safe housing, stress, income, personal habits, and the environment were the main contributors to personal health.

Treatment by the Health Care System

Participants were asked whether they or a friend have ever been treated unfairly by the health care system. When asked specifically whether they thought their race affected the way they were treated by the health care system, participants noted that "it's got nothing to do with race," and, "there is no racism at all unless you don't have that insurance."

Table 1. Self-reported Demographics Compiled from Focus Group Participants

Participant Characteristic	Focus Group
Age	
18-25	17.4%
26-35	13%
36-45	21.7%
46-55	21.7%
56-65	17.4%
>65	4.3%
Gender	
Male	30.4%
Female	69.5%
Race	
African American	95.6%
Latino/Hispanic	4.3%
Employed	
Yes	21.7%
No	78.2%
Household Income	
<\$10,000	60%
\$10,001-25,000	30%
\$25,001-40,000	5%
\$40,001-55,000	5%
Chronic Illness	
Yes	56.5%
No	43.5%

Participants expressed their frustrations with insurance coverage and the lack of choices when it comes to which doctors they can see. Participants also noted long wait times and “bad attitudes” by the clinic staff and insurance companies.

The case managers noted that their clients “definitely receive different care” than they do. They noted they have shorter wait times and receive better care and attitudes from the health care professionals than their mentally ill clients receive. The case managers, however, acknowledged it was difficult to pinpoint whether the differences were because of health insurance, mental illness, or race.

Comfort with Doctors

When subjects were asked how comfortable they felt asking questions of their doctors, most participants answered that they were very comfortable. Females and those with a regular doctor appeared to be more comfortable asking questions. Moreover, many female participants pointed out that overall they were more comfortable with a female professional.

Participants without a regular doctor were not comfortable asking their doctors questions. In fact, 1 person

currently without a medical home pointed out that he was afraid to ask questions in case it looked like he didn’t trust the doctor enough.

Participants noted that they didn’t have the freedom to change doctors if they weren’t comfortable with the one they had due to insurance limitations. Even participants without a current physician spoke of the “old time doctors” that would take care of you even if you didn’t have insurance. Many participants stated that having 1 doctor who was available when needed to answer questions and who knew them well was what determined how comfortable they were with the care they were receiving.

Barriers to Care

When asked about what barriers stand in the way of getting the best care, the overwhelming answers were money and insurance. Community action, not coming together to make changes and demand care, was also mentioned. The group of case managers pointed out that stigma about mental illness and a lack of understanding on the part of many health care professionals were often barriers specific to their clients; they also recognized the lack of money to get affordable, safe housing and to pay for quality food and healthy lifestyle choices as a barrier to health. One group mentioned customer service on the part of the medical and insurance communities as a barrier. Another group acknowledged race and socioeconomic status as a barrier, as well as the difficulty obtaining insurance and how complicated it was to try to use it. One participant even pointed out that his solution to avoid bills for needed medical care was to give a false name and address so the billing department couldn’t track him.

When asked what participants would change about our health care system, the most noted answer was insurance coverage including providing coverage for everyone, covering more of the costs like transportation and medications, and being allowed to choose your own physician no matter the insurance coverage. One group pointed out that the government is spending money in other countries before taking care of its own citizens’ health care. One participant thought it would be a good idea for insurance companies and government to not interfere with physicians’ decisions; eg, stop telling doctors what they could and could not provide for their patients.

DISCUSSION

There is no easy answer to the problem of health disparities. Asking questions of people who are at higher risk for adverse health outcomes is 1 way of determining areas to focus on in an attempt to eliminate disparities. Many important lessons were learned from these

Table 2. Focus Group Questions

1. Think about your present state of health. What do you think affects this most? For instance: family history or health habits (like eating and exercise), your surroundings (like your home and neighborhood), or the health care system (insurance, doctors, etc).
2. Have you or a friend ever felt you were treated unfairly by the health care system (the term health care system includes hospitals, clinics, insurance companies, etc) or a provider of health care? If so, how?
3. Think about all the times you've been to a hospital or seen a doctor. Have you or anyone you know ever felt like they didn't get the same care or as good of care as someone else by any doctor or hospital? Why do you think so? Do you think it has to do with your race?
4. Now think about your current doctor. How well do you think your current doctor responds to your needs? Do you feel like you have the option to change doctors if you don't feel your needs are being met?
6. How comfortable are you asking questions of health care people when it pertains to your own health?
7. What do you think are the biggest barriers or things that stand in your way for you and members of your community to get the best health care?
8. Today we've talked a lot about your health care and the health care system. If you could change 1 thing about your health care (the doctors, nurses, insurance, hospitals, etc.) what would it be?
9. Is there anything else you'd like to share that we didn't discuss yet?

focus groups as outlined in the identified themes. The first 2 themes identified are certainly related, however the authors of this study felt there was enough concern about insurance issues to warrant separating them.

Difficulty with Insurance Coverage, Accessibility, Stability, and Choices

An overwhelming number of participants who had a current doctor felt very comfortable asking questions and felt they had the ability to change doctors if needed. In fact, it seemed that it was more difficult for patients to stay with a single doctor they knew and trusted than it was to switch providers. The measure of quality of a doctor in this study seemed to be availability. Most participants desired to keep a relationship with their physician and were frustrated with the fact that insurance companies seemed to have control over who they were able to see. It was mentioned by the group of case managers that there is a very limited number of physicians who will accept their clients, and this becomes a big challenge in providing quality care. There was a striking difference between the groups that had a medical home and those without access; patients without access spoke of a lack of trust and frustration with the health care system. Many of them were uncomfortable asking questions of physicians.

Participants who had no current insurance or regular doctor also noted how hard it was to obtain insurance if you had no dependents. Without insurance there is very limited meaningful access to care; many participants were relying on free clinics or even deception to try to obtain care. Some very troubling findings were the ways people had to "beat the system." When care is needed, participants talked about using fake names or

going to different hospitals to avoid being stuck with a bill since they didn't have insurance. Another participant stated that even now that she has insurance she is afraid to go to the doctor because of a previous bill she received after obtaining emergency services years ago. These results are of concern because they impact the quality of care patients are able to receive since without accurate contact information, hospital staff lose the ability to do follow up or provide ongoing services.

There were also insightful comments into the community impact of this dilemma, including the increased stress that can lead to crime within the community and the lack of commitment to change because people are unwilling to risk losing what little they have. Increasing accessibility to insurance and simplifying the process of obtaining and utilizing it might relieve some patient frustration; unfortunately, there is no easy answer to increasing coverage.

Socioeconomic and Racial Factors

One of the more interesting results was the focus on quality of service and access to care when participants were asked about unfair treatment. Most discussions focused around wait times or attitudes of health care professionals. The majority of groups were asked directly if they felt their race changed the treatment they received; very rarely was the answer yes. There have been studies that still show a racial bias in health outcomes after controlling for socioeconomic status and insurance, but that wasn't sensed by the majority of participants in our groups. There was no observed difference between people who reported having a chronic illness and those who did not, although this was hard to track due to difficulties with the recording methodology. No direct measures of

Table 3. Pertinent Quotes from Focus Group Participants, Divided by Topic and Theme

Present State of Health
<p><i>Theme 3: Misunderstanding of the health care system and a lack of health literacy</i> “Family history and the system... They don’t, to me they don’t check everything they should. They check you through changes, they try different medications, but instead of looking to see what is really ... the problem just besides your family history, you know.”</p> <p><i>Theme 4: Lack of personal accountability for health and health care</i> “My family history has a lot of like sicknesses and diabetes, high blood pressure, hypertension, stuff like that. It’s in my genes.”</p>
Unfair Treatment by the Health Care System
<p><i>Theme 1: Difficulty with insurance coverage, accessibility, stability, and choices</i> “...some people will take time to make sure that they hit every area of a medical experience to find out if this is what your diagnosis is, but some people, they just push you right along ... as soon as you say you got no insurance, that’s it.”</p>
Comfort with Doctors
<p><i>Theme 1: Difficulty with insurance coverage, accessibility, stability, and choices</i> “I be scared to ask them cause I figure they know their job. And I be scared to think they think I’m telling them how to do their job. ...if you’re an auto mechanic, how would you feel if I’m telling you how to fix this car?” “I feel my doctor is real good. I like her, and I feel I can change [doctors] quick, too.”</p>
Barriers to Care
<p>“I think the biggest barrier would be that on the part of the concern of the people that are waiting on you is, um, if they don’t care about the health care that you get, then you wouldn’t get any good health care. So that to me would be your biggest barrier is how the people that you’re going to treat you. It doesn’t have anything to do with you. I mean, you’re going for service. If the service is lousy, it has to do with the people that are giving the service, so the biggest barrier is finding good service and staying with that...”</p> <p><i>Theme 1: Difficulty with insurance coverage, accessibility, stability, and choices</i> “I give ‘em fake names...Everytime I ever been to [a certain hospital] for anything I give ‘em a bogus name, a bogus social security number...”</p> <p><i>Theme 2: Socioeconomic and racial factors</i> “Money, money, money.”</p> <p><i>Theme 3: Misunderstanding of the health care system and a lack of health literacy</i> “...I don’t know where to pinpoint it, either on the doctor itself or my insurance company, you know, ‘cause if the doctor can’t cover it through my insurance then I never get it. You know, so either/or, one of them.”</p>

health status were used in this study, only self-reports of frequency of doctor visits.

Although there were isolated events that were identified as racially motivated, participants generally did not feel race was a factor in their treatment in the health care system. One participant pointed out he couldn’t tell if there was a difference without knowing how others were treated. Even the group of case managers discussed the difference between treatment of their clients and themselves by referring to the type of insurance or mental illness, not to race or ethnicity. Although many studies have shown there are racial health care disparities that are independent of insurance or socioeconomic status, this type of perception would lead one to believe these inequalities are buried beneath the surface of day-to-day interactions within the health care system.

Misunderstanding of the Health Care System and a Lack of Health Literacy

The lack of health literacy and understanding of the insurance and health care system was striking, even by those who had regular access to it. Participants were often uncertain who to blame for the problems they were having with

obtaining care. Doctor’s offices seemed to have little respect or understanding of the challenges facing patients in regard to arriving on time for appointments without reliable transportation. Physicians seemed to have little insight into the realistic role that a case manager plays in the life of a patient, or what could be expected in terms of compliance with time-consuming or confusing recommendation for a patient with a mental illness. Participants, including the case managers, noted that insurance companies are, at best, challenging to get ahold of, and provide little explanation or warning as to how they work or why things change as they often do.

Lack of Personal Accountability for Health and Health Care

Participants seemed to feel a sense of helplessness when it came to personal health. There was a distinct sense of a lack of opportunity to affect one’s own health. Reasons given included family history of health problems, a lack of access to insurance, and an inability to afford medications even with insurance. In fact, participants often cited family history as the key contributor to overall health. Very few people mentioned what they could do to affect their own health in a positive way. Whether this was due to lack of knowledge when it

comes to personal health habits like diet and exercise or whether our questions didn't allow the opportunity to discuss the issue is uncertain.

Limitations

There were some limitations worth mentioning in this study. First, 1 group was not recorded due to equipment malfunction; in this case we relied on notes only for our summaries and were not able to use direct quotations from that group. Second, although our facilitator was African American, our observers were not. This may have affected the comfort level of some patients to speak openly about race. In addition, 1 group was facilitated by 1 of the observers due to a scheduling conflict. No significant difference in themes or answers was noted in that group when compared to the others.

In the first focus group, participants were not specifically asked if race was a factor in their treatment by the health care system. This question was modified in the second group and all subsequent groups to include a specific question about race as this was felt to be more appropriate. Due to poor recordings and a lack of strict use of pseudonyms prior to speaking, we were unable to link demographic data to people's direct quotes. For future projects, it would be interesting to see if there would be a difference in themes based on experiences within the health care system, socioeconomic status, or overall health status.

As with most qualitative research, we also had a sample bias. The majority of participants were patients at a single clinic, which somewhat limits the ability to generalize findings. However, the 1 group of non-clinic patients and the group of case managers did not show any significant differences in themes identified.

CONCLUSION

The lessons learned from our focus group participants provide interesting perspectives on health care in Milwaukee. Surprisingly, there was very little mention of racial biases, although many people did have isolated stories. The overwhelming theme, however, was focused on the complexity of our current system and the difficulties with obtaining and maintaining access to care and to a physician who is trusted. Even possessing insurance does not guarantee coverage, as many of our participants pointed out. It is interesting to note that people found a way to bypass the system while still obtaining care by using fake names. This is disturbing to many of us in medicine not only as a symptom of a real problem within our system but in terms of direct patient care: there is no way to provide follow-up information to someone if you don't have any real contact information.

These findings are similar to the results of the Institute

of Medicine 2002 report on racial and ethnic health care disparities. The report notes 1 factor that contributes to disparities is the operation of health care systems and the legal and regulatory climate in which they exist.¹ When a system is so complex that even the people working within it find it challenging and confusing, it is logical that the people trying to use the services will find difficulties, and hence, find shortcuts to obtain needed services.

In the future, it would be interesting to expand the groups to include populations that may have different experiences within the system; specifically, do direct comparisons of satisfaction with overall health between groups that have access to care via insurance and groups that don't, as there was a difference within our groups between people with access and people without. It would also be interesting to do listening or learning sessions about patient advocacy. Finding ways to help improve a patient's understanding of general health and lifestyle choices may also be a cost-effective and useful tool to help increase a patient's sense of control and possibly improve some health outcomes. This would require a direct measure of general health.

Many more avenues of inquiry exist, but the most important thing is to continue to ask questions, to wonder why, and to examine ourselves within the medical community to protect vulnerable populations and improve measures of health.

Acknowledgements: Thank you to Renee Bade, BA, for her assistance in editing.

Funding/Support: None declared.

Financial Disclosures: None declared.

REFERENCES

1. Institute of Medicine. *Unequal Treatment: What Health Care Providers Need to Know about Racial and Ethnic Disparities in Health Care*. Washington D.C.: National Academy Press; March 2002.
2. Reither, EN, Lee, Sang Lim. Racial and ethnic disparities in AIDS incidence: an examination of Milwaukee, Wisconsin, 1990-2000. *WMJ*. 2007;106(7),380-384.
3. Division of Public Health, Wisconsin Department of Health and Family Services. Healthiest Wisconsin 2010: an implementation plan to improve the health of the public. <http://dhs.wisconsin.gov/statehealthplan/implementation/pdf-files/summary.pdf>. Accessed December 11, 2008.
4. Betancourt, Joseph. Eliminating racial and ethnic disparities in health care: what is the role of academic medicine? *Acad Med*. 2006;81:788-792.
5. Ruff CC, Alexander IM, McKie C. The use of focus group methodology in health disparities research. *Nurs Outlook*. 2005;53:134-140.
6. Dienes CL, Morrissey SL, Wilson AV. Health care experiences of African American teen women in eastern North Carolina. *Fam Med*. 2004;36:346-351.
7. areaConnect. <http://milwaukee.areaconnect.com/statistics.htm>. Accessed December 11, 2008.
8. US Census Bureau. <http://www.census.gov/>. Accessed December 11, 2008.

Collaboration Saves Time

Philip A. Bain, MD, FACP

ABSTRACT

Caring for patients today is very complicated and involves many clinical and administrative tasks. Clinicians are often asked to fill out a wide variety of forms, including forms that verify that the patient's clinical status is stable. Currently, these forms are filled out manually by the clinician or staff. Clinicians who use electronic medical records (EMRs) have the potential for significant time savings if the EMR can be used to eliminate manually loading data already housed in the EMR.

This article describes how collaboration between a government agency and a medical group that uses the Epic EMR resulted in an electronic version of a commonly used form. Once implemented, this form resulted in a significant time savings for the clinician. It is hoped that this project will serve as a template for future similar projects that could result in more efficient use of clinician and office staff's time.

INTRODUCTION

Patient care today is very complex. Clinicians perform a wide variety of administrative tasks such as filling many types of paperwork, which may include Family Medical Leave Act forms, insurance forms, nursing home forms, and forms certifying stability of medical conditions requested by agencies such as the Department of Transportation (DOT). Non-clinical clerical tasks can consume a substantial amount of a clinician's time, especially in primary care. This clerical aspect of the clinician's time is unreimbursed, adds tremendously to the workload and frustration of clinicians, and is a significant component of the "hassle factor" that many professionals claim is driving physicians away from practice. Any significant improvement in

physician workflow is likely to lead to improved clinician efficiency and satisfaction. This brief report documents an example of a collaborative effort between a government agency (Department of Transportation) and a health care system (Dean Health System) using an electronic medical record (created by Epic Systems). This project produced a more efficient workflow that saves the clinician time and creates an electronic version of a necessary document for the Department of Transportation (DOT). Hopefully, this example can be a template for a wide variety of forms that are currently in use.

Patients with certain medical conditions such as epilepsy are required to have periodic evaluations to confirm their condition is stable and they remain safe to drive a vehicle. The DOT typically sends a form (#3644) to the patient, who presents it to his or her health care professional for completion. The form is 4 pages and consists of a number of sections containing questions specific to different medical conditions such as diabetes, chronic obstructive pulmonary disease, and epilepsy. Because it encompasses a wide variety of conditions, many primary care and subspecialty clinicians use it. The clinician or staff manually enters the demographic information. The clinician then answers a series of questions pertinent to the patient's condition. Once completed, the health care professional gives the form to the patient, who sends it to the DOT.

This project began after one of the neurologists in Dean Health System (Dean) pointed out that this form typically took 6-7 minutes for him and his staff to complete. Because of his specialty interest in epilepsy, he estimated that he had to complete this form 15-20 times each week. He submitted his request to streamline this process to the chair of Dean's Clinical Decision Support Group (CDSG). The CDSG develops electronic medical record (EMR) based tools for use by clinicians at the point of care. The CDSG chair contacted the supervisor of the DOT Medical Review Section. The super-

Author Affiliation: Dean Health System, Madison, Wis.

Corresponding Author: Philip A. Bain, MD, FACP, Dean Health System, 1821 S. Stoughton Rd, Madison WI, 53716; phone 608.260.6488; fax 608.260.6457; e-mail philip.bain@deancare.com.

visor reported that their department is often frustrated by the number of forms they have to return because of illegible handwriting or because they were not complete, and she enthusiastically agreed to work together to develop an electronic version of the form.

PROJECT

The EMR team at Dean built an electronic version of the form. They estimated it took approximately 70 hours of build time, but admitted that a significant portion of time spent was because this type of project had not been completed before. They were confident that subsequent projects would not be as time consuming. Demographic data already contained in the patient EMR was able to be populated into the form electronically. Questions required of the clinician were formatted so that questions answered routinely in a specific way would be answered automatically, but could be changed. All but 2 questions were able to be answered automatically; these were often the only questions that were not frequently answered in a predictable manner.

The neurologist who initially made the request conducted a pilot test using the form for 2 weeks. The form previously took 6-7 minutes to complete. After the new process was in place, it took 30-45 seconds. The DOT personnel reviewed the completed forms and were satisfied that the electronic form fulfilled their requirements.

The CDSG released the piloted form for general use at Dean on July 1, 2008. Shortly after release, a clinic optometrist asked if the CDSG could make similar changes for a commonly used form in optometry. The new form took about 5 hours to build and is now in use.

CONCLUSION

This project illustrates how a workflow process was improved and streamlined through collaboration between a government agency (DOT) and a health care system (Dean) using an electronic medical record. The government agency benefits by receiving a complete and legible form. The clinician and health care system benefit by decreased time necessary to complete the form and decreased amount of rework involved in reviewing an illegible or incomplete document. The patient benefits as well. Specifically in this case, patients benefited by being able to resume or continue driving in a timely manner because the health care professional completes the form correctly at the time of the office visit.

In one survey, 13% of Wisconsin clinicians in the ambulatory setting currently use fully-functioning EMRs and 41% use partially-functioning EMRs.¹ Health care analysts expect this number will increase exponentially

in the next few years. Proponents of EMRs argue that they improve safety, enhance efficiency, and save money. This brief report describes how organizations can collaborate and produce a significantly improved workflow. Hopefully, this success story can be the springboard for a wide variety of similar projects that will benefit many organizations, clinicians, and patients in Wisconsin.

Acknowledgments: The author wishes to thank Jill Reeve from the Department of Transportation, Terri Prehn from Wisconsin Integrated Information Technology & Telemedicine Systems, and Michael Frucht, MD, from Dean Health Systems for their help with this project.

Funding/Support: None declared.

Financial Disclosure: None declared.

REFERENCES

1. Wisconsin Governor's eHealth Care Quality and Patient Safety Board. *Wisconsin Ambulatory Health Information Technology (HIT) Survey 2006-2007*; 2007. <http://ehealth-board.dhfs.wisconsin.gov/reports/physofficesurvey.pdf> Accessed December 11, 2008.

Proceedings from the 2008 Wisconsin Quality and Safety Forum, Part I

In 2008, quality and safety improvement initiatives in Wisconsin focused on developing an organization-wide culture of quality, and implementing processes to improve patient care and satisfaction. Below are descriptions of improvement projects undertaken by hospitals and other health care organizations, and showcased at the Wisconsin Hospital Association's 2008 Wisconsin Quality & Safety Forum. The projects are broken into 6 categories; clinical improvement, infection control, customer service, medications, performance improvement, and safety. The last 3 categories will be published in the next issue of the *Journal*.

CLINICAL IMPROVEMENT Development of a Therapeutic Hypothermia Protocol

*Kevin Jacoby, MSN, RN; Wheaton
Franciscan Healthcare-St. Joseph,
Milwaukee, Wis*

The development of the therapeutic hypothermia protocol at Wheaton Franciscan Healthcare—St. Joseph has been a continuous work in progress, with initial planning and order set creation in February 2007 and nurse/physician in-servicing/education and go-live (or patient enrollment) in March 2007. From inception to the present, both the protocol and orders have been through numerous changes to accommodate patient, pharmacologic, logistic, and multidisciplinary practitioner needs. Each revision was recommended and supported with requirement needs developed from enrolled patient data, evidence-based practice in current therapeutic hypothermia treatment modalities, and reviewed benchmark trends from over 20 other hospitals that have developed hypothermia protocols. Our institution's Initiative for Healthcare Improvement (IHI) Committee oversees and guides the initiative and consists of members from our Quality, Advanced Practice Nursing, Nursing Education, Management, Care Management, Respiratory Therapy, and Intensive Care departments. In May 2008, we approved a working, sub-final order set with plans for its inclusion as a final, official document.

One of our staff hospitalists, Rajesh Bhargava, MD brought the idea for development of the hypothermia protocol to our IHI Committee. Dr Bhargava who spent a summer working in New Zealand. During that time he learned that they were using a lesser-known protocol that had promising potential for resuscitated cardiac arrest patients. Feeling our institution potentially could use a hypothermia protocol with its neuroprotective benefits to improve the quality of lives in our frequent cardiac arrest population, Dr Bhargava drafted a trial order set. As 1 of the few hospitals in the Metro-Milwaukee area with a protocol, especially in its infant stages, we utilized national and international literature to support our development.

Encouraged by therapeutic hypothermia's potential benefits, we agreed on a relatively short timeframe for our first enrollment—1 month. From a nursing perspective, this meant we had to draft education materials on the protocol itself (inclusion and exclusion criteria), the order set, and provide in-services on the logistics of the initiative to the nurses of the emergency department and intensive care unit, while Dr Bhargava gave informational in-servicing to the medical staff and the resident physician teaching service teams.

To accomplish this, we enlisted the assistance of the clinical educators of the Emergency Department and Intensive Care Unit as well as a few staff nurses to disseminate the infor-

mation. In-services were held prior to shifts, unit practice council, and shared governance meetings for staff nurses who would be caring for the enrolled patients. Initially after rollout, logistical concerns regarding the availability of equipment, the ordering of serial lab work, and the unfamiliarity of the protocol became apparent through staff confusion, frustration, and delays in getting patients cooled down to goal range within the goal timeframe. To alleviate these issues, tip sheets were made for the lab schedules and the protocol's cooling and rewarming phases, as well as conversations with department supervisors regarding smooth and timely accessibility of supplies and equipment. Overall, despite over a year to streamline the process, each hurdle was overcome with minimal effort and unequivocal staff support and participation.

ED Nurse Driven Pneumonia Care Protocol: It Made a Difference!

*Sue Baird Holmes, RN, CNS; Wheaton
Franciscan Healthcare-St. Joseph
Milwaukee, Wis*

In January 2007, the Pneumonia Outcomes Team (Team) assessed trend pneumonia measure data. Door-to-drug times remained inconsistent. It was identified that timely Emergency Department (ED) nurse triage of possible pneumonia patients could be improved to decrease the time it took for patients to receive their first antibiotic. One strategy discussed was the use of a nurse-driven protocol that would assist with timely nurse assessment of possible pneumonia patients and lead to a reduction in the time it took for a patient to receive their first antibiotic.

The ED nurse representative to the team investigated the potential for a nurse-driven protocol, conducted a literature search for evidence-based respiratory assessment cures, and developed

an initial ED nurse-driven pneumonia protocol. The ED Nursing Practice and Development Councils, ED Medical Director, and Emergency Medicine Departments reviewed, finalized, and approved the evidence-based content.

After nursing staff education, the ED Pneumonia Protocol was implemented in April 2007. Positive nursing feedback concerning use of the protocol included ease of use and helpful cues for timely respiratory assessment. Door-to-drug times improved from 130 minutes to 95 minutes and compliance to antibiotic initiated within 4 hours improved from 86.2% to 95% for the first month after protocol implementation.

Methods used to support the protocol implementation included ongoing collaboration with emergency medicine physicians and the ED medical director. The ED nurse pneumonia team member continued to serve as a major nurse champion and collaborated with the nurse educator for nursing staff education.

The ED Pneumonia Protocol has been revised to reflect the most current evidence-based antibiotic recommendations. Protocol use is driven by the nurse, supported by physicians, and remains ongoing. ED nursing use of other patient population-based protocols contributed to the successful implementation of the pneumonia protocol.

Improving Colorectal Cancer Screening Rates Using Colonoscopy through Motivational Interviewing

Jackie Bearwald; Gundersen Lutheran, La Crosse, Wis

Motivational interviewing has been successful in programs helping patients with obesity, suffering from addictions, and smoking cessation. It has also been used to try to improve mammography screening rates. Motivational interviewing is a person-centered directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence, anger, and fear. The intent is to determine at what stage in the Transtheoretical Model of Change the patient is and move them to the action stage using motivational interviewing.

Based on barriers to screening identified in the literature, a survey for providers at Gundersen Lutheran was developed to determine their impressions on this topic and how a nurse might help improve this process of care. Surveys were mailed to 154 of our family medicine and internal medicine providers at the main campus and our regional clinics with 72% of providers responding. Fifty-eight percent supported face-to-face nurse-patient education and 61% supported follow-up phone contact with patients. Training in motivational interviewing was completed by nursing staff testing this change. This test of change was to do motivational interviewing by phone for patients who had not scheduled their colonoscopy within 6 months after being referred by their primary care provider and receiving a letter from the gastroenterology department to call and schedule their procedure.

Post-operative Pain in Urologic Day Surgery Patients: Oxycontin versus No Oxycontin at Discharge

David Grinder, MS, RPh; Mark Thompson, MD; Monroe Clinic, Monroe, Wis

Urologic surgery patients discharged from the Acute Care Unit (ACU) between June 12 and August 30, 2007, were instructed how to complete a pain assessment at least 4 times in the 24 hours post-operative. The form provided the Wong faces scale and a descriptive scale to assist the patient in determining a numerical pain score. The ACU nurse recorded the procedure, time of post-op arrival to ACU, surgeon, date and time of discharge from ACU, and the pain score at discharge. The patient was to indicate the time of pain assessment and what was done to relieve the pain. The patient was given a self-addressed stamped envelope to return the survey to the Monroe Clinic Pain Committee. The urologic patients were part of a larger survey of all ambulatory surgery patients.

Results were shared with the urologist and post-operative ambulatory pain management literature was reviewed. It was agreed that a dose of 10mg or 20mg of Oxycontin would be given

to patients at discharge in an attempt to achieve better post-discharge pain control. The self assessment form was provided to all urologic day surgery patients between February 22 and May 12, 2008.

Results: A total of 30 assessments were received, 17 patients received no Oxycontin at discharge and 13 patients received Oxycontin at discharge.

The average pain score at discharge and at specified time intervals up to 24 hours after discharge was calculated for both groups. The maximum average pain score for patients not receiving Oxycontin was 3.2 between 4 to 8 hours after discharge. The maximum pain score for patients receiving Oxycontin at discharge was 1.5 between 12 and 20 hours after discharge.

Use of Oxycontin prior to discharge of day surgical patients has been reported with mixed results. Our data suggests that in urologic day surgery patients use of Oxycontin prior to discharge can help reduce pain scores in the immediate 24 hour period post-discharge.

Project Move

Nancy Whitfield, RN, MSN, CNS; St. Mary's Hospital Medical Center, Green Bay, Wis

Problem: Inconsistent patterns of addressing mobility and functional care needs of hospitalized patients can result in significant deterioration and deconditioning. Nursing is responsible for baseline assessment of functional and activity status and initiation of basic activity regimens. The nurse's attention to this important aspect of care is often overshadowed by other patient needs. Mobility regimens may be initiated too late, and role responsibility confusion may exist between caregivers.

Purpose: (1) Develop and implement interventions to enhance activity and mobility levels among adult hospitalized patients. (2) Conduct literature review to identify hazards of immobility and practice standards for improved mobilization.

Findings: (1) Baseline documentation data on 120 patients found 83% had a mobility activity order. Forty-two percent received minimum activity to the chair or bathroom and 5%

received ambulation outside the room or for any specified distance. (2) Lack of clarity and consistency by nurses in documenting activity. (3) Lack of readily available equipment and assistive devices for ambulating patients. (4) Limited means of communicating activity levels between disciplines. (5) Literature identified need to have patient out of bed 3 times daily and ambulating 3 times daily.

Rapid Response Team Implementation

Danny Loosemore, Good Samaritan Health Center, Merrill, Wis

Rapid Response Teams (RRTs) have been shown to be an integral part of patient safety through responding to recognized signs and symptoms of patients who have the potential to code. While RRTs are important to implement in all hospitals, the logistics of establishing a team in a small rural hospital had its own set of challenges. Good Samaritan Health Center's approach to RRTs had to be created in such a way to meet our needs as well as perform as expected. The results of the implementation showed our hospital took a step in the right direction to improve patient safety.

According to the Institute for Healthcare Improvement (IHI), cardiac arrests can often be predicted 6 to 8 hours prior to the event occurring through the patient displaying signs and symptoms of the upcoming event. After review of code blue data and evaluating it against the early warning signs, a determination was made that a rapid response team would be an important addition to patient care practices.

A multidisciplinary group of physician, nursing, and support staff was formed to review literature and resources to create the rapid response team model that would both best suit the needs of patients and be feasible with the available hospital resources. Our methods included creation of a documentation tool to aid patient care staff in performing assessments in addition to staff education to make the changes permanent.

The documentation tool created was modeled around Situation, Background, Assessment, and Recommendation

(SBAR). This model was used to enable the nursing staff to communicate with the physicians in a clear and consistent manner. Information from the literature review in addition to the framework provided by the IHI was incorporated into the assessment tool.

Situation: The patient's current situation is assessed for early warning signs of decline using the criteria that evaluates cardiac status, respiratory status, level of consciousness, pain assessment, genitourinary problems, temperature increase/decrease, abnormal labs, and patient care provider perceptions.

Background: The patient's background includes current diagnosis, any comorbidities that exist, vital signs taken within 4 hours of RRT call along with vital signs after the call, and any procedures the patient had during the stay.

Assessment: The assessment piece provides an area to record current vital signs and areas of concern that lead to the rapid response team call.

Recommendations: This area of the form is completed with recommended interventions to help alleviate the symptoms the patient is experiencing to bring them out of their deteriorating state. After report is given to the responsible physician, other recommendations are recorded here as well.

Finally, outcomes are recorded to determine if the intervention was successful in bringing about a positive change in the patient's status.

Project Implementation: Execution of the RRT program came through development of the policy and procedure to educate the patient care staff on how it works and what steps to take to call a rapid response team into action.

The house supervisor designates staff members to carry the RRT pager for every shift. The RRT members include available patient care staff such as the house supervisor, respiratory therapy, and Emergency Department physicians or mid-level providers.

Once nursing or other patient care staff recognizes the signs of the potential for a patient to decline, the staff member pages the RRT who then respond to the room listed on the pager. For those times respiratory therapy is not avail-

able in-house, the nursing supervisor completes a respiratory care assessment form and, if it is deemed necessary, the respiratory therapist is paged to consult. The patient's nurse completes the assessment form along with any interventions completed and communicates all information to the responsible physician. Additional interventions are carried out as ordered and the patient is continuously monitored for improvement or decline. Communication is maintained between all team members and physician until the condition resolves or further intervention is needed.

The RRT calls are initiated when necessary and reviewed for possible improvement opportunities to the process.

Reducing Risky Drinking and Drug Use

Joan Fischer; Wisconsin Initiative to Promote Healthy Lifestyles, Madison, Wis

Wisconsin leads the nation in binge drinking and drunk driving. Diseases and injuries related to alcohol and drug misuse make it the fourth most common cause of death and hospitalization in this state. In response to this need, the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) is implementing evidence-based screening, brief intervention, and referral-to-treatment (SBIRT) services at 23 primary care clinics around the state, with more to be added in coming years. SBIRT's proven efficacy in more than 50 clinical trials has led it to be endorsed by a number of leading medical and health care associations, including the National Institutes of Health and the National Quality Forum. The Joint Commission is presently considering whether to make SBIRT services mandatory in all hospitals. Such services must be administered by Level I and II trauma centers. WIPHL began offering SBIRT services in spring 2007, with the goal of establishing SBIRT as a long-term, sustainable component of basic health care in Wisconsin.

For the patient, the process begins with a brief screen—a few questions about alcohol and drug use and other health behaviors—that is administered to all

patients 18 and older, once a year. The carefully designed questions have been shown to identify substance misuse at even an early stage. Patients scoring positive meet with WIPHL-trained health educators at the clinic to discuss options for change. Numerous studies show that these brief interventions (1 to 4 sessions of 15-30 minutes) are enough to help many patients greatly reduce or eliminate substance misuse. The health educator and patient may agree that a referral to treatment for more intensive care (residential or outpatient) is needed. Costs may be covered by WIPHL.

Wisconsin Rural Hospital Stroke Improvement Group

Michelle Gardner; WHA, American Stroke Association, Office of Rural Health, Milwaukee, Wis

In the state of Wisconsin, approximately half of hospitals are critical access hospitals and rural hospitals. It is important when establishing a stroke system of care that all hospitals in Wisconsin understand guidelines and best practices in the area of acute stroke care and secondary prevention. It is vital that every hospital in Wisconsin can accurately treat, transfer in a timely fashion if necessary, and provide evidence-based interventions to those stroke patients that complete their stay in the rural hospital. It is critical to the system that all hospitals have appropriate protocols and availability of stroke guidelines.

The goal of this project is to improve each rural hospital's infrastructure to ensure that a process is in place for acute and secondary prevention measures for stroke patients at every hospital in Wisconsin regardless of location or size.

The Wisconsin Hospital Association (WHA), the Office of Rural Health (ORH), and the American Stroke Association (ASA) are providing rural hospitals the opportunity to improve stroke care by inviting hospitals to participate in a stroke quality improvement project. Each participating hospital can use the on-line patient management tool through "Get with the Guidelines." In addition to access to all guidelines, point of care tools, and patient education, each hospital will be

able to participate in teleconferences to target best practices and areas in need of improvement.

In Wisconsin, many hospitals have small numbers of stroke patients, but collectively stroke patients that present at rural locations are numerous. Most rural hospitals initiate tPA, the only FDA approved "clot-busting" drug, and ship the patient to a Primary Stroke Center. Stroke patients that are not eligible for tPA often stay at the rural hospital and need the appropriate interventions, education, and follow-up to help prevent another stroke in the future.

The current areas of focus in the Wisconsin Rural Stroke Improvement Project have been the improvement of transfer protocols, administering tPA to appropriate patients, performing dysphagia screenings in a timely manner, and meeting the 5 components of educating the stroke patient. Learning sessions have also included the National Institutes of Health (NIH) stroke scale and establishing a stroke system of care in the state of Wisconsin.

The change has been significant. In June 2008, the group of rural hospitals met for its second in-person meeting. Most had established and implemented stroke protocols within their hospitals, had been training staff on the NIH Stroke Scale and had created other tools, such as dysphagia screening tools. Most hospitals have been looking at stroke data and sharing with the appropriate team members within their facility.

The WHA, ASA, and ORH will continue to establish learning sessions for the group based on the guidelines, data, and discussion around stroke quality improvement and best practices in stroke care.

INFECTION CONTROL Antibiotic Stewardship: Putting Evidence to Work to Improve Outcomes

Chris Baker RN, PhD; St. Mary's Hospital, Madison, Wis

Antibiotic stewardship promotes appropriate selection, dosing, timing, and choice of route for antimicrobial agents. The primary goal of antibiotic stewardship is to optimize clinical outcomes while minimizing the unintended con-

sequences of antimicrobial use including toxicity and the emergence and transmission of resistant organisms. A secondary goal is the reduction of health care costs associated with the use of antibiotics.

In the fourth quarter of 2007, St. Mary's Hospital in Madison, Wis, implemented a clinical antibiotic stewardship pilot program to evaluate the clinical, operational, and economic implications of antibiotic stewardship. Program resources included (1) 1 full-time clinical pharmacist practicing in the role of stewardship pharmacist, (2) 2 Infectious Diseases (ID) physicians providing 1-to-1 scheduled, clinical consultations for the stewardship pharmacist, (3) operational support from the pharmacy's administrative director and clinical supervisor, and (4) a dedicated data analyst. The pilot population was comprised of patients diagnosed with community acquired pneumonia (CAP).

Using electronic case finding, as well as provider referrals, the stewardship pharmacist reviewed clinical, medication, and immunization records for CAP patients on a daily basis. The stewardship pharmacist then consulted with the ID hospitalist to review findings and to develop recommendations. Recommendations were then discussed with the attending physician. If the attending physician concurred, the stewardship pharmacist wrote necessary change orders. In addition, the stewardship pharmacist would order immunizations to be administered based on the hospital's screening protocols. The most frequent interventions were suggesting alternate antibiotics based on national guidelines, making an IV to oral switch, and educating providers about evidence-based care for CAP. Additional interventions noted were avoiding significant adverse reactions, avoiding drug interactions, and discontinuing the antibiotic when CAP was ruled out.

Heightened Surgical Site Infection Surveillance

Paul Thomas RN, BSN, CIC; Saint Clare's Hospital, Weston, Wis

After a large quality improvement project was undertaken in the Surgical Service department among the total joint

replacement subspecialty, it was vital to know our current surgical site infection (SSI) rate. The Infection Prevention and Control Department at Saint Clare's Hospital created an overlapping, multi-resource SSI surveillance program that includes but is not limited to:

- Resource utilization via monitoring daily records; emergency department visits, the hospital's admissions, discharges and transfers
- Attending interdisciplinary inpatient rounds
- Reviewing microbiology department culture result reports
- Encouraging surgeons to self report SSIs
- Patient post-operative SSI screening calls by Saint Clare's Hospital volunteers
- Soliciting feedback via surgeon specific cumulative procedures surveys
- Rounding with purpose in the inpatient units

It is paramount for a hospital to accurately know its SSI rate. This is the starting point that guides process improvement activities that prevent HAI and eliminate sentinel events and/or unanticipated death.

Implementation of Guidelines to Reduce Catheter-Related Bloodstream Infections

Dena Jarog, CNS; Saint Joseph's Hospital, Marshfield, Wis

In 2006 the catheter-related bloodstream infections (CRBSI) rate for the units being studied was reported as 4.6 per 1000 catheter days. This was a 68% increase from 2004. Central venous catheters (CVC) provide much-needed access in the sickest patients, although they may place critical care patients at increased risk for bloodstream infections due to the frequency of CVC access and the severity of the patient's illness.

To address new mandates from Centers for Medicare & Medicaid Services (CMS), critical care patients within the facility, having a non-tunneled CVC in place for greater than 24 hours, were part of a program implementing the Institute for Healthcare Improvement (IHI) insertion and maintenance

bundles created using evidence-based guidelines developed by the Centers for Disease Control and Prevention (CDC).

Using computerized tracking mechanisms, the infection control department observed nosocomial CRBSI rates higher than the National Healthcare Safety Network (NHSN) benchmark mean in the critical care units for the last several quarters. In the past, follow-up action has been unit specific education on proper line care techniques, and while the rates have dropped briefly, they have remained stubbornly high overall. The mean CVC infection rate for the surgical intensive care unit in 2006 was 3.1 infections per 1000 line days, the medical intensive care unit (MICU/CCU) had 2.7 infections per 1000 line days, and pediatric intensive care unit had 6.4 infections per 1000 line days.

During rounds, the physician staff, advanced practice nurse, and nursing staff assessed CVC dressings each day. Observations revealed that some of the dressings were not in optimal condition. Some of the occlusive dressings had old blood under them and others were loose due to patient diaphoresis or other skin conditions experienced by the patient. As part of this project, this issue was addressed during the roll out of the central line maintenance bundle. During a brainstorming session of the central line infection action group, it became apparent that there were assumptions being made about the knowledge of the nurses and physicians placing lines and maintaining the sites.

Using direct observation during daily morning rounds and informal bedside interview of staff nurses and physicians, gaps were identified. They were non-compliance with the use of the CDC recommended insertion bundle, poor compliance with hand hygiene, poor technique with changing dressings, and misuse of the swabs due to inexperience and misunderstanding of education provided. Other gaps were non-compliance with the CDC recommended daily assessment of need for continued CVC use, and poor technique when accessing ports for medication administration or when drawing from the ports of a

central venous catheter. Following discussion regarding the gaps, the action group decided to begin the focus on the insertion and dressing practices as they relate to the CVC in order to reduce migration of bacteria through the site.

In April 2008, education for the use of the CDC guidelines and CHG patch was implemented. Infection rates for April, May, and June 2008 are at 0 for all units involved. Staff will continue to audit compliance with dressing maintenance and insertion technique. We will also continue to gather data to determine sustainability of the rates over the next year.

Pre-Operative MRSA Screening Program for Patients Undergoing Elective Implanted Surgery

Karen Peterson, RN, MSM; Wheaton Franciscan Healthcare All Saints, Racine, Wis

Surgical site infections (SSIs) account for 38% of health care acquired infections in the surgical patient population. A post-operative surgical site infection can lengthen a patient's anticipated length of stay by an average of 7.5 days and add thousands of dollars to the care cost and result in significant patient morbidity and mortality. A Methicillin Resistant Staphylococcus aureus (MRSA) post-operative SSI can add additional care costs as the infection is more difficult to treat with usual antibiotics.

A review of surgical site infections from July 1, 2006, to July 31, 2007, identified a total of 9, or 6.7% of post-operative SSIs developed following implanted surgery, ie, total hip, hernia repair with mesh, peripheral vascular bypass surgery with graft, implanted shoulder, or pacemaker surgery.

A long-standing MRSA screening program is in place for known previously positive cultured patients upon readmission to Wheaton Franciscan Healthcare All-Saints, but a process was not in place for MRSA screening of patients scheduled for elective surgery.

To improve quality outcomes by reducing the risk of MRSA post-operative

SSIs, a program for screening select elective surgical patients was proposed and approved by all general, vascular, orthopedic, urological, and plastic surgeons. In collaboration with surgeons and infectious disease physicians, patient populations identified include those undergoing a total hip, knee, shoulder, or spinal fusion; hernia repair with mesh; peripheral vascular bypass; and cardiac rhythm management implant, ie, pacemaker, as well as penile prosthesis, artificial urinary sphincters, and breast implants.

Methods: A multidisciplinary team developed a process that is utilized by patient care staff in the physician office setting. Physician office staff are responsible for identifying and following patients who are scheduled for a MRSA-screened operative procedure.

The screening process implemented focuses on an initial MRSA screening culture of the bilateral anterior nares prior to surgery. The timing of the culture is based on the date of surgery and/or history of previous MRSA in the select patient population.

A positive MRSA screening culture is followed by implementation of a decolonization protocol. The patient is re-cultured 2 days following completion of decolonization. A repeat positive MRSA culture is followed by a second decolonization and the patient's fluid is re-cultured 2 days following completion. In the event that the bilateral anterior nares remain MRSA positive following the second decolonization, the surgeon is encouraged to use Vancomycin as the pre-incision antibiotic.

Surviving Sepsis Campaign

Lori Harmon, RRT, MBA; Society of Critical Care Medicine and Aurora St. Luke's Medical Center Milwaukee, Mount Prospect, Ill

Rationale: More people die in 1 year in North America from severe sepsis than from breast cancer, lung cancer, and colon cancer combined. The incidence of sepsis is strikingly high and significantly underestimated. Data suggest that the prevalence of severe sepsis may double over the next 25 or 30 years; so the implications for resource allocation and utilization in North America are

enormous. Hospitals across the United States and some countries internationally are having success by organizing multiprofessional task forces dedicated to working through the challenges associated with early patient identification and implementation of the sepsis bundles. The Surviving Sepsis Campaign (SSC) evidence-based bundles target rapid intervention in the emergency departments (EDs), floors, and intensive care units (ICUs) much like treatment of stroke and myocardial infarction. Annually, severe sepsis strikes an estimated 750,000 people in the United States with associated costs being borne by insurers, government, patients, and hospitals. Early intervention in the ED and hospital wards can mitigate increased morbidity and mortality. Since approximately 55-60% of all septic patients present to the ED, Aurora St. Luke's Medical Center (ASLMC) selected the ED to launch the bundles. ASLMC also implemented the SSC at another site location-Aurora St. Luke's South Shore (ASLSS).

In June 2006, after a hospital-wide educational program, physicians and nurses began using the sepsis screening tool provided by Institute for Healthcare Improvement (IHI) to screen patients for sepsis upon arrival to the ED with an annual volume of 63,000 patients. The educational program and the sepsis committee is known as the LIFE Campaign (St. Luke's Initiative for the Implementation of Early Goal Directed Therapy and the IHI bundle). Patients were risk stratified into severe sepsis, septic shock, and cryptic shock based on the IHI definitions and with point of care lactate. They were then admitted to the ICU with a standard order set containing all the IHI bundle elements as well as an antibiotic appendix.

Early Goal Directed Therapy (EGDT) and the resuscitation component of the IHI bundles were started in the ED on patients in septic shock or cryptic shock and continued in the ICU under supervision of the electronic ICU physician. Individualized feedback to emergency physicians was provided by committee chart review to ensure compliance of bundle elements.

Data for bundle compliance was compiled 1 month before the formation of

the committee and 2 months after the rollout date.

Ongoing data collection and feedback to physicians and staff is given on a routine basis. Any case not meeting the bundle elements is reviewed by the Sepsis Physician Co-chairs with feedback given to those staff involved.

CUSTOMER SERVICE

Real Time Feedback for Real Time Care: The Use of Retired RN Volunteers in Patient Centered Quality Improvement

Sherri Waid; Saint Clare's Hospital, Weston, Wis

Saint Clare's Hospital wanted to go above and beyond in patient care. To learn more than would be available in the typical survey tool, we undertook a hospitalist survey to help us identify potential patient concerns after discharge. Patient concerns are frequently in the area of follow-up appointments with providers, follow-up testing, and medication compliance. Ultimately we wanted to increase patients' comprehension of care after hospitalization to prevent readmission, and to support the healing process.

We adhered to the **plan, do, study, act** methodology.

Planning involved selecting volunteers with a clinical background, developing training materials, role playing phone calls, shadowing staff through the call back process, and developing survey and tracking tools and relationships with clinical staff.

For implementation (**do**), volunteers conducted call backs within 72 hours for each inpatient who was seen by our hospitalists. The results were entered in a tracking tool. Any patient care concerns were entered into an electronic incident reporting system for follow up.

In **studying** the data, the tool was thoroughly completed and patient concerns were mapped and shared with the hospitalists for process improvement.

Some of the lessons learned (**act**) were adjusting callers' schedules to accommodate high census, revising the survey tool to make it more patient centered,

and knowing when to refer the patient to their patient care provider or back to the hospitalists' nurse practitioner. To validate the program, we have tracked the patient response to the call. Most are very appreciative of the extra attention. Readmission data is shared on a quarterly basis at the Performance Improvement committee.

The survey tool and its results continue to evolve over time to improve the care and quality of services provided to our patients.

Resident-Centered Care

Joan Bahr; Southwest Health Center, Platteville, Wis

The Resident-Centered Care initiative was undertaken to improve resident satisfaction. The process for change initially included a multidisciplinary team, including the nursing home administrator, the director of nursing, activity manager, food/nutrition services manager, and social worker. The initial process to implement the change included attending various conferences across the various disciplines, teleconferencing with facilities that had implemented resident-centered care and asking questions, and visiting a facility that had implemented resident-centered care.

To measure the program's success, the following goals were established for 2007:

- Implement consistent assignment of a core group of staff to the same residents 80% of the time.
- Change the dining experience from tray service to restaurant style dining.
- Offer greater resident choice in when to get up, when to eat, and when to go to bed.
- Offer greater resident choice in bathing.

As plans progressed, the interdisciplinary team increased to include 2 certified nursing assistants, 2 food service workers, maintenance, and housekeeping. Resident-Centered Care involved a culture change within the facility. To prepare the staff for the change to

Resident-Centered Care, an inservice was prepared for all departments. The 4-hour inservice was attended by the entire nursing home staff.

Prior to the March 28, 2007, implementation date, residents or their POA-HC were interviewed regarding the preferred time to get up in the morning; how often, and how they would like to bathe. Also, prior to the implementation date, the food service department tested the meals by working with the food items and staff to determine the best possible method of service. The building was divided into 4 communities with each employee also included in a designated community. The employees were able to choose the community and/or were part of the community based on their position. The only 2 employees not assigned to a community were the director of nursing and the nursing home administrator.

As the Resident-Centered Care project progressed, adjustments were made. Also, the value statement for Resident Centered Care was approved as:

We will....

Communicate with residents in order to strengthen bonds and

Acknowledge the importance of relationships. Through available

Resources we will create an atmosphere that promotes community

Identity, while simultaneously addressing each person's unique

Needs. We will honor the values and standards set by their

Goals with respect and love.

The 1 year anniversary was celebrated April 5, 2008 with a party off-site. Changes over the first year were massive. The process continues with new emphases: the physicians have approved the use of alcohol by all residents (with only minor exclusions), the purchase of a portable bar for monthly "happy hours," the purchase and implementation of 3 raised garden plots, and the development of the communities by hold-

ing meetings with the residents and staff to determine activities for the community. Each community has a bulletin board that is decorated on a monthly basis by members of the community.

Volunteer Patient Advocate *Sister Sharee Hurtgen; Saint Clare's Hospital, Weston, Wis*

Volunteer Patient Representatives (VPRs) make frequent patient rounds to welcome the patient to the hospital, to increase patient satisfaction, address immediate patient concerns, and ensure patients are aware of the patient advocate services. The role is to enhance quality of care and quality customer service.

Prior to becoming a VPR, an individual needs to have served as a volunteer at Saint Clare's Hospital for 1 year.

The VPR visits patients on the assigned unit. They greet patients and assess the patient satisfaction, explain hospital systems such as call light, how to use the TV, how to order food, and assure that the patient has received Saint Clare Hospital Patient and Visitor Guide.

The VPR listens to concerns and either resolves them or brings them to the attention of the charge nurse. If the charge nurse is unable to resolve the concern, the VPR will inform the patient/family that their concern is being forwarded to the Patient Advocate.

The VPR also notes any compliments from the patient and records them. If patient has family at a distance the VPR may give patient a long distance phone card to contact family members.

During patient visits, the VPR asks questions regarding patient care, such as the following:

- Do you know how to use your call light?
- Has anyone gone over your patient booklet with you?
- Do you know how and when to order your meals?
- How have they been taking care of you?

Wisconsin Medical Journal

Instructions to Authors

SUBMISSIONS

1. Manuscripts: Manuscripts are considered with the understanding that they have not been published previously and are not under consideration by another publication.
2. Cover Letters: Each manuscript must be accompanied by a cover letter containing the following sentence: "In consideration of the *Wisconsin Medical Journal's* taking action in reviewing and editing this submission, the author(s) hereby transfer(s), assign(s), or otherwise convey(s) all copyright ownership to the *Wisconsin Medical Journal* in the event that this work is published in the *Wisconsin Medical Journal*." All co-authors must sign the letter.
3. Title Page:
 - a. The title page must designate a corresponding author and provide a complete address, telephone number, fax number and e-mail address.
 - b. Affiliations are needed for each author.
4. Disclosures: *Wisconsin Medical Journal* expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work must be acknowledged, as must all institutional or corporate affiliations of all authors. **Author disclosure declarations must be filled out and signed by each author and must accompany the initial submission.**
5. Authorship: The *Journal* follows the ICMJE guidelines for biomedical publications. See www.icmje.org/. "Authorship credit should be based on 1) substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) drafting the article or revising it critically for important intellectual content; and 3) final approval of the version to be published. Authors should meet conditions 1, 2, and 3."

COPYRIGHT

Accepted manuscripts become the property of the *Wisconsin Medical Journal* and may not be published elsewhere, in part or in whole, without permission from the *Wisconsin Medical Journal*. Abstracts may be reproduced without specific permission, provided that acknowledgment of the source is made.

PREPARATION OF MANUSCRIPTS

Submit papers to: Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701 or e-mail: wmj@wismed.org. **Submissions that do not meet the following requirements will be returned to the authors for revision prior to review by the Editorial Board.**

1. Manuscripts should be computer-generated. PC compatible floppy disks, zip disks or cds are acceptable. A printed copy must accompany or follow all electronic submissions.
2. Use 1-inch margins and double-space throughout. 12 pt. font, Times New Roman is preferred. Pages must be numbered, beginning with the title page.

3. Please provide any illustrations electronically as EPS or TIF files or as clean black and white hard copy. Do not embed illustrations in Microsoft Word documents.

4. The following outline is recommended for the organization of original research:

a. *Abstracts*: 200 words or less, stating the problem considered, methods, results and conclusions. Use complete sentences and do not cite references. All manuscripts that contain original work **must** have a structured abstract. For an example of a structured abstract, go to: <http://jama.ama-assn.org/misc/ifora.dtl#Abstracts>.

b. *Methods*: Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures, and equipment well enough to allow replication. If the study involves human subjects, please indicate the IRB that approved the study.

c. *Results*: Provide test results. If tables or illustrations are used, they should emphasize or summarize only the most important observations in the text.

d. *Discussion*: Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the study's purpose. Recommendations, when appropriate, may be included.

e. *References*: Limit to 25 except for review articles, which may use up to 50. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

f. All illustrations and tables taken from other publications must be acknowledged, and written permission to reprint from the copyright holders must be submitted.

g. Regular manuscripts should be <3000 words, or no longer than 15 pages, including references; review articles should be <4000 words or no longer than 20 pages, including references; case reports should be <2000 words or no longer than 10 pages, including references.

STYLE

1. Do not use abbreviations in the title or abstract, and limit their use in the text. **All abbreviations must be spelled out on first use.** Acceptable abbreviations of clinical, technical, and general terms can be found in the *AMA Manual for Authors and Editors* and *AMA Manual of Style*, 9th ed.

2. Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")

3. Supply the full and correct names of drugs. Use generic names of drugs, unless the specific

trade name of a drug is directly relevant to the discussion. Brand names may be inserted in parentheses.

4. Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.

5. Provide each author's full name and highest academic degree in the byline.

6. Figure legends must be typed double spaced on pages separate from the text and figure. Abbreviations used in the figure must be listed in the legend and all symbols must be explained. All lettering and symbols must be of a readable size—12 pt is recommended.

7. Tables should be self-explanatory and should not duplicate the text or figures. Please place tables at the end of the document, with each on a separate page.

REVIEW PROCESS

1. Original research, review articles and case reports undergo a peer review process, with members of the editorial board and others with expertise on the subject serving as reviewers. The medical editor has the final decision as to whether these types of papers will be published.

2. Editorials, letters, and commentary are reviewed by the medical editor, Society staff, and legal counsel. Editorials and letters are signed by the authors, are the authors' opinions, and do not necessarily reflect the policies of the Society. Letters are limited to 500 words and subject to editing for length, clarity, and style.

REVISIONS

It is rare that a paper is accepted without revision. Authors should submit their revised version by sending a hard copy of the manuscript with an electronic version on a PC-compatible disk or e-mailing the file to wmj@wismed.org.

EDITING

All manuscripts will be edited by the *Wisconsin Medical Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style. Suggestions for titles are welcome, but are subject to editorial constraints.

GALLEY PROOFS

The author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting minor and typographical errors only. Revisions in the paper are not possible at this stage and should have been made prior to final acceptance of the paper. Authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

QUESTIONS

If you have questions, contact the *Wisconsin Medical Journal* at 866.442.3800 or 608.442.3800, or e-mail wmj@wismed.org.



“Here kitty, kitty.”

You'd think it would be easy to spot a kid with a vision problem, but the signs aren't always so obvious. One in four children has a vision problem, but only an eye doctor can tell for sure. And, since 80 percent of all childhood learning is visual, good grades and good vision go hand in hand. For more information, visit www.checkyearly.com.



**Check Yearly.
See Clearly.®**



Jonathan I. Ravdin, MD

Partnerships are most effective tool for eliminating disparities

Jonathan I. Ravdin, MD

Dean and Executive Vice President, Medical College of Wisconsin

What separates those with easy access to quality health care from those without? What separates those who have a higher disease burden and poorer outcomes from those who can expect longer, healthier lives? In some cases, it's no more than a property line, but geography is only part of the equation.

The disparities in health and health care that weigh heavily on our communities are also based on age, ethnicity, gender, and economics, or a combination thereof. These factors can result in disadvantages that efforts by individuals or their health care professionals are unlikely to overcome. Partnerships, however, have proven effective as tools for restoring parity to the health care system.

Partnerships capitalize on the strengths and unique skills of each participant, be they an academic, community, or health care organization. The union of stakeholders with knowledge and resources provides an opportunity to empower whole communities to improve their health and, hopefully, their quality of life.

The concept is fairly simple, but the design and implementation is often complex. Large segments of our population face very serious health issues, and the disparities, nationally and locally, are glaring.

Take, for example, life expect-

tancy in the United States. The most recent figures available show Caucasian women living to an average age of 81 while African American men have a life expectancy of 70 years.¹

There is inequity nationally in access to care as well. More than 15 percent of our population is uninsured, and within this group, further disparities exist. The uninsured rate is 10.4% for Caucasians, 19.5% for African Americans, and 32.1% for Hispanics.¹⁻²

The Medical College of Wisconsin's hometown of Milwaukee is the seventh worst city for percentage of families living in poverty (26%) and fourth for children living in poverty (41%). While Wisconsin has one of the lowest 3 uninsured rates in the nation (estimated between 7.2% and 8.5%), approximately 16% of residents in Milwaukee do not have health insurance for all or part of any given year.²⁻³

The overall rate of infant mortality in Milwaukee is double that of the state (12 per 1,000 births versus 6) and includes significantly disparate rates for African Americans (19.4) versus non-Hispanic Caucasians (5.3).⁴ Only 67% of non-Caucasians receive any prenatal care whatsoever. The No. 1 cause of death in Milwaukee for people between the ages of 15 and 34 is homicide, followed by

injuries and suicide.⁵

These statistics may or may not startle those practicing on the front lines of patient care, but they do—without question—state a case for the need for leadership by health care and public health professionals. By virtue of their expertise and resources, medical schools have the aptitude and arguably the responsibility to work to reverse disparities. Seeing such inequities among our neighbors in Milwaukee is an unremitting reminder that new efforts are needed, and in many cases, warrant further expansion.

The Medical College of Wisconsin looks on this as a challenge to harness a passion for caring and a commitment to making a difference in improving the health of our communities. We will be leveraging our tremendous collective clinical knowledge, our educational programs, our research discoveries, our public health knowledge, our organizational capabilities, and our advocacy to bring positive change to bear.

Present and future partnerships will be a cornerstone of our endeavors. The Medical College of Wisconsin's clinical care services are built on a history of strong partnerships with our hospital affiliates, including Froedtert Hospital, Children's Hospital of Wisconsin, and the Clement J. Zablocki VA Medical Center. We have also initiated a number of collaborations with other local health systems to

expand access to patient care provided by our expert faculty.

Through the years, our desire to foster healthy communities has led to multiple partnerships with neighborhood stakeholders, civic leaders, and other academic institutions. These programs have made such strides as increasing literacy, expanding AIDS education, and reducing injuries.

Robert Golden, MD, Dean of the University of Wisconsin School of Medicine and Public Health and Vice Chancellor for Medical Affairs at the University of Wisconsin-Madison, and I meet on a regular basis to coordinate our efforts and planning with regard to improving the health of our communities through the endowments resulting from the Blue Cross Blue Shield conversion to a for-profit stock corporation in 1999.

The Medical College's Advancing a Healthier Wisconsin initiative, which was created from the proceeds of this conversion, has enabled us to extend our partnership model to a host of new projects to improve public and community health. In particular, the Healthier Wisconsin Partnership Program component has funded 102 projects that are driven by community-academic partnerships.

Some of the newest partnership projects are engaged in such activities as:

- Reducing socioeconomic and health disparities in an urban, African-American, Milwaukee neighborhood by strengthening a community-based health coalition and implementing programs to promote healthy life skills and community self-sufficiency
- Impacting morbidity and mortality from chronic disease through increased disease prevention and health promotion activities for the mostly rural, underserved population in 4

western Wisconsin counties

- Developing an automated, Web-based geographic information systems infrastructure for public health staff, researchers, and students that can provide convenient, mapped population health information from a variety of data sources to support community health improvement planning

The power of partnership is also valuable for improving training and education for professionals active in public and community health activities. The Healthy Wisconsin Leadership Institute, for example, is a continuing education and training resource supported through a partnership between The Medical College of Wisconsin and the University of Wisconsin School of Medicine and Public Health. This collaboration is helping build a workforce and develop leaders equipped to protect and promote the health of the public throughout the state.

The Medical College of Wisconsin has also launched a 4-year doctoral program in public and community health this year. The program is the only of its kind in the nation that is structured to blend the core rigors of public health with community-based participatory research into 1 curriculum.

By training a competent workforce, by using partnerships to take public health initiatives directly into the community, and by exercising our leadership and expertise to make a tangible difference in society, we give ourselves a very real opportunity to reduce the health disparities that burden too many across our region. We are committed to promoting health equity in our community, nationally, and even internationally, through research partnerships, education, clinical care delivery, and community service.

References

1. Arias E. *United States Life Tables, 2004*. National vital statistics reports. Vol 56. No 9. Hyattsville, MD: National Center for Health Statistics. 2007.
2. DeNavas-Walt C, Proctor BD, Smith J. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Washington DC: US Census Bureau; 2007.
3. Athens JK, Booske BC, Taylor KW, Rohan AK, Remington PL. *Wisconsin County Health Rankings, 2007*. University of Wisconsin Population Health Institute. 2007.
4. *Fetal Infant Mortality Review*. City of Milwaukee Health Department; 2004.
5. *Milwaukee Community Health Profile*. City of Milwaukee Health Department.

The Americans with Disabilities Amendment Act— Are you ready for the changes?

Michelle Leiker, JD

On January 1, 2009, the Americans with Disabilities Act Amendment Act (Act), the most comprehensive change to the American with Disabilities Act (ADA) within the last decade, will take effect. The Act will require both large and small employers to completely overhaul their approach to reasonable accommodation requests from employees under the ADA.

What is Behind the Changes?

Congress enacted the ADA in 1990 to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities. Shortly after this, a number of federal courts began to reject the majority of ADA claims brought before them. These decisions led to a series of US Supreme Court rulings that narrowed the range of coverage for individuals with serious impairments. The Equal Employment Opportunity Commission (EEOC) also put into place an ADA regulation instructing employers to determine if an employee was considered disabled without considering mitigating measures (eg, medications, prosthetics, hearing aids), which further limited the protections initially provided by the ADA.

Disability advocates and members of Congress disagreed with the US Supreme Court rulings and EEOC rule. As a result, advocates pushed for change to provide the broad coverage originally envisioned by Congress. The Act was intended to rectify the impact of the court rulings and EEOC rule that, in the word of the Act, “have created an inappropriately high level of limitation necessary to obtain coverage under the ADA,” which resulted in decisions holding that “people with a range of substantially limiting impairments are not people with disabilities.”

What Changes Does the Act make?

While the Act makes numerous changes to the ADA, the most significant changes are noted below.

- *Definition of “substantially limits” enhanced.* While the Act essentially retains the definition of disability, it did expand the interpretation of certain words in the definition, thereby commanding a broad reading of the term “disability.” The Act specifically overruled the EEOC and the US Supreme Court’s interpretation of the meaning of “substantially limits.” It discarded the “unable to perform/severely restricted” standard and ordered the EEOC to revise the agency’s regulations. While the term “substantially limits” does

not change in the ADA itself, the Act clarifies that the new standard will be less stringent, and will no longer require an impairment to be as serious as under prior interpretations of the ADA.

- *Definition of “major life activities” expanded.* Until now, the ADA was silent on what constituted a “major life activity.” A major life activity is an area of an individual’s life that needs to be adversely affected in order for the individual to claim a disability.

The Act contains a very broad list of conditions that should be considered major life activities. The list sets forth a number of items (eg, caring for oneself, lifting, bending, breathing, learning, eating, reading, sleeping), but notes that while the list sets forth examples, it is non-exhaustive. The Act clarifies that an impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability, and that a person can be considered disabled under the ADA if he or she has an impairment that substantially limits the major life activity of working. The Act further expanded the definition of “major life activities” to include “major bodily functions” (eg, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respira-

Ms Leiker is the Assistant General Counsel at the Wisconsin Medical Society.

tory, circulatory, endocrine, and reproductive functions).

- *Mitigating measures almost completely eliminated from consideration.* The Act requires that a disability be determined without considering mitigating measures, such as medications, prosthetics, hearing aids, mobility devices, and learned adaptation. The only exception to this rule is that “ordinary eyeglasses or contact lenses” should not be considered when assessing whether an individual has a disability.
- *Impairment requirements clarified.* The Act clarifies that an impairment that is episodic or in remission can still be considered a disability if it would substantially limit a major life activity when active.
- *“Regarded as” prong refined.* The Act expands “regarded as” protections by prohibiting discrimination based on an employer’s perception of a mental or physical impairment, whether or not the individual can establish that the impairment actually limits, or is perceived to substantially limit, a major life activity. The Act clarifies that the “regarded as” prong will not be used when an impairment has an actual or expected duration of 6 months or less and is minor. Furthermore, the Act provides that individuals covered only under the “regarded as” prong are not entitled to reasonable accommodation.

What this Means to Employers

Employers should:

- Review their policies and practices governing the ADA’s interactive process and revisit the essential functions of positions at their company to ascertain what functions are the core responsibilities that may require accommodation.

- Proceed with caution when responding to accommodation requests from employees. Employers can no longer use the now-defunct Supreme Court standards for making disability determinations.
- Be prepared to offer accommodations to a wider percentage of their workforce.
- Keep in mind that if the disability is obvious, a duty to accommodate may exist even if the employee has not requested an accommodation.
- Maintain records of accommodations requests made and accommodations provided or denied, along with documentation of the reasons for such decisions.

Does the ADA Apply to You?

The ADA applies to those workplaces with 15 or more employees. This number includes part-

time and temporary employees, and applies if an employer had 15 or more employees for at least 20 weeks during the current or preceding calendar year.

Summary

Significant change is coming quickly, and employers need to be prepared. The Act will move the focus from a “disability” inquiry to an individualized interactive process, and will likely increase the number of individuals protected under the ADA. The defenses and employer modes of responding to disability claims will be narrowed while the range of ADA coverage will expand considerably. Additional information on the ADA and the recent amendments can be obtained by calling the Department of Justice’s ADA Information Line (800.514.0301), the EEOC (800.669.4000), or by visiting the DOJ’s ADA Web site (<http://www.ada.gov/>).

© 2000 National Crime Prevention Council

Ad Council

Peer Counselor

What do you want to be labeled as?

Get involved. 800-722-teens weprevent.org

WALK THE LINE GAME

U.S. Department of Justice
Black Prevention Center of America



Christopher P. Thomas

Follow your plan for retirement

Christopher P. Thomas

When you tell your patients they need to lose weight, exercise, or stop smoking, they sigh and nod their heads in agreement. When your financial adviser tells you that you need to save for retirement, do you respond likewise?

Recent market volatility sometimes makes you rethink your plan and tolerance for risk. Lifestyle changes require effort and self-discipline, but the long-term rewards can be great. Here are some recommendations to help you get started on the right path.

1. Assess your current condition.

If you're struggling to make the mortgage and credit card payments every month, you probably aren't thinking about saving for retirement. Look at your lifestyle and spending habits and decide if you are living beyond your means. It is OK to live for today as long as you also plan for tomorrow.

2. Check your vital signs.

Assuming your situation is not acute, you need to take a regu-

lar look at your family income, expenses, debt level, and investment earnings. As you get closer to retirement, some expenses—home mortgage or children's college expenses, for example—will decrease. Other expenses—health insurance, prescriptions, and travel—will likely increase. Early detection allows you to make small course corrections in your spending or savings that could make a difference during retirement.

3. Set goals.

What does "retirement" mean? To you? To your spouse? Many people want to retire before age 65. You may continue working, even though you are "retired." This often means working fewer hours or starting a second career and becoming responsible for your health care costs and retirement savings. More leisure time also means more time to travel and pursue hobbies you might not have had time for in the past.

4. Create an action plan.

No matter how good your plan is, it will not be much help unless you take action. Your action plan should include (1) an assessment of your tolerance for risk, (2) a strategy for broadly diversifying your investments, and (3) periodic rebalancing

of your portfolio to make sure your investments are meeting your expectations for earnings and staying within your parameters for risk. You can create and manage your own investments; however, many people prefer to delegate this to a professional financial advisor.

5. Stick to it.

Staying invested for the long term is a proven strategy! If you had invested \$10,000 in the S&P 500 index on January 1, 1980, and reinvested the dividends, your money would have appreciated to \$306,322 by December 31, 2007. Remember, "discipline" comes from the word disciple, ie, someone who follows. Follow your plan and watch your retirement savings grow.

6. Act now.

Physicians typically start their careers later and with larger student loan debt than others their age. Fewer earning years, longer life expectancies, and an uncertain economic future mean you cannot afford to procrastinate when it comes to retirement planning.

Like your patients, you know what you need to do. Establish good spending and savings habits today and enjoy financial well-being for years to come.

Christopher P. Thomas is a financial consultant with SVA Wealth Management, Inc., Registered Investment Adviser, an affiliate of Suby, Von Haden & Associates, SC.

Advancing outpatient prevention: A new MetaStar project

Jay A. Gold, MD, JD, MPH

MetaStar is currently recruiting primary care physician practices for a new Medicare project that will use clinical data to identify barriers and gaps to providing necessary care and to identify and track interventions to improve patient outcome. The key methods of eliciting improvement are health information technology and care management processes.

The clinical topics covered by this project are (1) Breast cancer screening (mammography), (2) Colorectal cancer screening (Fecal Occult Blood Test [FOBT], flex sig, Barium enema, colonoscopy), (3) Influenza immunization, and (4) Pneumococcal immunization.

Eligible practices will have implemented a Certification Commission for Health Information Technology (CCHIT) certified electronic health record, be at least 40% primary care, and have basic

care management capabilities. Practices chosen will participate in data submission for the 4 topic areas and quality improvement interventions.

To assist practices, MetaStar will provide the following:

- Tailored quality improvement assistance
- Best practice sharing facilitation
- Quarterly data reports and analysis
- Electronic health record utilization assistance
- Patient-specific intervention assistance and resources
- Change package for each content area and appropriate resources
- Public relations support to highlight the practices' commitment to quality care
- Data submission assistance
- One-on-one assistance to practices in need
- National best practice sharing and problem solving
- National recognition for participation

Commitment from enrolled practices will include

- Signed participation agreement*
- Completed Care Processes assessment*
- Minimum of 2 hours of care

management and/or prevention education completed by each site (CME provided by MetaStar)

- Data submission for the 4 prevention topic areas for at least 75% of patient panel*
- Implementation of quality improvement interventions
- Identification of key contacts at each participating location*
- Support of process and program by leadership
- Best practice sharing with other participating practices

Practices also have the option to participate in the data submission component only. Items with an asterisk (*) listed above highlight the necessary tasks for such participation. No quality improvement assistance will be provided to these practices.

The number of practices with which MetaStar will work in this project is limited. For more information please contact Jesi Wang at 608.441.8269 or jwang@metastar.com.

Dr Gold is Senior Vice President and Chief Medical Officer of MetaStar, Inc. 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.

Index to Articles: 2008

Authors of Peer-Reviewed Articles

- Ahmed, MD, PhD, Mohamed S.: 4-191
 Ai, MD, PhD, Zhaowei: 6-298
 Albanese, BS, Aggie: 7-320
 Anderson, RN, BSN, Heidi: 5-231
 Anderson, MD, Henry: 4-169
 Asplund, MD, FACS, Mark W.: 5-244
 Athens, MS, Jessica: 4-169
 Atwater, MD, Brett D.: 6-298
 Baciak, Krystal: 3-118
 Bade, MD, Elizabeth: 8-374
 Bain, MD, FACP, Philip A.: 8-380
 Baker, PhD, Timothy B.: 5-237
 Bandi, MD, Gaurav: 2-91
 Banerjee, BS, Indrani: 8-374
 Baskaya, MD, Mustafa K.: 1-37
 Bekkedal, PhD, Marni: 4-169
 Bergum, MPA, Alison: 8-369
 Bica, PhD, Lori A.: 5-225
 Boeke, MS, Melissa C.: 1-25
 Booske, PhD, MHSA, Bridget C.: 1-25, 3-124
 Brandow, DO, Amanda M.: 3-131
 Breslin, MD, MPH, Tara M.: 6-292
 Brousseau, MD, MS David C.: 3-131
 Bukstein, MD, Don: 2-69
 Burzynski, RN, Mary: 2-62
 Chan, MD, MPH, Micah R.: 7-335
 Charipar, MD, FACP, Ron: 4-176
 Charipar, MD, Elizabeth: 4-176
 Chawla, MD, Paramjith S.: 2-76
 Cheng, MD, Yee Chung: 4-191
 Corden, MD, Timothy E.: 1-20
 Davis-Malesevich, MD, Melinda: 2-62
 Eddy, MD, Jennifer, J.: 4-187
 Einstein, MD, Michael: 1-40
 Euclide, RN, MBA, Jeff: 5-231
 Evertsen, MS, Jennifer: 8-374
 Fiore, MD, Michael C.: 5-237
 Flejsierowicz, MD, Magdalena: 4-191
 French, MBA, RHIA, CPHQ, CHPIT, Bill: 1-33
 Friedsam, MPH, Donna: 8-369
 Galletly, JD, PhD, Carol L.: 2-84
 Getzin, BA, Anne: 8-369
 Gideonsen, MD, Mark D.: 4-187
 Gilles, BS, Heather: 3-118
 Gold, MD, JD, MPH, Jay A.: 1-33
 Guerard, BS, Emily: 2-69
 Gutowski, MD, Karol A.: 6-292
 Hagen, PhD, Erika W.: 7-320
 Halanski, MD, Matthew A.: 1-20
 Hartlaub, MD, MSPH, Paul: 5-231
 Havens, MD, MS, Peter L.: 2-84
 Havens, BS, Sarah: 3-118
 Hinshaw, MD, Molly: 7-335
 Hoffman, BS, Sarah: 7-327
 Hooks, Tisha, PhD, MS: 3-118
 Hu, MD, Johnny L.: 1-40
 Izci, MD, Yusuf: 1-37
 Jackson, MD, Thomas: 5-237
 Jaffery, MD, Jonathan B.: 7-335
 Jamelske, PhD, Eric: 5-225
 Johnson, MD, Eric A.: 1-40
 Joossee, RN, BSN, Laura: 5-231
 Jorenby, PHD, Douglas E.: 5-237
 Kam, BS, Jared: 3-131
 Knox, BA, Kjersti E.: 8-369
 Kotov, MD, Petio: 4-191
 Krall, MD, Edward J.: 6-279
 Kwiecinski, RN, JD, Maureen F.: 2-84
 Kochar, MD, MS, Mahendr S.: 2-76
 Lambert, RN, Pamela J.: 6-287
 Lawrence, MD, Steven L.: 4-181
 Logan, PhD, Brent R.: 2-62
 Mack, DPM, Gregory, P.: 4-187
 Malecki, PhD, Kristen: 4-169
 Mareedu, MD, Ravi K.: 7-331
 Mathiason, MS, Michelle A.: 6-287
 McBride, MD, MPH, Patrick: 8-369
 McCarty, PhD, Daniel J.: 5-225
 Meinen, MPH, RD, Amy: 5-225
 Mesa, MD, Juan E.: 7-331
 Moftakhar, MD, Roham: 1-37
 Morzinski, PhD, Jeffrey A.: 4-181
 Nakada, MD, Stephen Y.: 2-91
 Napier, MD, FACS, Tim: 3-136
 Nattinger, MD, MPH, Ann B.: 2-62
 Neuburg, MD, Marchy: 2-62
 Olson, PA-C, Jeremi T.: 3-136
 Pack, MD, Quinn R.: 5-237
 Palta, PdD, Mari: 7-320
 Panepinto, MD, MSPH, Julie A.: 3-131
 Penniston, PhD, RD, Kristina L.: 2-91
 Petroll, MD, Andrew E.: 2-84
 Pfau, MD, Patrick R.: 1-40
 Pinkerton, PhD, Steven D.: 2-84
 Piper, PhD, Megan E.: 5-237
 Rabago, MD, David: 2-69
 Radjenovich, Mary Ellen: 4-181
 Rao, MD, MBA, Venkat K.: 6-292
 Rhee, MD, MPH, John S.: 2-62
 Remington, MD, MPH, Patrick L.: 1-25, 4-169
 Rieselbach, MD, MACP, Richard: 8-369
 Rigby, PhD, Elizabeth: 3-124
 Robert, PhD, Stephanie A.: 3-124
 Rohan, PhD, Angela M.: 3-124
 Rooney, Brenda, PhD: 3-118
 Sadek-Badawi, MBCh, Mona: 7-320
 Salamat, MD, PhD, M. Shahriar: 1-37
 Schrager, MD, MS, Sarina: 7-327
 Shapiro, MD, FACS, Stephen B.: 6-287
 Smiley, MPH, Sabrina: 8-374
 Spier, MD, Bret J.: 1-40
 Spring, MD, Michelle A.: 6-292
 Stacey, MD, D. Heath: 6-292
 Stearns, MA, MPH, Majorie: 5-231
 Treat, MA, Jennifer: 3-136
 Weston, MSW, Patricia: 5-237
 Williams, MS, Nathan: 1-33
 Windmiller, BA, Jennifer: 3-136
 Wolff, MD, Matthew R.: 6-298
 Yevzlin, MD, Alexander S.: 7-335
 Zahner, DrPH, RN, Susan J.: 1-25
 Zurick, III, MD, Andrew O.: 1-40
- Authors of Non-Peer-Reviewed Articles**
 Barry, MS, Leonard W.: 2-101
 Bartholow, MD, Tim: 8-360
 Bedinghaus, MD, FAFP, Joan M.: 2-59
 Bergin, MD, Steven: 8-357
 Brokopp, DrPH, Charles D.: 2-113
 Brown, MD, MPH, Richard L.: 1-5
 Buchanan, JD, Brian L.: 4-207
 Busalacchi, Stephen J.: 1-8, 4-164
 Cote, AIF, Sean: 4-211
 Coyne, JD, Sarah E.: 6-305
 Czarapata, Jay, CFP, CRPS: 1-44
 Dunn, MD, Michael J.: 2-103
 French, MBA, RHIA, CPHQ, CHPIT, Bill: 4-213
 Foldy, MD, MPH, FAFP, Seth L.: 2-59
 Foulks, Jr., CPA, CAE, CFO, Robert J.: 6-301
 Frey, John, III, MD: 2-56; 4-167; 5-221, 6-277
 Friedsam, MPH, Donna: 8-363
 Gold, MD, JD, MPH, Jay: 3-145; 4-213; 5-270; 7-347, 8-396
 Golden, MD, Robert N.: 3-142, 5-367; 7-343
 Grossman, MD, Jeff: 8-367
 Hansen, CLU, Maureen: 5-269
 Hitchcock, Mary: 1-12
 Jain, Shaili, MD: 2-57
 Jones, Kyle Branford: 3-115
 Katcher, MD, PhD, Murray L.: 2-115
 Katayaman, JD, Alyce C.: 6-305
 Lamberton, Leandrea, MD: 6-286
 Land, Dian: 1-12
 Lee, BS, Victoria S.: 1-10
 Leiker, JD, Michelle: 7-344, 8-393
 McCarragher, JD, Molly J.: 3-147
 Meyer, Thomas, MD: 6-285
 Meyer, Walt, MD, DMD: 5-223
 Moffic, MD, H. Steven: 1-5
 Moorthy, MD, A. Vishnu: 1-16
 Moskol, JD, Kerry L.: 6-305
 Ravdin, MD, Jonathan, I.: 4-209, 6-303, 8-391
 Rieselbach, MD, MACP, Richard: 8-363
 Schlenker, MD, MPH, Thomas: 2-113
 Schramka, JD, SPA, PFS, CVA, E.G.: 6-307
 Simmons, MA, Greg: 3-145
 Simmons, MA, Kay: 3-145
 Starnes, CEO, W. Stancil: 7-349
 Sullivan-Fowler, Micaela: 1-12
 Thomas, Christopher P.: 8-395
 Turney, MD, MS, FACP, FACMPE, Susan L.: 7-319
 Vasudevan, MD, Sridhar: 5-265
 Vermeulen, MS, RPh, Lee C.: 4-213
 Wegehaupt, MD, FAAP, Paul K.: 1-5
 Wegner, MD, MPH, Mark V.: 1-16
 Zabawa, JD, Barbara J.: 5-263
- Peer-Reviewed Papers**
 Acute Thigh Compartment Syndrome Post Femoral Vein Catheterization: A Case Report (Asplund): 5-237
 Administration of Tissue Plasminogen Activator for Acute Ischemic Stroke in a Rural Wisconsin Hospital (Charipar, Charpiar): 4-176
 Amyloidosis Presenting as Lower Gastrointestinal Hemorrhage (Spier, Einstein, Johnson, Zurick, Hu, Pfau): 1-40
 Behavior Modification and Risk Perception in Patients with Nonmelanoma Skin Cancer (Rhee, Davis-malesevich, Logan, Neuburg, Burzynski, Nattinger): 2-62
 Calciphylaxis Responsive to Lanthanum Carbonate: A Case Report (Chan, Yevzlin, Hinshaw, Jaffery): 7-335
 Collaboration Saves Time (Bain): 8-380
 Comparison of the Nicotine Lozenge and Nicotine Gum: An Effectiveness Randomized Controlled Trial (Pack, Jorenby, Fiore, Jackson, Weston, Piper, Baker): 5-237
 Comparison of Open and Laparoscopic Techniques in Elective Resection for Diverticular Disease (Shapiro, Lambert, Mathiason): 6-287
 Comparison of Wisconsin Neonatal Intensive Care Units with National Data on Outcomes and Practices (Hagen, Sadek-Badawi, Albanese, Palta): 7-320
 Doctors who Doctor Self, Family, and Colleagues (Krall): 6-279
 Exploring the Effect of the Referring General Surgeon's Attitudes on Breast Reconstruction Utilization (Stacey, Spring, Breslin, Rao, Gutowski): 6-292
 Fulminant Myopericarditis from Phenytoin-Induced Systemic Lupus Erythematosus: A Case Study (Atwater, Ai, Wolff): 6-298
 Influence of Double-Credit Evidence-Based Continuing Medical Education on Presenters and Learners (Lawrence, Morzinski, Radjenovich): 4-181
 Fit Kids/ Fit Families: A Report on a Countywide Effort to Promote Healthy Behaviors (Joosse, Sterns, Anderson, Hartlaub, Euclide): 5-231
 Local Public Health Department Funding: Trends Over Time and Relationship to Health Outcomes (Boeke, Zahner, Booske, Remington): 1-25
 Long-term Follow-up of a Single Rural Surgeon's Experience with Laparoscopic Inguinal Hernia Repair (Napier, Olson, Windmiller, Treat): 3-136
 Measuring the Environmental Health of Wisconsin's Counties (Athens, Bekkedal, Malecki, Anderson, Remington): 4-169
 Minutes in Motion: Motivating a Community to Move (Rooney, Hooks, Baciak, Havens, Gilles): 3-118

- Nasal Irrigation for Chronic Sinus Symptoms in Patients with Allergic Rhinitis, Asthma, and Nasal Polyposis: A Hypothesis Generating Study (Rabago, Guerard, Bukstein): 2-69
- Navigating the Health Care System: A View from the Urban Medically Underserved (Bade, Evertsen, Smiley, Banerjee): 8-374
- Parental Perception of Quality of Hospital Care for Children with Sickle Cell Disease (Kam, Panepinto, Brandow, Brousseau): 3-131
- Patent Foramen Ovale with Right to Left Shunt as a Cause of Hypoxia: Case Report (Mareedu, Mesa): 7-331
- Practical Approach to Metabolic Evaluation and Treatment of the Recurrent Stone Patient (Bandi, Nakada, Penniston): 2-91
- Practical Considerations of Using Topical Honey for Neuropathic Diabetic Foot Ulcers: A Review (Eddy, Gideonsen, Mack): 4-187
- Preliminary Findings from an Evaluation of the USDA Fresh Fruit and Vegetable Program in Wisconsin Schools (Jamelske, Bica, McCarty, Meinen): 5-225
- Public Views on Determinants of Health, Interventions to Improve Health, and Priorities for Government (Robert, Booske, Rigby, Rohan): 3-124
- Short Report: Factors that Affect Specialty Choice and Career Plans of Wisconsin's Medical Students (Knox, Getzin, Bergum, McBride, Rieselbach, Friedsam): 8-369
- Spinal Intramedullary Cysticercosis of the Conus Medullaris (Izci, Mofkhar, Salamat, Baskaya): 1-37
- Successful Treatment of Aggressive HIV-Associated Multicentric Castleman's Disease: A Case Report (Flejsierogicz, Ahmed, Kotov, Cheng): 4-191
- Updated CDC Guidelines for HIV Testing: A Review for Wisconsin Practitioners (Petroll, Galletly, Havens, Kwiecinski, Pinkerton): 2-84
- What's New in Clinical Pharmacology and Therapeutics (Chawla, Kochar): 2-76
- Wisconsin Firearm Deer Hunting Season: Injuries at a Level I Trauma Center, 1999-2004 (Halanski, Corden): 1-20
- Women's Knowledge of Commonly Used Contraceptive Methods (Schragger, Hoffman): 7-327
- In This Issue
Where we live affects our health (Frey): 4-167
We are more than what we eat (Frey): 5-221
- A comprehensive journal, and the opportunity for discussion (Frey): 6-277
- Editorials**
Sinuses, sunburn, and prevention (Frey): 2-56
Reexamining the health care system (Frey): 3-117
- Invited Editorials**
What a piece of work is man: The Body Worlds exhibit at the Milwaukee Public Museum (Bedinghaus, Foldy): 2-59
The two-physician family and the medical treatment of our children (Meyer): 6-285
Lessons in objectivity: As a physician's daughter and now a physician mother (Lamberton): 6-286
- Commentaries**
Chronic kidney disease (CKD) in Wisconsin: Time to address this public health problem (Moorthy, Wegner): 1-16
- In Remembrance**
3-114, 7-316
- Focus on... a Century of Inspiration**
University of Wisconsin School of Medicine and Public Health: A Century of Inspiration (Land, Sullivan-Fowler, Hitchcock): 1-12
- Focus on ... Health System Reform**
The time is critical (Bergin): 8-357
Your patients are waiting... for your leadership (Bartholow): 8-360
The ailing health care system: SOAP note for physician leadership (Friedsam, Rieselbach): 8-363
Is there a doctor in the "home"? (Grossman): 8-367
- Letters to the Editor**
Global warming in Wisconsin (Moffic): 1-5
Studies unable to prove prayer is helpful for patients (Wegehaupt): 1-5
WIPHL helps doctors empower patients (Brown): 1-5
Wisconsin first state to screen all newborns for 'bubble boy disease' (Katcher, Brokopp): 2-113
Merging public health (Schlenker): 2-113
Right Man, right time for reform (Meyer): 5-223
- From the Office of General Counsel**
Economic credentialing issues (Buchanan): 4-207
Wisconsin courts weaken physician non-compete agreements (Zabawa): 5-263
Federal Appeals Court reverses lower Court ruling: reaffirms immunity for hospitals and physicians in peer review cases (Leiker): 7-344
- The Americans with Disabilities Amendment Act—Are you ready for the changes? (Leiker): 8-393
- As I See It**
Reflections on a summer internship in public health (Lee): 1-10
Studying the physician patient relationship: A 21st Century approach (Jain): 2-57
Staff of Asclepius: A New perspective on the symbol of medicine (Jones): 3-115
- Dean's Corner**
Efforts in pharmacogenetics will help patients get right amount of right drug (Dunn): 2-103
An Integrated school of medicine and public health—What does it mean? (Golden): 3-142
Medical College's progress a positive for Wisconsin (Ravdin, MD Jonathan I.): 4-209
NIH budgets, patient care, and health (Golden): 5-267
Talent, teamwork give rise to best kidney transplant outcomes in Midwest (Ravdin): 6-303
Thoughts from the White Coat Ceremony (Golden): 7-343
Partnerships are most effective tool for eliminating disparities (Ravdin): 8-391
- Your Practice**
Could declining home values affect your retirement plans? (Czarapata): 1-44
Seven key questions to ask when choosing a financial advisor (Barry): 2-101
Social Security: Take the money at 62 or wait? (McCarragher): 3-147
Ask questions to better understand investment fees (Cote): 4-211
Annuities: guarantee not worth cost (Hansen): 5-269
Another round of Stark law changes coming your way as early as October 1, 2008 (Katayama, Coyne, Moskol): 6-305
Seven reasons to consider a trust (Schramka): 6-307
ProAssurance/PIC Wisconsin offers preview of rate reductions and coverage enhancements (Starnes): 7-349
Follow your plan for retirement (Thomas): 8-395
- Your Society**
Service to others defines 2008 honorees for Wisconsin Medical Society Physician Citizens of the Year (Busalacchi): 4-164
Medicare win in Congress shows power of physician voice (Vasudevan): 5-265
New reporting requirements for nonprofit organizations (Fouls): 6-301
Resolutions due February 17, 2009 for Wisconsin Medical Society Annual Meeting: 7-317
- New Web site aims to alleviate physician workforce shortage (Turney): 7-319
- Your Profession**
Book Excerpt: White Coat Wisdom (Busalacchi): 1-8
- Proceedings**
Proceedings from the 2006 Annual Meeting of the American College of Physicians, Wisconsin Chapter: 4-195
Proceedings from the 2007 Annual Meeting of the American College of Physicians, Wisconsin Chapter: 5-247
Proceedings from the Wisconsin Research and Education Network's 2007 Research Forum: 7-339
Proceedings from the 2008 Wisconsin Quality and Safety Forum, Part I: 8-382
- MetaStar Matters**
MetaStar to Begin new Medicare contract (Gold): 3-145
Reduction of use of potentially inappropriate medications in the elderly (Gold, French, Vermeulen): 4-213
The 5 million lives campaign: Preventing medical harm in Wisconsin and the nation: (Gold): 5-270
2008-2009 recommendations for use of influenza vaccine (Gold): 7-347
Advancing outpatient prevention: A new MetaStar project (Gold): 8-396
- Annual Meeting**
3-149
- Instructions to Authors**
3-140, 8-389
- Call for Reviewers**
1-15, 2-107, 7-316, 8-366
- Call for Papers**
2-58, 4-214
- Member Communication Form**
3-157
- Classified Ads**
1-51, 2-107, 3-159, 4-216, 5-272, 6-312, 7-352, 8-399
- Foundation Donors, 2007**
1-15
- Thank You to Reviewers**
1-15
- Statement of Ownership**
7-342
- Erratum**
8-368

Classified Ads

INFINITY HEALTHCARE— Outstanding opportunity for ABEM (or AOBEM) certified/eligible physicians to join our well-established group, Infinity HealthCare, in an exciting practice setting located in Sheboygan, Wis. Sheboygan is located on the shores of Lake Michigan and is less than an hour from Milwaukee. This is a popular resort destination for fishing, hunting and all season recreational activities. The Village of Kohler, featuring The American Club and world class golf, is a few minutes away, as is Road America Race Track. The high quality of life, excellent school systems, and vibrant growth, make Sheboygan a wonderful place to live and work. The practice has 13K patients/annum, high acuity, and a Level III Trauma Center. Surgical backup is readily available and includes ortho, ENT/oral surgery, plastics, vascular, and general surgery. We have physician assistant partners and a high quality nursing and support staff. Excellent compensation and comprehensive benefit package includes the exceptional benefit of distributed ownership/equity. Please direct inquiries and CV to Mary Schwei or Johanna Bartlett, Infinity HealthCare, 111 E Wisconsin Ave Suite 2100 Milwaukee, WI 53202; ihc-careerops@infinity-healthcare.com; phone 888.442.3883; or by fax 414.290.6781.

INFINITY HEALTHCARE— Outstanding opportunity for ABEM (or AOBEM) certified / EM residency trained physicians to join a well-established, top quality group in an exciting new practice setting. Infinity HealthCare has assumed the ED management and staffing responsibilities at Sacred Heart Hospital in Eau Claire, Wis. A college town, Eau Claire is a major metropolitan center in northwest Wisconsin, surrounded by lakes and recreational areas within a short distance to Minneapolis, Minn. This represents a truly outstanding opportunity for qualified candidates to participate in the reorganization of a quality EM boarded physician practice while joining a highly regarded group, Infinity HealthCare. Excellent compensation and comprehensive benefit package including the exceptional benefit of distributed ownership/equity. The practice has 25K patients/annum & growing, tertiary neuroscience capabilities, Level III Trauma Center & Paramedic Medical

Control Center with group responsibility for the Paramedic Training Center, an efficient physical plant with UC/Fast Track area, physician assistant partners, and a high quality nursing and support staff. Please direct inquiries to: Mary Schwei or Johanna Bartlett at Infinity HealthCare Inc, ihc-careerops@infinity-healthcare.com, 111 E Wisconsin Ave, Ste 2100 Milwaukee, WI 53202, fax 414.290.6781 or at the toll free number 888.442.3883.

HALES CORNERS MEDICAL BUILDING FOR SALE/LEASE
860, 1,100, 2400 and larger sq. ft. available. Southwestern Milwaukee suburb. Contact Steve 414.238.5562.

FT/PT BC/BE—Emergency physician position available. Democratic group. Independent contractor status. Suburb of Milwaukee, Wis. Annual volume 42K/year. Please contact Veronique at Emergency Medical Associates, 262.928.2475, or veronique.swofford@phci.org.

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.

PRACTICE FOR SALE

Well established clinic practice in downtown Milwaukee, Wisconsin. Owner (Ob-Gyn) is retiring. Will stay to introduce patients to new owner. Practice consists of ob-gyn, family practice and pediatrics. The family physician and pediatrician will stay as employees for the new owner. Contact: shafimd1@yahoo.com, or call 414.241.9678, Fax: 414.287.1013.

Index to Advertisers

Alexandria Clinic.....	362
Allied Insurance.....	IBC
Aspirus.....	356
Aurora Health Care	400
Brainerd Lakes/St. Joseph's.....	356
Emergency Medical Associates.....	399
Fairview	359
Infinity Healthcare.....	399
Jesser, Steven.....	400
Madison Emergency Associates	400
Medical College of Wisconsin	400
Medical Property Associates, LLC ...	399
ProAssurance Group.....	BC
Remedy Medical Services.....	362
Schenck Business Solutions	359
Shafi Clinic	399
SVA Wealth Management	356
University of Iowa Hospitals & Clinics	400
University of Wisconsin CTRI	356
Wapiti Medical Group	400
Wisconsin Medical Society Education.....	353
Wisconsin Medical Society Foundation.....	353
WPS	IFC

THE 39TH ANNUAL WINTER REFRESHER COURSE FOR FAMILY MEDICINE FEBRUARY 4 – 6, 2009

Sponsored by The Medical College of Wisconsin Department of Family and Community Medicine.

This program is designed for primary care providers as well as nurse practitioners, physician assistants and other primary care physicians who practice in a variety of settings, including hospitals, nursing homes and offices.

This course will cover a broad range of primary care issues including pediatric and adult medicine, preventive medicine, geriatrics, women's health, and psychiatry.

For information visit www.family.mcw.edu or email meradjen@mcw.edu.



Aurora Health Care®

**Exciting
Internal Medicine
OPPORTUNITIES
in Manitowoc, WI**

Aurora Health Care is a not-for-profit, physician-led, integrated health care system in eastern Wisconsin. Aurora has 13 hospitals, over 100 clinics and 2 new hospitals due to open in 2010. Our main focus is providing quality patient-centered care. We were recently rated the top-performing health system in the nation for quality for our patients in Medicare's pay-for-performance quality demonstration project and the Aurora Medical Center in Two Rivers was just named one of the top 100 hospitals by Thomson Reuters.

Aurora Health Care offers 2 outstanding opportunities for BE/BC Internists at 1 of our 2 multi-specialty clinics in Manitowoc County. Two Rivers is a new position and Manitowoc is an established practice. Access a full range of support services and specialists at both locations and care for your patients at the new Aurora Health Center Manitowoc County, a 73-bed hospital featuring the very latest in diagnostic and treatment technology. Call is 1:5 to 1:6.

The twin cities of Manitowoc and Two Rivers are on the shores of picturesque Lake Michigan. Enjoy golf, charter fishing, boating, hiking, biking, cross country skiing, and snowmobiling. Great schools, low cost of living, and convenient location just 75 miles north of Milwaukee, 30 minutes south of Green Bay, make the Manitowoc/Two Rivers area perfect for those looking for small city charm with big city amenities. Recently rated 24 of 140 in the nation for small towns by the *Business Journal*, and also highlighted in the *Wall Street Journal* as a "booming economy" as manufacturing is growing in Manitowoc!

Aurora offers competitive salary guarantee, comprehensive benefit package and paid medical liability insurance. For a better way to provide health care, contact us at 800.307.7497 or www.Aurora.org/Doctor.

**EM Physician
Madison, Wisconsin**

Emergency Medicine Position. Immediate opportunity for a BC/BE EM physician to join our stable, well established, democratic group practice at Meriter Hospital in Madison, WI. Current ER volume is 44,000/year including 24-hour specialty coverage. We have midlevels, teaching opportunities, and a great location in Wisconsin's capital. Excellent compensation with a comprehensive benefit package. Partnership opportunities. Physician friendly state. For confidential consideration, send CV via e-mail to Dr. Paul Hick at drpkhick@gmail.com.



**Wapiti
Medical
Group**

**Opportunity for Family
Practice/ER Trained
Physicians**

- **Full or Part Time Shifts in Spooner, WI**
- **Increased Rate through Winter**
- **Several other Sites Available**
- **No need to Relocate**
- **Paid Malpractice**

**Contact Dr. Brad McDonald
888-733-4428 or
brad@erstaff.com
www.erstaff.com**

**AMBULATORY &
HOSPITALIST
GENERAL INTERNISTS**

The Division of General Internal Medicine at the University of Iowa is recruiting BC/BE general internists for both ambulatory & hospitalist positions in our non-tenure Clinical Track. Candidates will have substantial opportunities to teach Internal Medicine residents and medical students and participate in faculty development programs.

We welcome applications from experienced clinicians who wish to bring their expertise to an academic practice. Academic rank and salary will depend on candidates' qualifications, as consistent with University policy. All inquiries will be handled in a confidential manner.

The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply.



Initial inquiries should be directed to:
Gary Rosenthal, MD
Director, Division of General Internal Medicine, UIHC
319.356.4241
e-mail: gary-rosenthal@uiowa.edu
Interested candidates are invited to search the Jobs@UIOWA site: <http://jobs.uiowa.edu/content/faculty/> and search for requisition #56351

PHYSICIANS' ATTORNEY

Experienced and affordable physician legal services, including practice purchases, sales, and formations; partnership and associate contracts; disciplinary and licensing matters; real estate, collection, estate planning, and other contracting. Admitted to practice in WI, MN and IL. Initial telephone consultation without charge. STEVEN H. JESSER, PC 414.223.0300 and 800.424.0060, mobile 847.212.5620, shj@sjesser.com, www.sjesser.com.

**Advertise in the Official Publication
of the Wisconsin Medical Society—**

Call Heidi Koch, 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.

The insurance doctor is in. We'll diagnose your needs.

The Wisconsin Medical Society Insurance & Financial Services, Inc. is here to serve the medical community's personal insurance needs. That's why we offer auto, home and umbrella coverage through Allied Insurance.

Allied is committed to personal care, valuable expertise and 24/7 service—all things the medical community can appreciate.

We think Allied Insurance is the right insurance prescription for you.

Call us today to learn more at **800-975-3418**.



Wisconsin **Medical Society**
Insurance & Financial Services, Inc.



**Allied
Insurance**

a Nationwide® company
On Your Side®

The Wisconsin Medical Society Insurance & Financial Services, Inc.
is a proud partner of Allied Insurance.

Nationwide Mutual Insurance Company • AMCO Insurance Company • Allied Property and Casualty Insurance Company • Nationwide Affinity Insurance Company of America • Depositors Insurance Company • Nationwide Agribusiness Insurance Company • Des Moines, Iowa 50391-1100 ©2006 Nationwide Mutual Insurance Company. All rights reserved. On Your Side is a federally registered service mark of Nationwide Mutual Insurance Company.



**“For someone
who is used to
calling the shots...**

**...this is the best fit
for my practice.”**

In an uncertain world, you've told us what's important to you—greater control and a voice. You can get both with our policy coverage and claims service. Count on us for precise communication and follow through along with the strongest, most experienced partners in the protection business.

Founded by physicians, ProAssurance Group companies have the resources to control the effects of uncertainties and protect the respected identity you've earned. This means your attention can stay where you want it—caring for patients.

It's your call.



PROASSURANCE.

Treated Fairly

• *Physicians Insurance Company of Wisconsin, Inc.*

**Professional Liability Insurance & Risk Management Services
Rated A- “Excellent” by A.M. Best • ProAssurance.com • 800/279-8331**