The Wisconsin Partnership Program

Key Stakeholders’ Views:

- Role in the Transformation of the UW School of Medicine and Public Health
- Advancing Wisconsin’s Public Health System

Prepared by

University of Wisconsin Survey Center

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Incidentally, it’s easy to write prescriptions, but difficult to come to an understanding with people.

Kafka, The Country Doctor

I will say that I started off being very, very cynical and a reluctant participant in this whole thing, and now I’m very gung-ho about it.

SMPH physician
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Executive Summary

Introduction

This report summarizes the results of interviews conducted with stakeholders of the Wisconsin Partnership Program (WPP). The Partnership initiated these interviews as part of its preparation for its first five-year plan. Those interviewed included members of the faculty of the School of Medicine and Public Health (SMPH) and members of several groups outside the School.

Methods

Researchers with the University’s Survey Center conducted 41 in-depth personal interviews with the Partnership Program’s stakeholders. The interviews varied in length from 15 minutes to almost two hours. Researchers recorded the interviews, prepared transcripts, and conducted an analysis of their content.

Members of the joint OAC/MERC Evaluation Subcommittee selected the stakeholders to be interviewed and provided the questions. Interviews addressed three basic questions:

- In what ways is the WPP helping to advance the transformation of the SMPH?
- Do grants made by the WPP align with Wisconsin’s strategic plan for health, Healthiest Wisconsin 2010 (HW 2010)?
- What should be the WPP’s priorities going forward?

The WPP chose a qualitative research design to administer these questions. The WPP’s intention was to gather the views and opinions of a cross-section of the Program’s key stakeholders in their full diversity. The WPP therefore selected a wide variety of respondents to interview, including healthcare industry executives, UW center directors, WPP grant recipients, municipal public health practitioners, biomedical researchers, Community-Academic Partnership external partners, SMPH and other UW faculty, and state government health officials. Moreover, the interviews were conducted in a manner that allowed respondents to speak frankly and at length about the issues that, to their ways of thinking, related to the questions above. The interviewers did not attempt to challenge respondents on points of fact or opinion during the interviews. The data thus collected—and presented in this report—reflect the unfiltered perceptions, opinions, and attitudes of the respondents.

Findings

Respondents generally agree that the Wisconsin Partnership Program is the “engine” which powers the transformation of the School of Medicine and Public Health. Funds from the Program support public health research, initiatives for community engagement, and an expanded curriculum that increasingly includes public health. Without these funds progress towards the creation of an integrated School of Medicine and Public Health would proceed slowly if at all.

The process of transformation and progress towards full integration is just beginning. Respondents uniformly note that the transformation is in its infancy and describe themselves as taking baby steps in the direction of an integrated School of Medicine and Public Health. They recognize the unprecedented nature of this undertaking. To their knowledge no other school has attempted or achieved such a transformation. Wisconsin will be the first. They expect this transformation to proceed slowly. They also expect it to be uneven; some areas, such as curriculum, may transform more rapidly than others. Given the novelty of this experiment they expect to make mistakes and to correct them.

1Survey Center researchers included Ken Croes (Ph.D., Anthropology - Princeton), Edward Nelson (Ph.D., Sociology - Wisconsin) and Jordan Petchenik (MS, Sociology - Wisconsin).
Respondents have a pragmatic appreciation for the hurdles this effort faces. The School’s strength lies in medical research. It does not have a similar record in the field of public health. It lacks faculty with public health expertise. Some think that the School has moved slowly to fill the position of Associate Dean for Public Health. Incentives for those doing public health work are lacking as well. The School rewards academic research. Despite these difficulties, respondents praise the leadership provided by Dean Golden and other senior members of the School’s management team. They express confidence in the capacity of the School’s faculty to accomplish this feat.

Projects funded by the WPP align with the state’s health plan, Healthiest Wisconsin 2010. This alignment is due, in part, to the broad scope of this plan. Some of those interviewed felt that virtually any research project funded by the WPP could find some justification in this plan. Respondents with a public health bent suggest that this has allowed the WPP to fund some academic projects with little immediate effect on public health. On the other hand, these same respondents point approvingly to other WPP funded projects such as the Institute for Clinical and Translational Research and the Survey of the Health of Wisconsin. Going forward they suggest that the WPP place less emphasis on HW 2010 and define a narrower set of priorities that align more closely with public health.

Towards the close of the interviews, respondents pointed to new directions for the WPP. For example, members of the WPP should be more consistent in their criteria for judging proposals and should place greater emphasis on those which address prevention of disease and the health of the population.

A new school requires new faculty and a new curriculum. Respondents recommend that the WPP support the hiring of senior faculty with public health expertise. In terms of curriculum some suggest that medical students be encouraged and supported in the pursuit of dual degrees in medicine and public health. Graduates with dual degrees might then be eventual candidates for faculty positions.

Some would like the School to make a WPP-funded Master of Public Health (MPH) Program available more widely around the state. One way to accomplish this is to offer “distance learning.”

The capacity of the WPP to fund any of these initiatives is limited by past funding decisions, decisions made when the program was just beginning to find its way. Some respondents recommend taking a hard look at these projects and pruning those that aren’t producing. Funds released by this exercise might then be used to support new initiatives.
Theme I: The Wisconsin Partnership Program and Progress Toward the Creation of an Integrated School of Medicine and Public Health

Leading question:
How is the Wisconsin Partnership Program helping to advance the transformation of the School of Medicine into a fully integrated School of Medicine and Public Health?

Main points:
- Respondents have a pragmatic appreciation for the process of transformation.
- Most believe that the School is just starting to transform.
- Respondents point to changes in the School’s research, curriculum, community outreach and staffing as symptomatic of this transformation.
- Most agree that only minor progress, however, has been made in each of the above areas.
- Respondents identified many obstacles to transformation including a lack of expertise and interest in matters related to public health; little prior history in public health; the strength of the status quo; the lack of incentives for public health work; the strong incentives for existing academic research; the comparatively small amount of money available to fund the transformation.
- In the face of these obstacles respondents note the strong leadership provided by the Dean and other senior administrators.
- The transformation also aligns with national trends and with the NIH agenda.
- There is near unanimous agreement that funding from the WPP is central to the project to create a transformed School of Medicine and Public Health.
The Wisconsin Partnership Program: Key Stakeholders’ Views

The Nature of Transformation

Respondents recognize the unprecedented nature of the effort to create a School of Medicine and Public Health.

Respondents agree with Dean Robert Golden: creating an integrated School of Medicine and Public Health is an “admirably ambitious” undertaking.

During the interviews respondents volunteered various characterizations of the transformation, how it’s proceeding and what they expect. They recognize the difficulties inherent in such a transformation and they provided realistic appraisals of its progress to date. They expect the transformation to occur slowly and expect it to be uneven. Some areas will transform more rapidly than others. They note that transformation entails more than a shuffling of organizational boxes. It also involves a shift in the School’s culture and the faculty’s thinking about the practice of medicine. Given the pioneering nature of this project they expect to learn from mistakes and to correct them.

A transformation without precedent

Some see this effort to transform the School as unprecedented and audacious.

Obviously, it’s a very audacious kind of an undertaking. There’s no model for it. No medical school has done this before. There are plenty of medical schools in the country and there are plenty of schools of public health in the country, but to my knowledge, there’s never been a medical school that’s tried to become an integrated school of medicine and public health.

Let me first say it’s a huge challenge to do that. That’s why it’s exciting.

The School is entering unknown territory. Trial and error are inherently part of the process.

The other thing that’s really critical is that it isn’t like anyone has a map for doing this.

Transformation comes slowly

Though the transformation is underway, it is happening slowly and in the face of numerous obstacles.

It’s really baby steps in a lot of ways.

This is not going to happen overnight.

This kind of change comes really, exceedingly slowly.

It’s not like something like this changes overnight. I still don’t think we’ve internalized the idea that there’s ways to do this where the entire infrastructure benefits, and that there’s ways to incentivize things throughout the medical school and on the community side that actually benefit everybody.

I think at the moment there’s more talk of change than there is change, but that’s a very good thing because the talk of change has been long in coming, I think. So it’s most welcome and most refreshing.

I think it’s happening in all of those realms [research, outreach, curriculum]. In all of those realms it’s happening. It’s happening slowly, in small measures.

These kinds of institutions don’t change rapidly and there is lots of history, culture, and incentives to actually inhibit that transformation. So it’s going against the grain of culture broadly writ.

Slow change is good change

Well, institutions are very slow to change. And they should be. Institutions should not be susceptible to fads. It’s too dangerous. In order for something like this to be successful you need to have a continual realignment and assessment of whether or not where you’re going is also consistent with the rest of the missions of the medical school, and if not, why is that?
Transformation supposes a change in the School’s “culture”

Respondents recognize that this is not just a change in the “structure” of the School but in its “culture” as well. By “culture” they seem to mean changing the way that faculty practices medicine, conducts research, and trains students.

*The first thing you have to do is really change the culture of the School so that instead of just [thinking] about medicine and treating acute disease, to being a school that’s training people to treat disease, but also to create health. I believe you have to change the culture of the School.* I believe we can create a national model that trains the next generation of physicians differently.

Transformation includes new ways of thinking

*Thinking in public health terms has not yet reached all those in the School of Medicine and Public Health.*

For the medical school, I think it’s really important, and it’s revolutionary in thinking. I don’t think it has seeped into the essence of the medical school in terms of the people who do their job there. I think some people are thinking this.

It will take a long time for such thinking to take hold.

*The ship of state is not a metaphor that doesn’t mean anything. It’s hard to turn it. I think it’s going to take a long time for … to integrate public health into the way we think and into our very being.* I think it’s going to take a long time.

Some think that there is already movement in this direction.

*[There’s] an increased awareness that the academic side of the business needs to become more involved in ‘applied medicine.’ Here I’m thinking that ‘recognition’ is another term for awareness—a growing awareness of the need for academic medicine to become applied medicine.*

This person thinks that this exercise has already changed the way people think.

*I think it has been a very useful experience for our school. I think it has indeed catalyzed real change in our thinking. I think for a long time there was a sense that we learned a new way to talk, but not necessarily walk. And I think that that’s a thing of the past. I think that it really has created a fundamental change in the institution.*

Transformation will require patience

*Be patient with the transformation to the School of Medicine and Public Health. It’s a unique entity. You know, there’s not another school in the country that is both.*

Some areas are more susceptible to transformation than others

*Some of them can be approached much more quickly than others. For example, I think the educational piece can, with the proper funding and willpower, get done much more quickly than perhaps the research piece. The research piece I think is going to depend on having a substantial recruitment of new faculty, and that’s going to take some time and some money.*

Some describe the transformation as “intangible” and unfolding incrementally

*So I think there’s a general change—and this is an intangible—in most ways it’s intangible, but I think there’s been a general change in the sort of persona of the organization, and how it reflects on some of these things.*

*I’d see it more as incremental than integrative. I know people keep talking about integration, but I think that there are limits to that concept. And I think there’s an incremental part here. There are certainly places where integration is an absolutely tangible and necessary kind of piece. And for instance, medical school curriculum is one of those places.*
Transformation - Progress to Date

The transformation of the School is at a very early stage.

Most respondents agree that the transformation of the School is just beginning and will take a long time to achieve. They had different ways of describing the School’s progress. Some described it using nautical metaphors (“turning the Titanic”). Others talked about achieving a balance between traditional medicine and public health. One person described this balance using the image of a pendulum. Another sketched the picture that appears below. And some felt more comfortable talking about transformation as an “S-shaped curve.” Most agreed, however, that the current School was weighted strongly in favor of traditional medicine and the care of individual patients.

Transformation as a “balanced portfolio” of research and community engagement

This person spoke of the transformation in terms of achieving a balance between public health and medical research. In this person’s view the current situation inclines strongly towards traditional medical practice. (See Figure 1.)

If this is a really good school of medicine that’s taking care of individuals and here’s a school of public health, that’s 90 degrees. We’re saying we want to transform to be a really good school of medicine and public health, we want to get to 45 degrees, to have balance. Where are we right now? Where would I say? I would say maybe five degrees. Maybe. That would be generous.

This person continues:

People are saying we need a balanced portfolio. Right now we have a really unbalanced portfolio because we have by and large become really strong on basic biomedical science and clinical trials and those are really good things. We’ve got a lot over here and we’ve got almost nothing here. Is that balance?

Figure 1: Perceived Status of Balance between Public Health and Medical Research
Change as an “S-shaped curve”

Another respondent described the School’s transformation using an S-shaped curve. He and other respondents felt that the School was just beginning a long climb on what may prove to be a very steep curve. Few could predict how long it would be before the School achieved a high degree of integration. (See Figure 2.)

The School has just begun to transform

What I can see as a result of the transformation is that there is a growing understanding of what public health is. You’re starting to see some changes in the educational programs, the research initiatives, and some of the service outreach efforts, perhaps. Those are all beginning, and I think they are baby step stages.

I think it would be a bit premature to say that we’ve done anything other than set up a great strategic [vision] and a great systems architecture, for realizing what I think is an immaculate vision statement.

At least one respondent, however, thinks that change is well underway.

Whatever public health presence we’re going to achieve, we’re somewhere near half way, we’re certainly off the foot of the S-shaped curve. And I think that’s saying a lot. So we’re in a rapid growth phase right now. I think this one could take forever.

Transformation will take time and will depend, in part, on the willingness of the faculty to embrace the transformation.

I think I cannot predict the willingness of the faculty to willingly incorporate what’s being dragged before their eyes. So it’s a little hard to be predictive. In the idyllic sense I think we’ve defined what we want to do, and if we could say abracadabra we’d be up at the top of the curve, but we have an education process that we’re dealing with, as well.

Do I think the School has been transformed already? No. Do I think it’s making progress and showing signs that it will transform into the vision statement of Dean Golden? Yeah. I think there’s a strong chance, a strong likelihood of that.

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1 Interviewers intermittently used this image in subsequent interviews.
Change in name only

For some the transformation of the School is nominal only.

Some of it is very symbolic. I think that just changing the name of the School is helpful. It’s mostly symbolism right now. It hasn’t really permeated the institution. Do all the researchers think of themselves as in a school of public health as well as a school of medicine? Probably not.

Some observers from outside of the School see few signs of transformation beyond this change in name.

The name change has been the biggest change....As far as any great transformation, and great change of thinking, I don't see it. But I'm not intimately involved.

A few skeptics doubt that the proposed transformation is possible.

My bias is that public health is multi-disciplinary. Not medicine. Not nursing. Not epidemiology. So I don’t think it’s really going to be possible for the School of Medicine to transform itself into public health. I think it has an identity as a school of medicine.

Others are very enthusiastic about what’s happening.

Being part of this is the most exciting thing that has ever happened to me. This is without question one of the most exciting things that I could imagine happening at any medical school in the country right now.
Participants note how the Wisconsin Partnership Program has shifted the School’s research agenda.

During the interviews respondents described some of the changes they’ve seen in the research that is being conducted. Those who sat on the OAC and MERC could readily identify research projects resulting from the WPP and reflecting the emphasis on transformation. This was also true for researchers with active projects or who had submitted proposals for consideration. Those outside the School, however, were less aware of changes in the research portfolio. And some thought that the research program was receiving undue attention, often at the expense of community initiatives.

Translational research

The WPP has stimulated the submission of proposals containing “translational” components.

So what are we actually seeing? We are seeing in terms of the research portfolio an increase in attention to the community, to what people are calling type two translational research, the kind of research that is actually applied research; what happens not at the bedside necessarily, but as people say, at the curbside out in the community.

I think we already are seeing a shift in the research so that more clinical research is done and more type-two translational research is done. As evidence of the latter, we just had a round of applications for pilot money from the Institute.

We got 91 applications, 61 of which were for clinical or type-one translational research, and 30 for type-two translational research. We were quite pleased to see that magnitude. So that message is getting out.

Examples of the new agenda

Respondents could often cite examples of exemplar projects supported by the WPP that suggest an emphasis on population health.

I can’t speak with great accuracy about the OAC, but I think several of the MERC-funded projects speak to this. HIP is one, the Health Innovations Program. I think it’s an excellent example of something that heretofore would not have been funded internally, were it not for MERC—were it not for the Partnership fund.

The SHOW project is another one. WiNHR is another. So I think almost without exception the MERC has invested in things. Certainly another is educational and curriculum reform and support of the MPH program. I think almost without exception, and again, in contradistinction to where everybody thought this was going to go when it first started, the MERC has kind of got itself together and made investments in exactly the right kinds of areas.

The quality of the proposals has improved over time, reflecting a better understanding of public health.

As we have gone out for requests for applications, the sophistication of the public health grants has increased tremendously. So now I’m starting to believe that we actually have the horses to do what we claimed that we’re going to do in the transformation.
Interdisciplinary research

The grant process provides incentives for interdisciplinary research and is causing people to work in an interdisciplinary manner.

The whole idea of the collaborative grant applications is a shift. Because somebody from the basic science department has to collaborate across departments and think about how they're going to work together. So it's not just their own discipline that they are caring about anymore. They have to work with somebody in the primary care department or somebody in another department that could help them expand the scope of their work and actually form some synergy about how to think about it. I think that's really a big shift.

OAC and MERC are working more closely together.

Another feature of the transformation, or at least evidence that the transformation is taking hold, is that there is a closer working relationship between OAC and MERC. And clearly to me, OAC is more, I was going to say 'keeper of the flame,' but that's not really true. We both have public health in our portfolio. I think MERC has a broader remit which is to ensure that we ensure the excellence and stature of the School in all of its missions including public health.
Signs of Change: Community Outreach

Respondents point to new community initiatives as indicative of the effort to transform the School and recognize the role of the Partnership in supporting these projects.

A number of respondents could readily point to new programs aimed at engaging with communities around the state. It would also be fair to say that most do not have a comprehensive view of these community engagement projects. Still, the existence of these projects provides evidence that transformation is proceeding. At the same time, some are disappointed with the progress to date, doubt the School’s commitment, and note the obstacles to outreach.

The WPP and community engagement

Participants noted that Partnership dollars are supporting the creation of connections with communities around the state and agree that this is a good use of these monies. This faculty member points to the progress the Partnership has made in creating these connections and its role in sustaining them.

We have a community engagement program that’s part of us. That is primarily what the Wisconsin Partnership money is used for. So the $3.4 million they’ve put into that is, in my opinion, a good investment. But we, quite frankly, live by metrics. So I can show the advances that have been made because of the contributions, and we’re out there forming groups of people in the community to make us aware of what the community feels, or the important needs health-wise in the community. We’re getting feedback from that. So those are tangible metrics that have resulted from the Wisconsin Partnership money.

Some of the community programs that have come out, as well as the Institute for Clinical and Translational Research, I think are a key representation of [transformation] as well.

Exemplar projects: ICTR, HIP, SHOW, WiNHR

Respondents pointed to the Institute for Clinical and Translational Research (ICTR), the Health Innovation Program (HIP), the Survey of the Health of Wisconsin (SHOW), and the Wisconsin Network for Health Research (WiNHR) as projects that are emblematic of the new emphasis on community partnerships.

[Outreach examples?] I would say that one of the goals behind the Health Innovation Program, the fact that it’s half funded by the Wisconsin Partnership Program and half funded by six community organizations, is the type of direction that we need to go. That actually attempts to get the engagement and partnership with the community right up front. Another example would be the Health Extension Program that is part of ICTR. That is actually placing individuals out throughout communities around the state.

I agree that there’s been greater community involvement. I don’t necessarily agree that it’s driven, well maybe it is driven predominantly by OAC, but I do see in MERC a tremendous increase in the emphasis on community partnerships.

I think there’s a lot of talk about community engagement. I think where it’s actually happening is the Institute for Clinical and Translational Research—the formation of statewide research councils to try to develop a research infrastructure.
Outreach takes time

It takes time to cultivate relationships with communities and, as a result, these community-academic partnerships have been slow to form. This respondent notes the progress that the School has made in this area:

There are some exciting sponsored programs and community initiatives. It doesn’t surprise me that this is slow to start. You have to build trust. The University has not supported the kinds of relationships that build community trust so you can readily partner and move forward. When I say that, it sounds like I’m being very critical. However, this university is much further ahead than most in developing community partnerships. That’s why I think we’re probably as far ahead as we could be and I think the potential to move further is very exciting.

Outreach is limited and incentives are lacking

To be sure, there are those who think that the pace of change has been too slow and that there are obstacles to creating community partnerships and to conducting applied community research.

In terms of some of the outreach efforts, I think those are really quite limited.

Incentives for engaging in community outreach are lacking.

The problem is, we haven’t had any incentives, recognition, or support for cultivating those relationships. We’ve got faculty running around so busy trying to be successful in the academic environment, and the academic rewards are by and large grants and publications. That’s not going out and being [active in the community] because you’re not going to get promoted on that basis.

This respondent suggests the creation of institutional incentives for faculty who engage with communities.

So we’ve got to shift the institutional recognition and reward to say this is something we value. And we have resources to support that.

Meaning of community outreach/engagement

Some are very clear about what community outreach means and what it entails.

This idea of community engagement means that there’s a real marriage and reciprocity—we listen to each other, we have the same goals, and that is to improve the health of the people. So how can we bring this expertise from the academy and their expertise of the local conditions to make that happen in a long term fashion?

Others think that faculty members don’t know what community engagement means and doubts that it has anything to do with them.

I think most people when they say the word ‘engagement’ don’t know what they mean by the word. When the rubber hits the road on this stuff, I think most of what is considered community engagement is seen as: ‘That’s the stuff they do over there.’ One of the missions of the community-academic partnership (CORE) is to actually change that and make it core to how the medical school functions.
Most see a modest change in the curriculum of the School.

As with other parts of the transformation, knowledge of changes to the curriculum varied. Those who had little involvement with teaching also had little awareness and little to say. Those who did comment felt that there had been some changes to the curriculum but that these changes were, for the most part, modest. They also acknowledged the difficulty inherent in trying to change the School's curriculum. The infusion of a public health component is regarded as the biggest change to the curriculum in years.

In terms of the education, within the School, we have a new course in epidemiology and public health the first year. So that’s giving the students some kind of introduction. It’s the only new required course we’ve had in a decade here in the medical school and that happened as a result of Javier Nieto and his department. If you said, ‘what can I point to that is really tangible’, the MPH program, that’s new, that’s different. We have a new required course in the medical school. That’s new and that’s different. Still, though, that course for the medical students is a bare bones introduction. There’s not much beyond that. The rest of the curriculum is almost unchanged in terms of public health transformation. So, to me, looking ahead that is the next challenge is to take that introduction and roll it out and how can we really make sure that’s strengthened and emphasized?

That leads us into the next area of curriculum. Is it changing? It’s changing in the sense that the students are getting offered some social sciences, multiple lectures on epidemiology, some lectures on health care policy, some lectures on social determinants of health. So the content is being provided. However, the operationalization of that content and the inherent understanding of what is medicine, is far, far behind.

I think the institution of a Masters in Public Health within the School of Medicine and Public Health is a real clear marker.

The creation of the epidemiology course, and the increase in the number of hours put to that course. So you could make an argument that, yes, one course and some dedicated time is not sufficient to change medical students, but it’s a very important first step. That would need to be followed, then, by additional opportunities throughout their educational pathway that increased in the level of intensity. So at the time they leave their fellowship they now are ready to work in an applied setting that allows them to bring together both concepts of medicine and public health.

[Students] should be involved in research projects or community projects. And now, with the public health addition to this, and it’s been added in a very big way because of the funding available through OAC and MERC, we really have completed the spectrum.

Respondents also note the difficulty in making changes to the curriculum.

It’s a very difficult thing to change a medical school curriculum. There are many mandates and requirements that can create barriers to trying to change things. And I just would want to say that Dave Mann, who leads that committee has been extraordinary in really trying to seek out the avenues that allow us some flexibility to improve things.
Some feel that the curriculum is largely unchanged

I think there’s considerable excitement and discussion about curriculum reform, but not so much action in that direction at this point. Certainly, the MPH Program is an exception to that and has been quite successful.

The curriculum hasn’t substantially changed that I’m aware of. They have to change the faculty to do that. You can’t take an old dog and teach it new tricks.

I haven’t seen or heard of substantive changes in a way of thinking about educating students that has a concept of medicine and public health as an integrated concept.

Then there are those who think the pace of change has been too rapid.

I’ll make an incendiary statement here which I don’t want the mic turned off for. I think we may be expanding at a rate that’s greater than we can accommodate. We’re a little bit ahead of ourselves. [In terms of public health content into the curriculum?] Right, it feels like a scatter gun approach. Rather than focused and well integrated into what already exists. ‘Let’s just plop it on and let the chips fall where they may.’

Without the WPP there would have been no change in the curriculum

WPP fueled these changes to the curriculum.

…without the incremental funding that we receive from the Partnership, these [medical school curriculum] changes wouldn’t happen, because they hadn’t happened before even though the intention might have been there. […] if we don’t have the funding for making that change it’s going to be on everybody’s wish list and it’s not going to happen.
The Wisconsin Partnership Program: Key Stakeholders’ Views

Signs of Change: Faculty

Transforming the School entails adding faculty who have a commitment to public health.

A new program requires new people. Many respondents recognized that the School lacks professors with public health expertise and accomplishments. They believe that the transformation of the School can be accelerated through the hiring of senior faculty with public health experience.

By and large we have very few faculty who have a deep understanding of public health, who have any experience in doing community development activities, so we’ve got to build up the capacity of the faculty.

I hope to see is a continuing increase in the number of faculty who do this kind of work. People can’t do what they don’t know how to do. So to change what we’re doing we are going to need to change our faculty.

Remember that the new faculty learned from the existing faculty. So we’re going to have to engage in changing personalities and ideas; just getting a SWAT team to eliminate all of them won’t work.

Existing faculty are starting to take an interest in public health

In addition to adding new teachers and researchers respondents report that existing faculty are paying more attention to public health matters. More people are attending presentations on public health and taking more of an interest in public health research.

I think we’re starting to see some increase in the kinds of faculty who are interested in doing this sort of work. I think this work has garnered some increased credibility in the organization, and what I hope to see is a continuing increase in the number of faculty who do this kind of work.

A good example to me is— I can’t exactly remember who the speaker was, but we have a series of people come in and talk about population health related things and try to relate research sorts of things. Three of four years ago you would have got a handful of people coming to these kind of presentations. Now, we have a packed house when we have these.

So I think people are sort of coming out of the closet, if you will, on issues of health services research, population health, community-based health research, people I think who have always been somewhat interested in this. In particular, younger people are now feeling some freedom to express their interest in this.
Incentives and recruiting

The School must offer incentives if faculty are to be fully attracted to public health.

It’s not as easy as just providing faculty with a small amount of funding and saying go forth and build a community partnership that helps the community do something. You have to have the right people that want to do this. You have to make sure that they are rewarded internally and you have to make sure that it aligns with the external incentives that everyone is subject to at this place.

Some think that the School has not energetically pursued the hiring of the new faculty needed to fit the new agenda.

And there has not been, to date, an explicit attempt to deal with the magnitude of what it would take to really, really get the right faculty in the door, get them enthusiastic about providing their expertise to communities in areas where they have expertise and learning from communities about where the other things that they’re doing need to go in order to be helpful.

WPP support for new faculty

A number of respondents look to the WPP to provide funds for the hiring of new faculty with a public health bent.

I think some of the ways in which we use our resources from both the partnership fund and the CTSA grant have to be directed at bringing new faculty on board. Certainly, in terms of where monies have been spent from MERC and from the partnership fund in general, I think there’s been a really dramatic shift.
Obstacles to Transformation

Creating an integrated School of Medicine and Public Health faces formidable obstacles.

During the interviews, and with little prompting from the interviewers, respondents volunteered the obstacles confronting this initiative. One respondent provided this overview of the obstacles to creating a transformed School of Medicine and Public Health.

What are the things that are keeping us back? It’s culture. It’s financial incentives. It’s academic rewards. Those are enough. There might be more.

Another characterized the effort that will be needed to wrench the School onto the path of public health as follows:

This is going to require a sustained, Herculean effort to swing the pendulum back from the focus that the medical school has had here before.

Lack of understanding of what constitutes public health

Some think that the faculty doesn’t know what public health is. Similarly, rank and file faculty may not understand what integration means. Senior administrators grasp this concept but that understanding hasn’t penetrated all levels of the organization.

So when you talk about public health, one of the problems is that because we have for so long neglected public health, and you have a conversation here that now we’re going to be a School of Public Health, most people say, ‘What does that mean? We don’t understand that.’

I have to tell you, I’m not exactly sure what it means to say a ‘fully integrated school.’ I think that that’s a very abstract notion at this point for us. I think we’re very far away from really grasping that. One of the things that you always need to remember when you approach these kinds of big things is that there’s a lot of thinking and a lot of discussion about this at the executive level, at the higher administrative levels. How much of this thinking is really going on down at the grassroots level is quite another thing.

If you ask a basic scientist, what does that [transformation] mean to you, I think you’ll have a hard time getting an answer, because they don’t know. They don’t know what that means.

When you really get right down to it, I’m not sure I and most researchers really have a clue of what the transformation is. We’re a School of Medicine and Public Health and there’s an MPH program now. But if you really ask me to write down how we’re transforming, even if on the test you had the question and a whole page implying write a lot, that would be my answer.

At the same time there is also a lack of understanding of what “engagement” means. It is also likely that there is a similar confusion over the meaning of “community.”

I think that there’s a lot of different ways to do that. I think that when you think about community engagement—as someone who’s charged with thinking about this a lot, I think most people when they say the word ‘engagement’ don’t know what they mean by the word ‘engagement.’
Lack of skills

Researchers lack the skills, the temperament and, in some cases, the inclination needed to work with communities.

And I think that at times researchers like to do research and gather information. That’s their comfort zone. But actually getting into the nitty-gritty of communities and getting your hands dirty with problems, that’s tough. That’s not their skill sets. Well, that is a skill set that public health people have.

Researchers in the University go into communities and they’re a disaster. They’re used to shouting at each in a faculty meeting, and they go into a local health department and they’re the Lord Almighty and this is the way it’s going to be and it doesn’t work that way.

That is not what they were trained for, that is not how they were educated, and frankly, that is not what they want to do.

It takes a while for people to understand how to work with somebody. Academicians often speak a different language than community people. Even if you think you’re saying the same thing.

Little experience in working with communities

Related to the above, the School had little or no prior experience in the field of public health, in working with communities or in educating students. It is starting from a very low bottom.

We’ve done a lot of work in the first five years of the Partnership Program. I see that work as catalyzing our ability to transform. Unfortunately, we started from ground zero if you think about it.

I’ll just say that this transformation is something that I felt was long overdue. Really almost embarrassed that our school, when I joined the faculty we had only almost nothing in terms of public health. And our Department of Preventive Medicine was not involved at all in teaching. Our students knew nothing about public health.

Lack of incentives

The School’s rewards align with traditional academic practice: faculty who bring in grants, conduct research and publish papers win promotion. Those who teach or who are engaged with community outreach receive little recognition.

You don’t get tenure for being a great clinical teacher of population health. You get tenure for doing basic research, for doing NIH-funded research, because the medical school cannot set its own values. The School, the University sets the values.

The only incentives that count at this place are the research incentives. I am not paid to teach. There are people who will tell you differently, but there is no doubt in my mind that what happens with my teaching is not valued at the same level as what I bring in, in terms of research. And I am definitely not paid in order to do the very, very hard work of beginning to understand what it means to build community relationships.

What I’m hoping is that…if we really transform the School, [community] research will be valued as much as the work of sitting in a lab and the work of futzing around with, say, cholesterol.

If you get to the point of starting to think differently and act differently, then the School has to start valuing you differently and valuing what you’re adding.
Fear of change

Some informants think that resistance to transformation arises from faculty members’ fear that they will lose something as a result of that transformation.

There are a lot of people who are scared to death that they’re going to lose something. Because that’s the basic fear in any change, that people are more worried about what they have to lose than what they have to win, and that’s something that’s going to take time, and attrition, and retirements, and various other things to get by, but it’s also going to take leadership....

Implications of transformation for those engaged in research

There is considerable worry about how “basic scientists” and science will fare in a transformed School of Medicine and Public Health. Will the School redirect funds to support public health at the expense of basic research? Will researchers be asked to assume some yet-to-be-defined responsibilities in the arena of public health? Just what, if anything, will be expected of the School’s researchers?

I really don’t know [what ‘transformation’ will entail for the SMPH’s basic scientists]. The words say one thing and words are great, but in practice I’m not sure where this is taking us in the future. If we continue to foster the public health component of the medical school, I’m not sure where that leaves basic science. I’m a little concerned that some basic scientists are going to get left behind, that some of the funding that’s available to more clinical kinds of studies and population health studies are going to receive a greater share of the pie. And maybe that’s fine. Maybe that’s the goal, but I think there’s some concern from my colleagues in the medical school in the basic science departments, and those that do basic science, what that means.

What are we being asked as a basic science department in medical school, are we going to be asked to teach some component of public health in what we already do?

I mean, I hear the words and we were told that we’re going to be brought along with this, but no details. What does that mean, brought along? Are we going to be asked to do more? Are we going to be asked to transform our own programs into translational work? Are we going to have to link up and collaborate with a clinician? Is that part of our transformation? I mean, I don’t know and that hasn’t been explained to my satisfaction, to many of my colleagues. What does that mean to us?

And I think a lot of people feel that they hope it doesn’t mean anything, because their fear is that what it means is that they’re going to have to do more and it’s going to be harder to secure some of the funding that’s available to the research community, or, like I said before, that this transformation is going to require additional efforts from basic science departments that aren’t—we’re not trained to be public health.

And there’s concern—again, I want to somewhat be a mouthpiece for what I’m hearing my colleagues in the basic sciences say, and that is they’re concerned. They’re concerned, what does this mean? What does this mean to a basic scientist in a medical school? I think their concern is: we’re going to have to change our curriculum; we’re going to have to start teaching population health. None of us know exactly what that means.

The other alternative is that the administration doesn’t know what to do with the basic scientists and they basically just say, ‘Well, we’re going to put our efforts in the public health component of the transformation. We’re going to bolster that side of the School and just going to basically let you guys do your thing, because we don’t quite understand you. We don’t know really how to bring you along in this process.’
Issues related to the allocation of WPP dollars

Respondents voiced a number of concerns about the allocation of Partnership monies:

- Initially attempts were made to spend Partnership dollars on traditional medical school projects
- The endowment generates a relatively small amount of income
- Prior commitments limit options for funding new projects

Respondents recalled efforts to use the new Partnership funds in the same way they would use any “outside” money: to support existing academic research.

I think that early on the notion was that this money would be used for the same sorts of things that outside funding has always been used for. There was certainly a notion of using it for bricks and mortar, but there was also a notion of using it for the traditional, basic science kind of endeavors, both in terms of using it to capitalize equipment purchases and in terms of funding research.

Some think that money from MERC has been allocated along traditional lines: to support the traditional research agenda or to make up for shortfalls in NIH funding.

What I’m seeing by and large on the MERC is, ‘Let’s fund what we’re strong in.’ That’s what we’re already doing. What about where we have a void in? What about what we’re not doing? There’s not very many people raising that because who’s here are the people who’ve been successful with what we’ve been doing and that’s pretty much basic science research or clinical research but it’s not community oriented health and development programs.

I think that there’s also been a lot of money that has been spent and allocated to maintaining the status quo. ‘Well, we got a grant from the Feds for five million. We thought it would be eight million. We really like to do more. So how about you give us the other three million?’ And MERC says, ‘Okay, we’ll do it, yeah.’

So what’s happening is NIH funding is flat so the basic scientists are nervous as all get out, because they don’t have anywhere to go for extra funding. So guess where they are coming?

The WPP endowment generates only a fraction of the money needed to achieve a transformed School of Medicine and Public Health or to improve the health of the citizens of Wisconsin.

We’ll probably come to talk about money somewhere in this interview, but I think that that’s a very important limitation on this whole thing. I think that we have reached a point in time where the expectations about what we can do far exceed the resources that we have to do those things.

When you get to it, it’s not a lot of money. It’s a lot of money but it’s not a lot of money. Even to change the School, certainly it’s not a lot of money if you’re trying to use that mechanism to improve the health of the state.

The WPP’s capacity to promote new initiatives is limited by funding decisions made during the Program’s early days. This leaves little money for new initiatives over the next five years.

And I think what we’re running up against right now is that as we look at the next five-year plan it’s a very different landscape than the first five-year plan, because the first five-year plan really had a blank canvas, in that all the money was there. None of it had been spent and it was all there to run out. We’re now faced with a very different situation in which at the end of five years we have many projects from the first piece that still require funding. And which in the best or the worst of all worlds might use all of the available money for the next five years. Unless you do that the next five-year plan has much less discretionary money in it than the first five-year plan did.
Tradition and the status quo

The project to create a transformed school is butting up against tradition, the status quo and the entrenched power of those interested primarily in academic research.

We are a very hierarchical and traditional institution. There’s big money power, prestige, ego and the status quo.

For me the biggest challenge is to see if the Partnership can shift that dynamic towards really focusing on the health of communities rather than maintaining the status quo.

Strong forces support the status quo.

Almost all the forces [in the SMPH] are to the status quo, and there’s very few—very little force for change. And I think that… we need change.

Transformation meets resistance from those engaged in medical research.

There’s a lot of resistance. You know, the power in the medical school is not the public health and the public health researchers. It’s the medical researchers. It’s the guys that are pulling in the NIH grants and the guys creating labs and writing large federal grants. So politically, it’s a tough battle within the School itself, you know.

This person highlights the importance of medical research within the School.

We haven’t talked about the research mission, but if you want to talk about what makes this medical school run, it’s the research.

Differences in underlying thinking and the conduct of research

Integrating traditional medicine and public health means integrating what some respondents see as two different approaches to understanding, researching, and delivering health care. As one respondent summed it up:

[T]here’s sort of a we and them [attitude between medicine and public health]… they all have their different visions of what constitutes achieving public health.

The two camps approach problems differently.

If you think about public health and law, they’re very much aligned in that lawyers think about policy approaches, think about law, think about regulation. But if you get a doctor or a doctor in training and say, ‘How are you going to solve this problem?’ they think about what the patient needs and not about the environment.

They undertake their research with different methods.

[T]he clinical departments by and large are not going to accept that [the research methods that public health accepts]…. because biomedical research is reductionist. Find the one molecule in this pot of stew that’s causing this problem…The [gold standard] of medicine is randomized, placebo-controlled, double-blind study. Well, the social sciences and qualitative research, and the idea of contamination because you make an intervention and 50,000 things happen before you re-measure…our basic science colleagues hate that. It’s a fundamentally different value system. Now, can it be changed? The answer is yes. Ought it be changed? I think the answer is yes. But it will take a long time.
Supportive Forces of Transformation

The leadership and support of senior management is one of the forces propelling the transformation of the School.

Respondents agree that the transformation benefits from, and has the backing of the School’s senior managers. In this regard, they note the strong contribution of Dean Golden in defining a vision for the School and then taking steps to realize that vision. The people we talked to were very positive about the new Dean’s impact on the School.

Leadership from the Dean

The core question you ask, I think, is this goal evolving into a School of Medicine and Public Health? I think the new Dean has not just put words to it but has actually taken specific steps that help make that happen.

It was a little lonely in the past doing public health in this medical school and that’s dramatically changed. It’s changed in terms of the access and voice we have with the Dean. It’s changed in terms of what the Dean emphasizes which percolates throughout the system.

I think Bob Golden is doing a really good job championing a vision. But he can’t make it happen. He can be the champion. But he’s got to activate a lot of teams.

With the arrival of Dean Golden there certainly has been the appropriate level of enthusiasm and the appropriate type of leadership catalyst to at least move in that direction.

My disappointment, is that there hasn’t been anybody who’s stood up and said, ‘We’re charging in a new direction’ and moved people along in that way. The Dean has done something, and that’s the first example of trying to move people along.

I think the Dean’s leadership is key in pushing this.

Other departments also have leaders who align with the transformation:

This goal and direction has helped us formulate what we’re about in a new way. When we meet as a leadership team we talk about it. How does this match with being a School of Medicine and Public Health? The Chair is saying it. We have a Chair who is a believer in this model.

One respondent noted that the transformation undertaken by the University is in step with a larger transformation in the health care industry, and that, in some respects, the University is playing catch up.

Going back to some of the integrated delivery systems in the State of Wisconsin, and I’ll use Aurora as an example. With over 1,000 physicians, Aurora has done some tremendous things in the state. They have a whole cradle to grave philosophy, and in that philosophy they’re looking at ways to improve the health of the people of the state. And they’re doing both bench research and more clinically oriented research, but they’re working with their communities every day, which involves all of Southeast Wisconsin. So I think some of the larger integrated delivery systems in the state are a little farther along in that whole transformation than what is happening at the University.
The time is right for transformation

Health care as a whole, in this respondent’s view, is shifting to embrace public health, making the timing of the transformation propitious. Being in the vanguard, however, means that road maps are lacking.

[T]here is no road map [for our transformation], because it is a different world today in healthcare. […] Health care now has realized that there isn’t enough money, that the system is broken, that it needs to be redesigned to keep people well, to have incentives for health, not just health for sickness care. So we may have arrived late as a school in the concept of public health, but it might be just in time to take advantage of a new vision of healthcare.

The UW Institute for Clinical and Translational Research (ICTR) and the NIH Clinical and Translational Science Award that funded its establishment aligns well with the new direction of the School.

The whole thing and the NIH [CTSA] funding, that’s independent of this transforming the School idea but it’s in the same direction. That’s supportive. That whole effort, and the fact that NIH would support it, is also breaking with culture. It is also not fully accepted but it has such a huge dollar sign on it that you have to pay attention.

And despite the difficulty of navigating without roadmaps, many have robust confidence in the ability of the faculty to successfully accomplish this transformation.

I have great faith that we are at the University of Wisconsin and there are faculty here who believe at their core in the concept of the Wisconsin Idea, and that of all the universities that could figure this out [this transformation], this university is probably better positioned than any other university I can imagine to actually figure this out.

Advocates for community initiatives have a stronger presence on the MERC

I think there is and there has been and there probably always will be a fair amount of politics around all this money. I think the politics has changed so that people who have been interested in this applied sort of research have gained a voice that they didn’t have before. And what was a very small and loyal opposition party I think is now a very strong, if not majority at least a very strong voice in the political process.

But surprisingly, there’s on MERC and in the University, in the medical school, people who understand what the SMPH idea is and are really behind it. People you wouldn’t necessarily think.

One of the most important supports for the transformation—incentives to faculty to conduct new kinds of research—is still lacking in view of this respondent.

If you want to talk about what makes this medical school run, it’s the research. And it’s absolutely critical that when you think about transforming, when you think about trying to get [community] engagement and when you think about trying to change education, if you try and do that without thinking about how you’re going to re-incentivize research, you will get nowhere, because the only incentives that count at this place are the research incentives.
The Partnership Program is a Force for Transformation

WPP funding provides the primary support for creation of an integrated School of Medicine and Public Health.

There is widespread recognition that the WPP is a major force pulling for the transformation of the School. The WPP provides the money that supports all facets of the transformation. Respondents also cite the supportive influence of the NIH CTSA as well.

No Partnership dollars—no transformation

The way I see this is there is no possibility of transformation without the economic engine of the Partnership Program. I think the Partnership Program is the banker for the transformation. There simply is no other money for this transformation to take place, with the exception of the CTSA. I think those are the two catalysts. I think that this institution, to its credit, has taken both of these catalysts and been more genuine in the process of changing than many other institutions, which have simply talked about it.

When I say I like it, I do like it. Because I think it’s done a terrific job in the beginning of actually driving the transformation of the School. And at this point it is the program that gives the transformation legs. It was conceptual at first. Now the reality of it is coming out through projects that we see emanating from MERC funded proposals which I think is just terrific.

So for years I’ve been trying to nudge this institution to do what I felt was more engagement in responsiveness to the community. So for me the whole WPP has been very powerful engine, resource, to try to move the institution, to provide incentives for those things to happen.

I think both the Wisconsin Partnership and the Institute of Clinical and Translational Research are major parts of the movement to focus on population health, and that element of the public health mission is being fulfilled in part in that way.

WPP funds redirect faculty effort towards public health.

I think the WPP can certainly help move this because there is a lot of money there. And if we can say as a WPP, this is what we believe in, and if you want to use this money this is what you have to use it for. That’s powerful. And I think that we’ve moved maybe a quarter of an inch. You can see in the applications that the people aren’t quite there yet.

I think that we have a different sort of umbrella that now sits over the School, and in particular in terms of funding. People are always looking for sources of funding, and this is a new golden goose for them. They are required to pay attention to the rules. I think it’s clear that the rules have changed. That what we’re interested in is different than what it used to be.

This person notes the importance of the MERC in funding public health research.

It changed from the perspective that there is funding to support public health. So we have a MERC grant that allows us to engage in an expanded degree of funding for public health research. We have the capacity to apply for a whole new set of grants that are available for young investigators, mid-level investigators, and organizations, and this is one area where they could do more improving on, that really emphasize, how is this going to improve the health of Wisconsin’s residents? You look at some of the grant announcements and they say, ‘How long will it take for the findings to impact the health of people on the ground?’ And those kinds of directions have an enormous impact in terms of the overall direction of the institution.
Partnership dollars produced the Master of Public Health Program.

We had an idea for an MPH program long before the WPP came along, and that was never supported at any level in the School. It was looked upon as a trade degree. ‘This is a high class institution. We do Ph.D. training. We don’t fiddle around with trade degrees, even if Hopkins, Michigan, Harvard, Yale…even if it’s good enough for them. No, no, no, this is Wisconsin.’ All of a sudden, we’re going to have an MPH program, as soon as the WPP came along.

**Grant writing shifts applicants’ thinking**

Some think that the very process of writing and submitting a grant to the WPP causes applicants to change the way they conceptualize their research. The application process requires them to consciously emphasize the connection of their projects to the health of the population.

Some people can integrate their thinking when they’re writing about how this can advance the health of the people of the state. Or, I’m doing basic science. How does that fit with epidemiology? Does the person who’s applying for the money understand how what they’re doing can translate into health? People who haven’t had to think that way have to learn how to think that way. I think MERC is part of teaching people how to do that.
Theme II: The Wisconsin Partnership Program’s Alignment with Healthiest Wisconsin 2010

Leading question:
To what extent do the funding decisions made by the Wisconsin Partnership Program align with the state’s strategic plan for health care?

Main points:
• Most respondents were at least aware of Healthiest Wisconsin 2010 (HW 2010).
• A slim majority felt that they knew enough about the plan to respond to this question.
• Some feel that the WPP’s funding decisions align with HW 2010.
• Others feel that HW 2010 is overly broad and provides little strategic direction for the Partnership Program.
• OAC applicants are more likely to rely on HW 2010; MERC applicants less so.
• Some respondents question whether the WPP’s funding decisions should be driven by HW 2010.
Familiarity with *Healthiest Wisconsin 2010*

Knowledge of and familiarity with the state’s strategic health plan varied widely.

Overall, we found that respondents vary with respect to their knowledge of *Healthiest Wisconsin 2010*. For some it is a touchstone of their everyday work. Others know little about its contents; it provides little direction for the work they undertake. Some note its historical importance in providing early guidance to the WPP.

**Integral to daily work**

Some SMPH faculty members, administrators and researchers see *HW 2010* as integral to their work.

*Once a week the Dean’s team meets and we invariably are talking about some element of this. So it becomes part of you.*

*HW 2010 is the bread and butter of what we do in this department. This is what we are all about. If you read the mission statement and all, this is what we do here every day. I mean, you ask the chair of the department of biochemistry what he thinks of this, but for us, all we do is more or less about this.*

*It does become part of you. It’s just pretty straightforward as a way to improve the health of the public.*

**Important as an early guide to the WPP**

SMPH faculty involved in the early days of the WPP cite the role of *HW 2010* in providing them with measures of success.

*It was a big process before the Partnership was even funded, and then when it was funded it took a while for people to say, ‘What’s going to be our benchmarks? How do we know we’re doing good?’ And some of the community of public health members said, ‘Well, this [HW 2010] would be a good benchmark.’*

*HW 2010 can help “medically oriented” institutions adopt a public health perspective.*

*But it does help focus, particularly an institution that’s heavily medically oriented, towards a more public and population health perspective. So to that degree it’s good. So, I think it’s an important document.*

**Provides guidance to the public health community at large**

*HW 2010 shows the public health community where to direct its efforts.*

*This was written for the public health community of the state. So if they are going to write a new one they should do it in the same way that they did it before. I think it’s very effective for setting direction for them.*

*You know, I think it is easy to use. It’s just one benchmark, but I think it gave a pretty good snapshot of what’s going on in the state and where there’s opportunity to improve at the state level.*

*We absolutely refer to it. Our mission and vision are all about making Wisconsin the healthiest state through the physician-patient relationship. And it’s broader than just healthcare. It’s about access and quality. And when we look at our strategic plan we have aligned many of our initiatives with it.*
Others know little about the document and its contents

Not everyone we spoke with was familiar with HW 2010, however. Some had read the plan for the first time before the interview.

I can’t say that I’ve ever looked at it until this morning when I pulled out my pack and prepared for this [interview].

A number of respondents were somewhat familiar with HW 2010, but they chose not to comment on the alignment between HW 2010 and the WPP. They felt that they did not know enough.

I’m probably not the best person to comment on all of the ways the [WPP] funding has gone out.

[Are you familiar with HW 2010? Is it a living document for you and your work?] I know it, but not by heart. If you mentioned something from it, I would probably recognize it. [From your perspective, have the Partnership’s funding decisions been in alignment with the goals of HW 2010?] I would say, yes, they have. But this is the kind of thing that there might be a little different kind of input for. What I mean is, if they [the WPP] really want to know the answer to that question, I’d have to study it a little and get back to you.
Respondents question the utility of HW 2010 as a guide for funding.

**Healthiest Wisconsin 2010: Breadth is necessary**

Many respondents commented on the sheer comprehensiveness of HW 2010. Some, like the SMPH faculty member quoted below, argue that HW 2010’s broad scope is necessary to mirror the complexity of Wisconsin’s health problems.

You want it to be comprehensive. You don’t want to pick one of the programs and leave everything else out. You need to be comprehensive. The point we’re trying to make here always, all the time, is that determinants of health pretty much are basically almost everything. Everything’s related to health, and not just healthcare or physicians’ work or whatever it is. It’s the environment. It’s the inequalities. It’s access. It’s economics. It’s policy. It’s politics. It’s everything, so it needs to be comprehensive.

It’s pretty broad. So to me, I think it’s great. I kind of think it’s good that it is pretty broad.

Almost any proposal can be made to align with HW 2010

In contrast, other respondents question the strategic utility of HW 2010. When asked if the WPP has aligned with HW 2010, they respond that HW 2010’s scope is so wide that it would be difficult not to align with it.

It would be hard not to have something that was aligned with HW 2010. It has such broad categories. And while they do try to narrow it down, I think if the community has identified a need that is truly a need within their community, more than likely it would fit someplace within the health plan.

So when somebody says, ‘Do you align with Healthiest Wisconsin?’ you say, ‘Yes, everybody on the earth does! Name me anything that doesn’t align!’

This means that grant applicants can find some justification or language in HW 2010 for any proposal they submit.

They [grant applicants] always find a way to meet the requirement. And it’s broad enough that you can. [It almost sounds like you’re saying that alignment is secondary in order to obtain the grant?] I would tell you that at this stage, to many faculty members, it is. They have an idea, they have their own vision of what they want to do and they want to get it done, and they have to find some funding to get it done. So there’s no question, certainly at the beginning, that you would find that they just adapt it to fit it to this [pointing to the HW 2010 document].

Some charge that MERC uses the scope of HW 2010 to fund research that, in the critics’ view, should be ineligible for WPP grants.

They are using the latitude and the overarching inclusiveness of the state’s health plan to squeeze in a bunch of small molecules science.

An OAC grant reviewer commented that even within the context of a single HW 2010 priority area, there is ample room for interpretation about what fits.

If you are just looking at any one area, there can be a fairly wide range of interpretation as to what is important to undertake under that priority area.
Another respondent suggested that this wasn’t so much a problem with HW 2010 as it was with the review process. They fault reviewers who uncritically accept claims that a given proposal aligns with HW 2010.

That’s actually not a failure of the document. It’s a failure of the reviewers that accept lip service to these activities, where almost anything that is said is viewed as actually having met the priorities.

Too general to provide strategic guidance for the state

For some SMPH faculty members, HW 2010 itself lacks strategic direction and is therefore not as effective as it could be. It identifies many conditions but fails to provide a crisp, limited set of priorities.

[T]here’s not a single loosely defined health problem that I know of that doesn’t exist in this document. So this document lacks specificity, focus, and direction. Of course we want to make Wisconsin the healthiest state. But you’re not going to do it with the disease of the month. You’ve got to be able to say, ‘Where are the major directions for the next five years?’ And that means somebody not getting their favorite disease on the list. It also means picking things that you can actually change.

It’s just that if you look at it—so what’s their vision? Wisconsin is a place where all individuals reach their highest potential, communities support the physical, emotional, cultural, spiritual needs of all the people and people work together to create healthy, sustainable, physical and social environments. So that’s pretty basic. How can you change that?

When I first became part of the Program, I read the document [HW 2010] and reviewed it, but at some level it’s kind of like motherhood and country and apple pie. You want to make people healthier. If you’re a good public health person there’s nothing in there that surprises me.

The breadth of HW 2010 also poses problems for those trying to write a grant. Consider this comment from an external community partner:

The HW 2010 document is huge. If there’s any way to simplify it, that would be extremely helpful. I know there’s the executive summary, but when you’re actually trying to align your proposal to the goals, it takes an awful lot of in-depth knowledge and understanding of what that’s really saying.

Others charge that HW 2010 sets fine goals but fails to provide direction to reach them.

There’s nothing wrong at all with the Healthiest Wisconsin 2010 or the projects they’re funding. But it just seems to be too loose, not focused enough, and not much for outcomes.

I’m not a big fan of its utility. I think it has some marketing value. I think the goals are so high, and there are so many of them, and they’re done without any regards to building it in dollars.

I think if you are going to develop a statewide plan for a decade of improvement, then it is very difficult to prioritize within the multiple needs that exist within the state. I think that’s both a political and a practical reality. I think in the state we are a lot better at planning than we are at implementing. And it’s a lot easier to write a plan than implement a plan, and frankly in the planning process itself for 2010, it stops short of defining how those goals are going to be met.

Even those who have successfully linked their MERC funded research to HW 2010 question its ability to achieve its own goals. This researcher found language in HW 2010 to justify bio-medical research, which might seem remote from public health.

It’s not at all hard to talk about that [the biomedical research funded by my MERC grant] in the context of public health, because that indeed is what we’re pursuing in the end. We have used language from documents like this [pointing to cover of HW 2010], but I must say that when I see a document like this, while it has some inspirational quality, the reality of achieving the goals, it seems to me, is remote.
And yet one respondent, who acknowledges the disparity between HW 2010’s stated goals and their limited realization, sees that as precisely the gap that the WPP can fill.

It’s not like there was an agreement across a broad spectrum of [state] agencies involved in the improvement of public health as to who would do what and how they would work together [to effect the goals of HW 2010]. That’s one of the real values the UW Partnership Program has established. By reinforcing the 2010 objectives, by reinforcing the priority areas, and really driving [community-academic] partnerships to address those rather than individual agency approaches—I think that that’s one of the areas that we’ll see in the long run really having some improvement.

WPP must embrace a narrower set of priorities in the next plan

A respondent whose work in state government provides thorough familiarity with the scope of HW 2010 advises the WPP to target the grants it makes over the next five years.

I think that one weakness of round one [i.e., the WPP’s first five years] was that a very broad state health plan, good though it was, permitted pretty much lots of anything to be marketed. I think, clearly, it makes sense for the University to try and do some more directed work.

A SMPH faculty member who believes that the WPP’s decision to align with HW 2010 led it to “cover the waterfront” in its first five years counsels the WPP to consider more targeted granting in its next five years.

It was our original goal to attempt to cover all the priorities of the state health plan, and as a result we look like we’re attempting to cover the waterfront so to speak. This distributes our resources to such an extent that it might not be the best strategy. We might do better if we concentrated on a limited number of health issues or problems. I think it was a good strategy for the first five-year plan, but I would rather see us set some priorities and concentrate our resources on a limited number of health issues in the next five-year plan and perhaps beyond that, because not each one of these priorities in a state health plan can be given equal weight. They’re not all equally important.
Healthiest Wisconsin 2010’s Role in Guiding Grant Proposals

WPP grant applicants and reviewers differ among themselves with regard to how closely HW 2010 guides their work.

It appears that grant proposals vary in their alignment with HW 2010. Some applicants believe that applications to OAC align more closely with HW 2010 than those made to MERC.

Applications to MERC

MERC members provide mixed assessments of the how closely MERC grant proposals align with HW 2010. One MERC member, for instance, observed:

Virtually every proposal references the document. So in that sense it serves a real purpose.

Another MERC member, who claimed limited familiarity with HW 2010, sees any potential alignment between MERC grant applications and HW 2010 as more incidental than intentional.

Applications to OAC

OAC grant reviewers find that OAC grant applications align with HW 2010.

I know from the two years that I was a reviewer—certainly the reviews that I actually did myself, but also in looking at which programs were funded—that there’s a very clear link between Healthy 2010 and the community grants program.

Other OAC grant reviewers also see close alignment with HW 2010. They believe the applicants know that OAC takes HW 2010 seriously.

The categories [from HW 2010] that we fund, those proposals that don’t address those areas are not scored high. So I think we’re right on target.

I think it [the guidance OAC grant applicants find in HW 2010] is substantive. Those [principles in HW 2010] are our [OAC members’] guiding principles. I think they recognize that we’re serious about it.

While only a few OAC grant recipients were interviewed, all acknowledged that demonstrating alignment between their applications and HW 2010 was a clear requirement.

It is a criterion in the application for the community[-academic partnership] grants that they [applicants] identify which health priority areas of Healthiest 2010 they are attempting to address with both applications.
Alignment has increased over time

Both OAC and MERC grant reviewers commented that alignment of grant proposals with HW 2010 has improved over the WPP’s first five years.

An OAC grant reviewer put it this way:

I have to say now in the fourth or fifth year the grants are much more aligned with the plan, and they know, and they do believe, that their goal is to improve the health of the public. [So there has been what sounds like a real learning curve by applicants?] Yes, absolutely.

And this MERC grant reviewer has also noted improvement.

We would get proposals from people who wanted to do public health research, but the proposals were not particularly sophisticated, with exceptions. I think what’s been remarkable to me, even over the last two years, is that as we have gone out for requests for applications, that the sophistication of the public health grants has increased tremendously.

Comments from grant applicants tend parallel reviewers’ comments. That is, while MERC grant applicants vary in their efforts to align with HW 2010, OAC grant applicants consistently report that OAC guidelines require them to refer to HW 2010 in their applications.

One MERC grant recipient put it this way:

No, I don’t refer to it [HW 2010] for grant writing. The major grant that I wrote for the Partnership Program is the living image of what the Wisconsin Partnership wants to be. So we are a living appendage of what they wish to be.

Alignment with HW 2010 is often instrumental rather than inspirational

HW 2010 does not appear to inspire researchers to refocus their research. Rather, some cite the document for instrumental purposes, that is, to use language that legitimizes the research they want to conduct.

One external respondent whose staff includes MERC grant recipients assumes that the staff referenced HW 2010, and that doing so is how the granting game is played.

Well, I would assume that the people [among my staff] who are writing the grants, if this [pointing to HW 2010] was mentioned as an important piece, then they would look to it as guidance in how to structure and focus their grants. I mean, that’s the way you play that game. You see what’s of value to the people [grantors] and see if it matches with yours. And then go after it. I mean, there’s nothing in that that’s bad.

Another respondent, a recipient of a MERC grant for basic biomedical research, answered this way when asked if his grant application referenced HW 2010:

Oh, yeah, certainly. Certainly in the beginning there’s references consistent with the goals of that [pointing to HW 2010].

WPP grants leverage NIH applications

This respondent sees WPP grants as a means for laying the groundwork to win larger NIH grants for basic biomedical research. The alignment of this strategy to win NIH funding with the goals of HW 2010 is an open question.

And part of the object here is, if you provide seed monies, can you parlay or use the seed monies in matching fashion or develop the data so you go to national funding agencies, NIH and things like that. I mean that’s one of the real big advantages to this [WPP] is that this generates an entirely new source of seed money for research. And you don’t get funded with an idea anymore at NIH. You get funded with an idea plus some data to back you up.
To be sure, this researcher notes the benefits of this strategy for the University and the state.

If I get a hit in some results [from the MERC-funded research] that suggests I might have something tantalizing, the starting point at NIH is about $250,000 a year for five years. So it ends up being one and a half million dollars just to carry out the research. And, you know, the benefit to the people of the University, and ultimately the people in the state is that for every dollar I get from NIH for a grant, the University gets another $0.46 to help the operating budget. And so the seed monies, you know, help the state economically in ways that people probably don't imagine.
**Understanding Alignment**

**Respondents’ perceptions of WPP’s alignment with **Healthiest Wisconsin 2010** vary with their perceptions of public health.**

Different respondents define “public health” differently. Their understanding of public health affects the extent to which they agree that the WPP is aligned with HW 2010.

One respondent spoke to the challenges of defining the term.

*Public health is huge. It can be anything almost—anything from water and air to policy, economics, health systems, epidemiology—so when you talk about public health, one of the problems is that because we have for so long neglected public health, and you have a conversation here that now we’re going to be a school of public health, most people say, ‘What does that mean? We don’t understand that.’*

**Narrowly defining public health**

Some interpret “public health”—and by extension, both the WPP’s funding mandate and WPP’s alignment with HW 2010—narrowly, to mean upstream health determinants, prevention measures, and mass intervention, as opposed to individual treatment. In their view, basic biomedical research is excluded from or only tenuously connected to public health.

One respondent illustrated these different perceptions using obesity:

*Well, shall we find new ways to find new genes or new medications to treat obesity, or should we use these [WPP] funds to try to find ways to make people change the way they behave?*

This respondent went on to argue that the WPP should not fund basic biomedical research.

*The mandate of the WPP is very specific about things that improve the health of the public, and funding certain genomics and stem cell research and whatever may prove to be good in, you know, 10 or 15 years down the line, but maybe not. I see NIH as being the right mechanism to fund that. That’s the mission of the NIH, to fund new discoveries. There are colleagues in the School who think that these funds should also fund basic science, pure basic science, that is, basic science that is not even pretending to have any applications. I disagree with that.*

Some respondents who espouse the narrow view say that MERC-funded projects in particular do not align with HW 2010.

*I think the WPP does an excellent job in that regard [aligning with HW 2010] on the OAC side. I’m not impressed on the MERC side….You look at the initiatives that MERC is funding, and it’s not really evident how they align with the state health plan priorities.*

Earlier in the interview, this same respondent expressed the opinion that:

*WPP could be better about providing MERC awards to initiatives that are really very clearly ‘public health’ by public health’s definition, not by medicine’s definition. It would be helpful in a couple ways: one, it would give the medical school more credibility in the public health community as truly in the process of transforming, and not just talking about it. And second, it would be helpful because it would help educate medical school faculty about what’s public health and what’s not. Because if you couldn’t get a MERC award for something that wasn’t public health, then you’d start to learn that you can’t use the words ‘community’ and ‘translation’ and ‘multi-disciplinary,’ and dress up a biomedical intervention and make it public health.*
Sometimes during interviews, respondents would go to their computers and open the WPP website or one of the WPP Annual Reports and tick off the projects that, in their view, were not aligned with HW 2010. Pointing to them on the page, one respondent commented: “These are research grants! They’re research grants!”

When I look at the MERC grants, you know, improving cancer care, okay. Well, cancer care is biomedicine. It’s individual interventions. It’s not public health.

When you talk about preventing cancer, now you’re talking public health, and improving cancer care is not public health. Public health people won’t feel like that’s public health. And so when public health people look at that they’re, like, the School is using public health dollars to support biomedicine.

Or let’s take regenerative medicine or human proteomics—not going to cut it for a public health person. A public health person is going to say that’s basic science or it’s biomedicine. It’s way downstream. It’s not getting at stuff before people get sick. It’s not helping to try to keep people healthy. Even more importantly, it’s not connected to a population-level intervention. These are still mainly individual level interventions. Now, on the other hand, something like the MPH program [pointing again to the WPP Annual Report], or the Survey of the Health of Wisconsin, I think any public health person would go ‘That’s great. We’re so glad that MERC is using its money to support that kind of thing.’

Another respondent, who perceives “tension” between the funding of public health and biomedical research, counseled greater reflection about MERC’s funding mandate:

[There is considerable tension between the vision of working with communities to improve health … the reality of working with communities, which is messy research and messy interactions … and traditional biomedical research…. Wisconsin Partnership monies are supporting tissue banks! There’s a real stretch between tissue banks and community! I think we see this played out locally and played out nationally so that NIH has said it doesn’t have anything to do with health, it has to do with biomedicine. So we will continue to have to be self-critical. In terms of saying, ‘Okay, are we funding traditional biomedical research or are we really holding our feet to the fire in terms of our focus on the Healthiest Wisconsin?’ And that’s always tough. That’s always the tension.

One respondent reports that members of the public view MERC as having too few members representing non-UW interests, and that this leads them to doubt that MERC’s grants align with HW 2010.

The WPP needs more public members on some of the advisory panels. On MERC, there’s some representation, but I think that it’s kind of viewed as closely held by the University. I think that in and of itself sometimes leads to perceptions that, or questions among the public about, to what extent is the 65 percent funding really addressing Healthiest Wisconsin? I’m, personally, not questioning that at all. I’m just saying that I’ve heard that in the community. And since you hear that, that means the WPP really needs to give more specifics about what that link is. And so if you’re hearing concerns that it is not directly linked, and the UW feels that it is, then obviously there’s an educational shortfall somewhere.
The Wisconsin Partnership Program: Key Stakeholders’ Views

WPP is aligned with HW 2010 fairly well in this respondent’s view but the shortage of academic partners in core public health areas dilutes this alignment.

Well, I think that they’ve done a fairly good job of having connectivity to HW 2010. But there aren’t even 50 academic partners from the core public health arena. So your academic partners are coming out of other areas other than core traditional public health systems research or public health systems in general, [so there is] going to be a bias. Even if the projects are anchored in public health, finding an institutional academic partner who has that as their core [is hard]. It’s less likely to happen. That may grow over time, but it’s not there [now].

Broadly defining public health

In contrast to those above, who do not include biomedical research under the heading of “public health,” several respondents argue that biomedical research does play an integral role in public health. Some respondents cite examples of basic science research that has been translated into widely used medical procedures. For instance, one respondent, who had earlier stated that he sees all of WPP’s funding decisions as wholly in alignment with HW 2010, justified his view by listing specific translations of discoveries of techniques for diagnosing, screening, and treating cancer.

From what I’ve seen in cancer research, in terms of basic research on cancer that’s been translated into public health benefits, a good example here is screening techniques for colon cancer. The techniques that are now widely used for colonoscopies came out of basic research. Another example is basic research in physics that’s improved the use of radiation therapy, which is used all over the world. Also, imaging, which started with basic research, is now very widely used for all kinds of things and has had a major impact on diagnosis and treatment.

There are other respondents who acknowledge the utility of short term, classically defined public health interventions, yet who would broaden the notion of public health. They note that many developments have involved a temporal lag between discovery and translation into tangible and widespread health benefits. And they see the combination of these two elements—immediate public health interventions and long-term research commitments—as the source of the unique contributions that the WPP can make.

My personal view of this is that improving the health of the citizens of Wisconsin should be very broad-based. I think there should be somewhat more immediate deliverables, in other words, can we improve very quickly some facets that are going to improve the health of our citizens? But I also think it needs to be looking ahead five to 10 to 15 to 20 years or even beyond that as to areas of research that are going to be laying the foundations now, so that we can be at the cutting edge a few years from now. [Is it fair to characterize the research that you’re describing as being in broad alignment with Healthiest Wisconsin 2010?] Oh, it’s totally within alignment, totally within alignment.

Likewise, another respondent, who believes that the WPP’s “alignment with the state plan is extremely good,” pointed to the need for a “broad portfolio” that values the long term contribution of basic science long run to the health of the public.

It’s really important in a program like this that you maintain a broad portfolio. It would do us no good to expend our efforts and time in a purely public health area unless we’re able to couple that with the developments emerging out of basic science that are going to affect that. I can remember once an unnamed person at one of the WPP meetings said, ‘We don’t want the University and medical school to do something… that’s going to win the Nobel Prize. We want them to have an effect on the health of populations,’ and I thought that was an example of the deeply lacking understanding of the impact of discovery. On that very same day, they awarded the Nobel Prize to the person who invented magnetic resonance imaging. Now, something like 25 or 30 percent of the population of the United States has an MRI every year for enormous benefit to their health and lifespan… You have to have a broad portfolio because you don’t know. So [the WPP has] invested in things that might superficially appear to be very basic science driven, but in fact are fundamental and seminal to our ability to translate discovery.
The Role of WPP Vis-à-Vis the State

Some respondents, who acknowledge and support the overlap between *Healthiest Wisconsin 2010* and the projects funded by the WPP, nevertheless wish to carve out a distinct role for the Partnership as a university entity vis-à-vis the state.

The Partnership Program and *HW 2010* support one another.

I think our alignment with the state plan is extremely good. We can be extremely aligned and supportive of the state plan, but that isn’t necessarily going to translate to someone seeing more patients. It may translate to us building whole new programs in given disease areas or topical areas. Take smoking, okay? The University can be really helpful on the smoking front. We can communicate. We can educate. We can disseminate. We can be out there in the public doing this very, very easily, much more effectively than almost anyone else. It’s very hard for a state agency to do that. So it’s very easy for us to stay heavily aligned in something like that. Some of the state health plans, though, are really associated with societal issues that are much more challenging for a university to have an impact on. We can study the systems or we can study the potential pathways to improvement, but this really requires changes in, for example, state allocations at the public health level. We can serve as a resource and make recommendations, but are not going to get our boots on the ground, so to speak.

Another respondent echoed this view, that there is a natural and substantial overlap between *HW 2010* and the Partnership Program, but also argued that there are necessarily areas of non-alignment. In this respondent’s view, because the WPP originally defined its mission as encompassed by *HW 2010*, it missed the opportunity to spell out the unique contributions it could make.

So do I know what’s in it [HW 2010]? Yes. Do we [the WPP] link some of the education with what they’ve put in there? Yes, because there’s a lot of overlap. But this [HW 2010] was a roadmap for a whole different purpose. This is a document that was developed for our public health community in the State of Wisconsin. And it was developed through a very strong and deliberative process over five years, and it stands the test of time quite well. What didn’t happen is for someone to say, ‘Now, given this document, what is the implication for a School of Medicine and Public Health? How would you plug into that?’ We just said, ‘Oh, we’re going to use this as our guideline; we’re going to adopt this.’

This respondent went on to say that most of the MERC-funded projects were outside the purview of *HW 2010*, which seemed necessary and natural for a university.

I think that’s where most of the work in the MERC is done, outside [of HW 2010]. But again, I think that’s the function of a medical school, which is to say, we are not in the delivery of public health. We’re in developing the new knowledge and the training for people that will then go out into the workforce and go from there.
One respondent drew a parallel between the WPP from HW 2010 and that of the Wisconsin Academy of Rural Medicine (WARM).

Just to take the WARM program, for example: it wouldn’t have made it in there [into HW 2010] because these people that wrote this plan don’t see that they have any influence or reason to worry about the training of health professionals. That’s what a School of Medicine and Public Health can and should be doing, and that’s different from what the state workforce needs to do out there.

And another respondent put it this way.

HW 2010 is an important document. I think that it would be unfortunate if it was the only input into setting priorities for the Wisconsin Partnership Program. The opportunity in building a School of Medicine and Public Health is to do something that is not being done out there, which is to actively figure out how you set priorities that simultaneously take advantage of both the healthcare system and the public health system, and the existing priorities and alignments of those systems. And that’s a little bit different from that document, although a lot is covered in that document, but it’s just that this is a document that came from DHFS. I think that we would be doing a disservice to the State of Wisconsin if we limited ourselves to one source of input for setting priorities for the Wisconsin Partnership Program.

One respondent, a Community-Academic Partnership Program external partner, advocated a looser link between the WPP and HW 2010 so that the WPP could respond to “emerging needs.”

It was a big issue that was pushed by the public health community as a part of this [the WPP] to make sure that we’re all rolling at the same time in the same direction, and the state health plan is our guide at some level. The problem with everyone’s moving in the same direction is to shift when we see something change, suddenly, like bioterrorism or a flu pandemic. How does that impact access to care issues and making sure that we get everybody covered so they’re not going to the doctor and infecting everybody at their office or a factory or whatever because they don’t have health insurance? So I think a too rigid adherence to the health plan can be detrimental to innovation and emerging needs. I think there has to be some judgment exercised in how you look at the state health plan and you must have some flexibility to address emerging needs that are out there.

A state health official, in contrast, praised the WPP’s alignment with HW 2010 and urged the WPP to restate its “direct connection” to Healthiest Wisconsin 2020.

I think there’s excellent alignment. I think that it [the WPP] has helped to advance statewide awareness of the state health plan and increase the depth of understanding of a lot of people in the public health system about the state health plan. So I think we count it as a success that both of the medical schools that received the Blue Cross Blue Shield conversion funds have referenced, more or less depending on which school, Healthiest Wisconsin 2010 as a foundational document. I think the most important thing for 2020 is to restate the [WPP’s] direct connection to the state health plan. It’s really important. What I would not like to see is us having three different plans: one at the UW, one at the state, and one at the Medical College. So I think that’s number one for me.
The WPP and Healthiest Wisconsin 2020

Respondents involved with WPP in its first five years offer suggestions for Healthiest Wisconsin 2020.

A few respondents offered suggestions to improve the next state health plan, Healthiest Wisconsin 2020. In general, these people want HW 2010 to place greater emphasis on “upstream health determinants.”

We haven’t looked at identifying the problem and trying to fix it. We were so narrow in scope that we didn’t consider people’s living conditions and their financial status, and all the other issues that determine one’s well-being. Unless you can fix these other components, you’re going to have much less influence on the things that we’re spending most of the resources on right now.

HW 2020 should be written in a way that considers the unique contributions of the WPP and of the School of Medicine and Public Health.

Should it be rewritten with the Partnership in mind? It seems to me like they’re overlapping but separate and that more of a dialogue between the two would be helpful to understand what is the role of a School of Medicine and Public Health in helping to effect this plan, but not own this plan or be bounded by this plan.

A government health official, who sees HW 2010 not only as a state health plan but as a public health plan for the state, asked the WPP to consider how to partner with the state in the area of information systems in the years ahead.

It’s been a challenge to get traction on funding for infrastructure priorities because of the concern about supplanting the state’s responsibility for public health with the [WPP] dollars. While I understand that, I think that because Healthiest Wisconsin 2010 is a public health system plan, not a state government plan only, and because these infrastructure priorities really have the potential to move the whole system ahead, I would ask the WPP to think about how we could partner more effectively on achieving progress in these areas, the information systems coordination. We haven’t been successful in having our efforts to integrate our various data systems funded, and that’s a concern.

One respondent expressed hope that HW 2020 will focus on the health needs of an aging population.

My one concern is that I can’t believe that 2020 would come out without a specific focus on the geriatric population. If they’re going to look at improving health in the state of Wisconsin, they have to do that with that in mind.

And one respondent remarked that the key to improving the WPP’s next five-year plan and HW 2020 is to set clear priorities and sustainable and quantifiable methods for implementing them:

I think in fact one of the key issues, both for Healthiest Wisconsin 2020 and the next [WPP] five-year plan is, do we have a sense of priorities about what really matters and what really works? And how do we set priorities? And if we do set them, how do we get them done? And get them done doesn’t mean just some nice decorating project that works well in one place, but get some scale of impact. If you’re really trying to transform the health of the public in the state as a whole, [you have to ask:] What’s scalable? What’s sustainable? If it’s the good idea, but it takes political will that doesn’t exist, how do you build it? And I think both the University and the state need to think more deeply about all of that.
Theme III: Priorities for the Future

Leading question:
What should be the priorities for the next five years and are there specific health areas where the Wisconsin Partnership Program should be investing in to advance population health over the next five years?

Main points:
• Develop consistent criteria for judging healthcare initiatives, shifting the focus to disease prevention, and developing collaborative approaches to health care.
• Hire new faculty, with public health expertise, to accelerate and sustain WPP’s transformation.
• Change the School’s curriculum. Encourage medical students to pursue dual advanced degrees and to apply for the new faculty positions.
• Discontinue some projects. Fund some new ones. Continue to fund projects which seem promising, which require sustained funding in order to show results and realize a return on resources already invested. Some respondents note that certain projects and some past funding decisions are limiting the Partnership’s capacity to change.
• Certainly keep or expand the Master of Public Health program. All who referred to it approved of the MPH program.
• Do more to publicize WPP’s mission and accomplishments, inside and outside the university.
• The School’s initiative to address low birthweight rates and infant mortality among disparate populations in Wisconsin produced mixed responses. Some respondents lacked knowledge of the topic and were unable to comment. For others, the initiative is an absolute necessity.
Health Initiatives

A wide array of health initiatives was identified for the next five-year plan.

Respondents favor the development of consistent criteria for judging healthcare initiatives; they hope to shift WPP’s focus to include disease prevention; and they favor collaborative approaches to healthcare. No single theme emerged as dominant. Indeed, respondents rarely offered any priority without prompting.

Respondents spoke of various conditions rather than a single healthcare issue

Some respondents provided a list of conditions they considered priorities. The following comments reflect the variety of conditions respondents identified:

I think that if you just talked about population health you would say obesity. You can’t get away from that. Smoking, you can’t get away from that. In this state, substance abuse, infant mortality. You can talk about diabetes. You can talk about cardiovascular disease, but in reality there are a couple places I might want to be directive, such as in infant mortality.

Suicide prevention. There’s a high degree of girls, in particular the Hispanic community, much higher than the general population, that express thoughts of suicide. Childhood obesity is huge. Adult obesity—it’s the combination of cardiovascular disease, obesity, and diabetes—they all kind of go hand in hand. I would do something in each of the broad determinants of health: individual behaviors, new and effective strategies to leverage smoking, drinking, over-eating, poor nutrition, lack of exercise and lack of responsibility in personal behavior with respect to sex, seatbelts.

Specific health areas

Not all respondents spoke in general terms. Many mentioned specific health conditions in need of attention. One respondent advocated for prevention of obesity and improvement of nutrition because they have a “public health and prevention element.” This respondent added that WPP’s funding in this area should remain responsive to promising research directions.

It would make sense to identify some areas that have a public health and prevention element, like obesity and nutrition, and really go after that and concentrate on that [especially because these two are implicated in cancer].

Another respondent spoke of a focus on preventing obesity, rather than on smoking cessation and prevention.

I happen to think that the obesity problem, particularly in children and adolescents is the number one health problem in the state. Whereas the smoking problem, cigarette smoking particularly, is no longer in my judgment the most significant long-term health problem of the state, and so I would prefer that we not put much money into smoking cessation programs.

One respondent believes that physical health receives more attention than mental health and advocated for more balance between the two.

One of the things that seems out of balance to me is the amount of effort and energy that is spent on physical health relative to mental health… the balance needs to be restored…so looking at public health concerns, another element would be the balance between physical health and mental health.
Some respondents pointed to environmental health issues.

We’re an agricultural state. We’ve done a lot to the environment. When you do stuff to mother nature it’s usually not all good. So our ability to, for example, understand the relationship between onset autism and environmental sciences might be an extraordinary area where we could have a tremendous impact in childhood development.

If everyone is 200 percent overweight, guess what? We’re going to have a lot more obesity. We don’t need to spend any money to know that. But what we need to understand is why people with 12 percent body fat develop diabetes all of a sudden. Something’s got to be going on there that’s probably genetic, but also probably somewhat environmental. And we don’t know until we look widely on that area.

One respondent spoke of the aging population as a coming “geriatric tsunami.”

The geriatric demographics of our state and nation are about to hit: health care dollars, the management of their chronic diseases, the hospitalizations that we’re going to see, the need for creative solutions to housing and caring for people, the need to systematically look at aging. It needs to be part of any initiative that’s looking at a healthy state population.

Another respondent repeatedly advocated for dental care as a public health priority.

The medical community has to start taking the issue of dental health seriously, and the Partnership could be involved with that. Medical doctors have discovered that people’s mouths are actually connected to their bodies. The disadvantaged populations are hit harder. They have less dental care on the whole, both preventive and also treatment of problems after they occur, so any programs that take on this issue have to start with that.

Non-health specific priorities

Respondents sometimes seemed more comfortable suggesting priorities unrelated to specific health problems. What follows is a list of the administrative, policy-oriented, and strategic recommendations that respondents wish the WPP to consider for its next five-year plan.

Study and design effective, local interventions to address the socioeconomic disparities in the state.

I think the biggest area is health disparity. Look at what we can do to improve the health care of the people of the State of Wisconsin by leveling the playing field, so that everyone has what they need to be healthy. Now that could be food, that could be a job, that could be pre-natal care. But health disparities and the social indicators that create that situation are the things that are important to me…What can we do? Let the communities decide. It may be different on an Indian reservation than in the central city of Madison.

I would do some category with the socioeconomic determinants of health and how they relate to health outcomes...

Wisconsin is one of the poorest states in racial disparities and health outcomes and health access… Infant mortality for African Americans in our state is among the worst in the country. And some things are already known by what they’ve done in other places… I would say that [the WPP should try] to think hard about what impacts population numbers as a whole, and what reduces disparities, then within that, think about what the University can contribute that’s value-added beyond what other people could.
Identify local leaders and a limited number of viable projects, and then assist communities with their implementation.

I think [the priority] should be where do we see some indigenous leadership and opportunities that can make a difference? And that I think is a smart strategy, because at the end of the day if we follow the passion that exists in our individual communities, we’re going to create more change.

Focus the next generation of projects on a limited group of areas where they think they can get the most effect in improving the health of the communities, and then develop a long-term approach of both educational sufficiency, not just in Madison but across the state, and educational sufficiency of the care givers and assist communities to accomplish their own health-improvement strategies.

Identify the promising interdisciplinary research that could lead to advances in common diseases such as cardiovascular diseases.

We need to understand more about the cardiovascular condition of the public in a very general way… I imagine if we did a Doppler flow color shift ultrasound on the carotids of everyone over the age of 50 throughout the state, we’d have a much better understanding of the vascular condition of that population and what you might be able to do about it… And the coupling of these two would be an enormous impact on the state. One is very basic, elemental biology and the other is purely gathering statistics, elegant statistics.

Take a long-term view and place greater emphasis on prevention.

Lifestyle change, and preventive care, and taking the long view. If you look at substance abuse, smoking, obesity, the things that really are impacting our community so dramatically and account for a big chunk of the way we spend dollars right now in the healthcare system, we need to influence those so that ten to 20 years from now we’re not dealing with them in the way that currently exists… We can treat end-stage disease and I think we do a pretty good job of it, but that’s a whole lot of money being spent for a very small yield in terms of productive years when we should be dealing with it on the front end.

Choose the priorities that leverage the most resources from other quarters and build on the University’s existing strengths in the form of its existing research centers.

The question is, how do you create priorities in such a way that you actually leverage things?... It’s not just, how do you do something, but rather how do you do it in such a way that you bring in many, many more resources to the problem than you would have had otherwise?... And to me, priorities become, how do we align fundamentally with the goals and the mission of the School of Medicine and Public Health in such a way that the entire School has a mandate to continue to move in [an interdisciplinary direction]?

[Select only those projects that would] be a catalyst for change in broader systems. What I’m coming at is less about what would I buy with the money, than what criteria would I apply…. All of that ought to be really carefully done, and it might be a little different from the way they’ve done it so far….

We’d probably do best if we build on our greatest strengths… Our priorities should be based on having somebody here who is already a leader in that arena.

[The WPP needs more] targeted community academic grants that build on our centers of excellence within the School. So we have one of the best tobacco and research institutes in the country. Next year we might say we’re going to put two million dollars out there for x number of grants, for five grants in tobacco cessation. And their partners are going to be within CTRI; so really start to build those connections between the community and the School or OAC and MERC.

Continue to foster the creation of new public health physician scientists by renewing the commitment to the New Investigator Program.

Over time the New Investigators has really evolved. There’s a declining number of physician/investigators – physician/scientists. Fewer and fewer physicians are serving in research or scientist roles and it’s an enormous problem nationally and it’s also a problem here in Wisconsin. And particularly, there’s even a smaller segment of those physician investigators that are committed to public health. To have the WPP continue to be a driver of public health physician scientists would be wonderful, [to be part of] that really small group of priority areas, would be a wonderful thing.
Study and distribute findings on the cost-effectiveness of preventive measures as opposed to treatments after disease onset.

One of the things that I need help with is how do I measure success in smaller increments so that we can know whether or not we are doing something that’s a nice thing to do but it’s not making an impact? We need more help evaluating that. I think another thing that would be really helpful with regards to prevention is if we’re able to put a value on immunizations. By spending a dollar you save whatever or by preventing obesity, what are we saving? I don’t know if anybody has come up with a good way to attack that…It would be helpful to be able to say by having a program that is successful and having people stop smoking, by spending ten dollars here, it’s going to save $100 ten years from now or whatever. It would be nice to have some of that kind of economic information.

Focus on a short list of high priorities, and fund organizations that can “deliver the goods.”

We have clear measures of what causes morbidity and mortality and damages the health of Wisconsin…I would urge them to be more courageous and say, ‘We’re going to identify a couple, somewhere between two and five absolutely core priority areas, the crown jewels of the Wisconsin portfolio in public health for which we’re going to put added emphasis to have an added public health impact.’ And I think they can do that now. They’ve got some infrastructure. They’ve got some entities that can deliver the goods, one of which is our center. And I think the Partnership Program needs to be more courageous in identifying those two to five entities that have the biggest public health bang for the buck and dedicate the resources to allow that to happen to dramatically improve the health of Wisconsin residents.

My inclination would be to have half or two-thirds of the money set aside for a few high priority areas and the rest distributed across the state health plan priorities.

Once the priority health issues are identified, the Partnership Program should focus on the known risk factors.

Another area I think would be equally important to address would be a risk profile and how could we better manage the multiple risk factors that so many people have. Obesity clearly is of importance. But hypertension continues to be an under-diagnosed and under-treated disease. Diabetes is an enormous problem which has risen with the burden of obesity in our state. And finally high cholesterol. When you look at what kills people in a state like Wisconsin, it’s 60 percent cardiovascular risk factors: smoking, diabetes, hypertension, hyperlipidemia…Public health training tells me how do we dramatically drive down population rates of risk factors and illnesses? I’m really driven by the big numbers. What’s killing large numbers of people? What’s making them sick?

Require grant applicants to specify deliverables in terms of health outcomes or reducing the prevalence of a risk factor, and hold grantees accountable to their targets.

We could say, ‘For the next five years, we’re going to give these three to five entities a million bucks a year. And we’re not going to tie it so tightly around specific grant deliverables but rather challenge you to have a population-wide impact on a risk factor. So promise us you’ll get tobacco use rates down by two percent of the population from 20 percent to 18 percent and be innovative and creative and opportunistic to make that happen.’

To improve the health of Wisconsinites, study and reform the healthcare systems that serve and disserve them.

I think that we are not going to help people be healthier in Wisconsin until we actually are studying healthcare delivery systems. And thinking outside of the box and trying some really different stuff.
Initiative to Reduce Low Birthweight Rates and Infant Mortality in Wisconsin

Not all respondents could speak to this initiative; for others, its attention was an absolute necessity.

At the close of the interview, respondents were often asked to identify specific projects that would address the issue of low birthweight rates and infant mortality among disparate populations in Wisconsin. Some of those interviewed said that they lacked knowledge of the topic and were unable to comment. The following response typifies what was said: “I don’t know enough about that. I just don’t know enough about that. It’s not an area where I have any expertise.” Others commented on the absolute necessity of addressing the issue and offered suggestions for doing so.

The Partnership Program should direct some of its financial and personnel resources towards this initiative

Respondents who felt informed noted the saliency of the issue for the state and the need for the Partnership Program to be seen as a force for addressing such issues.

From a health perspective, this is a disgraceful issue for Wisconsin. It points to the tremendous inequities in care that exist, as well as the social and economic inequities that exist. So to the extent we recognize this problem, I think that we have an obligation and a duty to address it…

And so I think it’s a very worthwhile thing to do. We have people who are interested in addressing it. We have people who are expert in addressing it. We’ve got all the resources; we’ve got everything we need, all the right people and things are in place. So I think it’s an extraordinarily worthy endeavor. From a political point of view I think it’s also a worthy endeavor in that there has been significant criticism about how this money has been spent, how much of it stays in Madison versus how much of it is directed towards the rest of the state.

Access to adequate health care

Another necessary component is facilitating access to adequate health care. It would also have to look at the conditions of the women’s lives: Do they have safe living situations? Is there substance abuse in their homes? Do they suffer from domestic violence?

We need to improve access to prenatal care for women in high risk groups. We need to help improve access and education on birth control, especially in teenage girls…The question is, how do you go about giving access to girls that don’t want to get pregnant, to prevent those pregnancies? So for me those would be the key areas…and those could be for both MERC and OAC. I could see pediatricians and obstetricians and public health people trying to institute programs in schools or things to improve health education and providing access to contraceptives to young people.
This respondent acknowledges that those highest at risk are women of color.

The women who are at highest risk for adverse birth outcomes are women of color. They’re women living in poverty. They’re women affected by drug use. They’re women living in a violent situation or in a unsafe neighborhood…[And so it is necessary to look] at social and economic factors that influence health…

**Suggested approaches to address low birthweight rates and infant mortality**

Suggestions for addressing low birthweight rates and infant mortality included intervention and education, identifying successful models and methodologies used elsewhere, leveraging Partnership strengths and encouraging policy development.

Several respondents were advocates for direct intervention and education.

When you look at the disproportional impact on people of color as the people that are bearing the burden of this particular health outcome, then what you need to do is have projects that work within communities to identify and move forward on doing that direct intervention. But where does education come in? Education comes in front-and-center with understanding that there is racial bias in the way we deliver medical care…So even though we’ve got cultural competency training in medical education, I don’t see any outcomes that say what we’ve done is really going to make a difference in the fundamental way in which both patients perceive us and the way we perceive them. So I would like to see research on that.

I think we need to understand more about the fundamental causes, more epidemiology research on low birthweight infants, and I think that we should test some interventions, not just provide services…and do this in a scientifically solid fashion where we would study different approaches and find out what works first. Many people would say, ‘Hey, we know what the problem is. We don’t have enough services like prenatal care, etc. etc.’ I don’t think it’s as simple as that. I think we really need to learn more before we try to make a quantum leap to some interventions that we think will work…the ideal would be to have individuals who are trained and expert in the combination of epidemiology and social behavioral sciences. If you could recruit some minority people, African Americans, Hispanic Americans, it would be even better, because we do know that working in those communities is easier if you’re culturally knowledgeable or culturally competent and accepted.

I’ll give you three things to consider. One has to do with what I’ll call maternal health and nutrition outreach program that would include public service announcements, getting into the high schools, probably into the middle schools, and getting into the workplace. I think another one would be tobacco cessation, basically giving CTRI a green light to do more stuff with the women of child-bearing age, to do interventions. To get in there and stop the smokers because the smoking is a risk factor for that. And then I would probably do something along the lines of some sort of cohort study with, let’s say, a like state like Minnesota to find out actually if in fact it really is a problem.

Other respondents suggested the Partnership examine existing successful models, such as the Nurse Family Partnership.

I’m speaking of the Nurse Family Partnership. It’s an intensive nurse-home visiting program where the nurse goes out to these high risk pregnant women and continues after they deliver for the first two years of their newborn’s life. They’re visiting every week or at least every other week, and they’re doing all kinds of educational and behavioral kinds of interventions with the mom and the parents, to help create a safer environment for the baby, to make the pregnancy safer, to get them to stop smoking, getting off of drugs, getting into prenatal care, taking their vitamins, knowing how to take care of a newborn. It’s been shown to work.
I think there are lots of models that work. Nurse Family Partnership would be one that I would highly recommend that we fund in communities where racial disparities are high. I think a focus on coordination of systems would be important [such as] patient navigator, community health worker-type programs that affect the social and economic conditions of a community by providing meaningful, sustainable employment and by having that employment relate directly to the health status of the community would be important to pursue.

There are some pilots nationally that are called Centering Pregnancy and Centering Parenting. It’s a group-visit model for managing pregnancy and the first year of life that empowers women. They meet with peer support groups. They have group visits with the clinicians, there is education folded in. They take care of each other through the first year of their children’s life. I think anything around centering pregnancy as a very specific model that could be broadened to multiple communities would be amazing and it’s also potentially serving as a model for centering chronic disease. It’s not a copyrighted program, but it is a methodology, an approach to a kind of healthcare delivery that is not encounter by encounter between a patient and a physician but is much broader. There’s improved birthweight, there’s improved infant outcomes, there’s improved maternal outcomes, all sorts of great things.

Approach low birthweight rates and infant mortality by leveraging the strengths of many organizations and actors.

Fixing infant mortality in the State of Wisconsin is not something that should be solely the responsibility of the School of Medicine and Public Health. And if we take that on we are very, very foolish. It has to be taken on as a partnership with every major entity in this state who has as its mandate to solve that problem. And that’s the challenge of figuring out how to leverage this money…You may need to change regulations, You may need to change laws. You may need to change financial incentives. You may need to do a whole host of things that this medical school has no capacity to do without partners. So, I think about priorities that build the medical school as a partner with other major entities to solve problems, that build incentives for faculty in the medical school to become partners and to align with their other research goals. And that’s different than going out and throwing money at a problem to make it go away.

Policy development

[We could] influence statewide policy around childcare, childcare benefits, around employment, around maternity leave for employment. There’s a number of factors that can be influenced from a policy perspective.

Establish a council of representatives from target population areas.

Form an advisory council that includes people from Milwaukee, Racine and Kenosha, that includes people from the state that help with the design of the project.
Faculty Development and Recruitment

The School currently lacks faculty needed to catalyze and sustain its transformation.

New programs and directions require new faculty. Yet respondents believe that the School lacks the faculty needed to catalyze and sustain its transformation. From this point of view the Partnership’s priority should be the hiring of new faculty members with a focus on public health.

The School currently lacks the faculty needed to support the transformation

Numerous respondents mentioned that the faculty to catalyze and sustain the transformation of the new School are lacking.

We don’t have the faculty in some areas to sustain this kind of work. We actually need a substantial increase in the faculty in certain areas…We don’t even have exactly the correct departments.

Do we have enough faculty right now to accomplish the aims of the transformation, a community public health faculty? Everybody would say no. So we need to look honestly and say, ‘How do we accelerate that process?’

If we really want to transform the School we really do have to support the development of faculty members in the area of public health…but we can’t be that school unless we invest in some new faculty and new programs.

Respondents pointed to the lack of faculty with a public health background.

… if, in fact, some people are envisioning five percent or ten percent of our faculty being public health types they better get busy because we don’t have that kind of proportion at this stage.

We just simply do not have enough faculty in what I call family health and public policy. We have a Department of Family Health [in the SMPH], and they’re a very, very productive primary care group of people. But we need to have faculty in that department who are interested in the public population health aspects of primary care, more than we have.

By and large we have very few faculty who have a deep understanding of public health, who have any experience in doing community development activities, so we’ve got to build up the faculty to have the capacity.

We need center development for engagement in community health to house and help develop faculty members who really want to do community-based participatory research.

Faculty need better understanding of public health and the transformation

Some respondents noted that the School’s faculty needs a better “understanding of what public health is.”

If the medical school wants to be an integrated School of Medicine and Public Health, one of the first things that’s going to have to happen is that a larger core group of faculty and leaders are going to have to actually have a more accurate understanding of what public health is. There are already some people in the population health department, a few people in family medicine, that clearly understand it. But I’m talking about the School as an entity.
Basic science researchers expressed that they do not have a clear understanding of the transformation and what it means for their work. The WPP would have to invest some time and money into showing basic scientists how to connect with clinical faculty for translational work.

Basic science researchers hear this emphasis on translational research and I’m not sure most of us understand what does that really mean and what are the opportunities that a basic scientist would have? What are the questions that they’re asking and how that could be partnered with the clinical side of things? I think educating both sides would be great, and I could see having some money spent towards that goal in trying to link these guys together.

Recruit senior leadership

Several respondents felt the emphasis should be placed on recruiting senior leadership rather than young faculty.

If I were pressed to give you an individual answer what I would say is that given this concept of you are what your faculty is, that there needs to be substantial investment in a cadre of new faculty can lead the way in this kind of work.

I think we have kind of a pluripotential population of young folks here. So I’m not sure we need too many people on that end. I think we really need some senior leadership in areas of health services research and population research.

We need to recruit some faculty who can serve as leaders, mentors, guides to the juniors. I think they would probably come from schools of public health. They would probably be leaders that are well established and have a track record, a portfolio. They would bring in the prestige, the name, probably some grants or projects that they are working on, to improve the health of populations. We need to recruit them strategically in the areas that we want to cultivate in public health.

Cluster hires

Respondents endorse the concept of building new faculty through cluster hires.

We need strategic cluster hires in the areas of population health that need faculty…Cluster hires have been effective but they need to be five or six at a time rather than two or three at a time.

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Others pointed out the opportunities presented by building connections with other University programs but outside the SMPH umbrella of departments.

I would envision a school of public health as a collection of people, most of them not M.D.s, but MPHs or Ph.D.s in sociology, education, environment, community design… How do we build bridges to have much more collaboration across the schools as part of this program, so that we can make use of people that are sitting in the School of Education or the School of Social Work or wherever they are?

Change the tenure and promotion criteria

No matter where the new faculty come from, one respondent saw the need to change the tenure and promotion criteria.

The promotion and tenure criteria of the campus need to be changed. It has been very clear that a system like ours at UW–Madison, changing promotion and tenure criteria is extremely difficult, and we do tend to reproduce more of our own—what I call reductionist faculty; faculty that learn more and more about less and less are the ones that tend to get promoted. Also we tend to promote people who work as solo researchers. We don’t value collaborative community-oriented research as much. So I really think promotion and tenure criteria on the campus need to be changed and modernized.

Making community-academic partnerships a viable option for faculty may require altered expectations for tenure.

This university, as compared to some other large land grant, successful research universities, has done a poor job with the issue of how do we deal with imperatives around tenure for faculty with the amount of time it takes if they’re going to be a seriously good academic partner. I don’t think any progress has been made in that area. And the reality is, if you’re really serious about getting tenure, particularly in medical school, and if you get really serious about being an academic partner with a community, you’ll probably be cutting your own throat.
Education and Curriculum Development

The newly transformed School should include a curriculum that encourages dual degrees, particularly a Master of Public Health.

Some respondents believe that supporting changes in the School’s curriculum should be a priority for the Partnership. In particular, they suggested that more medical students should be encouraged to pursue dual advanced degrees, whether an MPH or Ph.D. Students trained in this way would be attractive candidates for SMPH faculty positions. Others suggested that a public health certificate be required for all medical students as well as for faculty.

Dual advanced degrees

Some respondents made the case for encouraging more medical students to pursue dual advanced degrees. Medical students with MPHs or Ph.D.s would make attractive candidates for faculty positions.

I think we do have a good M.D. Ph.D. program, but if there was some way we could say that we want to emphasize a Ph.D. in fields that are relevant to public health and that could be the population health sciences, the Ph.D. biostatistics, or sociology for example. There is no such thing as a Ph.D. in health policy to my knowledge…I would say it would be a good idea.

I personally believe in the Institute of Medicine’s recommendation that 30 percent of our M.D.s, people in medical school and students entering medical schools, get an MPH. So in my ideal world ten years from now, fully a quarter of our students would be enrolled in that M.D. MPH program.

Certificate in public health

Some respondents went even further by suggesting that all graduates, as well as existing faculty, be required to obtain a public health certificate.

…everybody who graduates with a four-year M.D. would have a certification in population health. That same sort of certificate program would be offered to all faculty. We would expect X percent to go out and get an MPH so that ten years from now ten or 20 percent of our faculty should have an MPH, but they should also be offered an opportunity to just do the certificate.
Team training

Some respondents suggested a transformed school would provide more team training, particularly as it relates to chronic disease management.

From an education perspective in terms of health areas that we haven’t done and which should be part of the Partnership’s next five-year plan I’d suggest chronic disease management. This has become so important. That’s where most of the morbidity is right now. So it relates to diabetes. It relates to heart disease. It relates to early identification of cancers, kidney disease. That’s all done in chronic disease management teams now, and we’re not training students on that model at all. What I would see as part of the next five-year plan would be to redesign the curriculum so that students really are working on chronic disease management teams. That’s how the important health conditions can translate into student education.

What has also been shown in terms of health outcomes is that when teams work effectively you have fewer medication errors, fewer safety issues, and you gain better health outcomes, such as diabetic management and chronic disease management.

This respondent explained that a team approach would bring together basic science research with public health application and achieve an “amplification” of their individual strengths.

We can sort of say, ‘Come in with a project that takes the UW and the Partnership to the next level’ and then they could develop an area, almost like an institute of expertise in the area. It should be something that builds public health relationships which is translatable to human disease. The Partnership should be facilitating this. All of a sudden, you’ll have these expanding areas of research. They get funded, they start to grow and they become bigger and bigger and bigger. Again, the amplification of it! So the Partnership could be seed money to...develop new areas of research that didn’t exist before and bring people together.

Related to a team-training approach was what one respondent called “inter-professional education.”

Inter-professional education means that we have the opportunity for disciplines [such as] pharmacy, nursing and medicine all in the same training arena working together in teams to understand what it means to be working together, because that’s what we’re doing in the hospital and in the clinics... What we’ve done here with inter-professional education is we put a panel on in front of the students and say, ‘Here’s what a nurse does; here’s what a pharmacist does.’ So we talk at them, but we don’t really teach it. What I mean by real is that they actually have a class together around something that they really work on together. Then the team training is real...[Think about] some of the disaster management issues where if you don’t have a team that’s already trained to work together you’re going to waste a lot of time and not have good outcomes.

Some believe that social and behavioral scientists should play a greater role in the next five years.

A huge part of this [next five years] is going to be to try and figure out how to engage the public in taking care of themselves 20 years before they’re deathly ill. How do you engage the massively overweight 15-year-old teenagers who, if they don’t change their behavior, will be on dialysis when they’re 30? How do you keep the 90 percent of the men between the ages of 25 and 55 from gaining weight? There’s a huge opportunity for the social sciences to be engaged in trying to implement what we know as best outcomes.
Community and global perspectives

Respondents spoke of the need to gain community experience and cited WARM for collaborative opportunities; others recognized global health as an important part of a student’s training.

M.D./Ph.D. students should go out and do their research or their service in the community in order to get funded. I think that’s a really good way of doing it but that’s maybe ten students and that’s not really getting it into the whole medical school. I think that we could probably work with, there’s a new medical school initiative, that’s called WARM Rural Medicine. They want to get people into the medical school curriculum that would encourage students to settle as physicians out in the state. They could work with that…WARM is wonderful.

Now a School of Medicine and Public Health and the Partnership Program are statewide, but I think it also has to be considered in a global arena, as we are living in a very wide world of medicine…For example, let’s say students are interested in parasitic diseases in Africa. First of all, they should see it, see what it’s like, see what the process there is and see what the scope of the situation is. Then they come back and sort of learn the tools and the various ways one can approach the problem. They say the boundaries of the University of Wisconsin are the state. I think it should be beyond the state, at a far different level.

Community-academic partnerships

Several respondents took the opportunity to talk about the Community-Academic Partnership Program. This respondent noted the partnerships are a two-way street, and getting everyone involved to acknowledge that will take some effort.

I’ve seen little to no investment in improving the quality and strength of either the academic or community partners to actually be academic or community partners…. It’s not about a community being research subjects for the academic or the academic being the source to the pot of gold for the community… a very small number of faculty are deluged because they’re the only ones available to be the acting partners. The reality is if you’re good partners you have to be together pretty much at the time of inception of the idea. You know, maybe a community says, ‘Okay, I got some ideas I’m going to work on.’ I think that’s the time they need to get a community academic partner who then works with them to problem solve, what are the various ways we might go, and then be part of the development process.

Another respondent called on the WPP to enhance its ability to connect communities with academic partners.

The development of some kind of relationship management bureau is key. I don’t know what to call it. For instance, if we have someone in Antigo who’s noticing they’ve got a problem and they want to team up with the medical school to figure out how to address this problem, where do they start? Who do they call? They call the Dean? We don’t have a current efficient mechanism for faculty who say, ‘I’m really interested with Native Americans on alcohol problems, how do I get going?’ On the other hand, our Native community who says, ‘We’ve got diabetes that’s skyrocketing and we don’t know how to address it. How do we find out?’ So we need some kind of a broker to help facilitate and cultivate and sustain these relationships. A service bureau. Some kind of a mechanism whereby the University could very efficiently catalogue what’s going on in terms of community engagement and also where communities could approach the University in terms of health related activities.
Funding WPP Projects

Program administrators will face the difficult task of deciding whether funding should be directed toward existing projects or new projects.

Respondents frequently mentioned that the Program today, and what it will be five years from now, is quite different from its origin. One respondent described it as a “different landscape” and that the first five years was working from a “blank canvas.” Thus, it was not uncommon for respondents to question which projects, meaning existing or new, should be funded.

Should existing or new projects receive priority funding?

The issue of whether or not to fund existing projects was often raised. In the minds of some, these projects need sustained funding in order to show results and realize a return on the money already invested.

I think they have to make a decision. What is an investment? Many of the projects are not going to be one-year successes. You have to be able to judge which of those are so important, so central to the mission, that it’s an automatic funding line in the budget…because there are long-term projects that they’ve made considerable investments in that cannot survive without their [continued] investments.

Sustainability is an important component of the community grant programs. But the reality is that there are many worthy programs that have been funded that aren’t at the stage of sustainability after three years. There are those in the community that would love to have the availability of some continued funding for one year, two years or some application process to allow continued funding so we don’t lose progress that’s been made during the initial years just because they’re not up and running by themselves.

These existing projects and past funding decisions, however, effectively limit the Partnership’s capacity to chart a new course.

As we look at the next five-year plan it’s a very different landscape than the first five-year plan, because the first five-year plan really had a blank canvas, in that all the money was there…. We’re now faced with a very different situation in which, at the end of five years, we have many projects from the first piece that still require funding, and which might use all of the available money for the next five years.

To address this issue existing projects should be rigorously reassessed. Are they producing, or likely to produce, results that justify continued funding?

I think we have to carefully assess the impact of our on-going programs, one by one. There is no entitlement here for any of the on-going programs to continue to be funded by MERC. They have to justify it. They have to [show] productivity to this point and potential impact over the next five years. It’s time to produce…. You don’t want to throw good money after bad. Neither do you want to ignore the fact that you’ve already made a substantial investment. So I think you have to start benchmarking those projects in very specific ways to understand, whether they’re going to produce in the way that we envisioned it.
Another respondent suggested that when making granting decisions in the next five years, the single, most important criterion to satisfy is: Is it driving the transformation of the SMPH?

I would test everything that is done in the next five year plan and ask the question of is it a driver?... Is the research plan driving the transformation? Is it doing the things to recruit the faculty to provide funding to have balance in the projects that are funded? If it’s not, it’s not driving the transformation. And then the same question for education: Are the educational programs driving toward an integrated curriculum, toward a strong graduate program in public health? The research part is a challenge because it’s so easy to do the internal academic scholarship, bench clinical research that is comfortable, customary, and well rewarded. And why change?...We need to be honest when evaluating the next five year plan...just be honest and not say that we’re using 100 percent of the money to drive the transformation.

This senior administrator voiced the opinion that past funding decisions will persist and continue to be funded.

I think most of the programs that had been funded over the last five years are going to need some continuing funding. I don’t suspect that any of them are simply going to be dropped cold. There may be some trail off in funding, but I think that most of them are going to require some longer-term funding. It’s inconceivable to me that there will not be that sustained funding for most of these projects.

Still another respondent suggested that funding decisions be made in part by a project’s contributions to the School’s transformation and a “balanced portfolio.”

Probably the most important thing to me is that we build a balanced portfolio. That as we think about how we’re currently spending our money and where we want to renew and where we want to innovate, that we’re supporting the transformation of the School with a portfolio that is balanced in all dimensions, short term to long term. That it’s balanced as far as research, education and community engagement; so that it supports the needs of the School, but it also supports the needs of the community.

Revisit the funding split between MERC and OAC

Some would change the 65/35 percent ratio altogether.

I would fund no research projects at all. [Focus on] awards for community programs that are actually doing public health kinds of things: maternal and fetal health, oral health; similar to what the OAC has gotten, but more money and more diverse. So it hits all 11 of the health areas. So I would definitely...change the ratio of the OAC/MERC funding ratio from 30/70 to 99/1 in favor of the OAC.

Another respondent believed there should be greater integration of OAC and MERC goals.

I think probably one of the most important things that needs to come out of the five-year planning process is that we look at the resources as one pool of money...We’ve created an artificial separation between OAC and MERC...If we really do believe we’re an integrated school, then there shouldn’t need to be one committee for public health and one for education and research...[The WPP should] develop more targeted programs, special initiatives to align with the state in what we think are the biggest health problems in the state...And in those bigger targeted programs, to begin to have more collaboration between OAC and MERC. So if OAC wants to take on...infant mortality...and develop some grants and some partnerships in Milwaukee, Racine and Beloit where the biggest problems are—they would come over here to MERC and then we would hire faculty members within the School in the public health arena that have perinatal problems as their issues.
Some questioned whether OAC-funded community projects are contributing to the School’s transformation.

Giving money away to communities, I’d say it’s a good thing. It’s a great thing. But I don’t think it’s driving the transformation of the medical school…I don’t think we’re using OAC to drive the transformation. I think were using very little of OAC. It’s a tremendous community benefit. It’s a service. The public loves it. They want it all. We gave them a third, they’re happy. It’s not driving the transformation.

Still another recommended that MERC funding be tightly constrained.

The public health community outside the building wonders a lot about the 65/35 percent ratio. The money is broadly defined by the terms of the trust that gave it to the University as all about improving the health of the public. This is gratuitous advice, but if the University is going to hang onto the 65 percent they’d better make sure that the MERC side of the money makes a smart translation to population health outcomes. The favorite researcher getting the favorite new equipment for the favorite lab, when that particular medical thing is only affecting a small number of people in our state…if you had ranked population health issues from one to 100, we’d be number 90, that’s a mistake for [WPP]…And I love the University and I love it enough to criticize it.

One MERC grant reviewer thought the MERC grant applicants should be required to categorize their research as Type 1 or Type 2 translational research. It would “force people to be thinking about what they’re doing and how it relates to the mission of the Wisconsin partnership.” Likewise, because different criteria need to be applied in the proper evaluation of Type I and Type II research, they should be reviewed separately.

When I was on the review panel for [MERC] applications I was very much disappointed by the fact that the people who sat around the table reviewing had different perspectives about a grant. So I would be reviewing a grant and it had good, basic science and it could be moved into the population, but it was going to take five or ten years to do it, but it was really important. That grant would be viewed by others as very low priority because it wasn’t going to get into the community within a reasonably short period of time…[On the other hand] there was a grant which had very superficial science that those of us who have a science background honestly didn’t like. But the other side of the table, which saw it moving into the community thought it was great because it’s going to affect the health of the community right away. To me, that is the most difficult definition for the Partnership to develop.

Collaborate with the Medical College of Wisconsin

Several respondents thought the WPP and the UW–Madison should collaborate more with the Medical College of Wisconsin.

There’s the Medical College of Wisconsin, they have the same pot of money. We were in a meeting the other night with people from Milwaukee, the Center for Urban Population Health, and they’re showing all the stuff they’ve been doing, and I said, ‘Isn’t the College right there? What are they doing and how do you two connect and communicate?’ ‘Well, we don’t really talk to each other,’ they said…Does this make any sense? They’ve got 400 million, we’ve got 400 million, we’re working in the same city and we’re not even talking to each other.
I understand why the governor chose to split it between the two institutions...But I really think there are certain things that could be done better if we had a collaboration between the two. Particularly, we're funding a number of projects for underserved populations, and they're in the middle of underserved populations.

I think we should continue to promote interaction and collaboration whenever possible with the Medical College of Wisconsin, and we should take advantage to the extent possible of UW system campuses that want to work with us. I think it will help us distribute better around the state and working more with UW–Milwaukee would be good for us and for them.

In my view, there should be more ways to leverage the Partnership funds to greater effect. Right now, the benefits of the Partnership money goes mostly back to the UW. But I think that more collaboration between the UW and other organizations could leverage the Partnership funds better, get more out of them. For instance, there are no collaborations between the UW and the Medical College of Wisconsin. That would be a natural collaboration.
Public Health and Workforce Development

The School could help expand the state’s public health workforce through its support of the Master of Public Health Program and by offering distance learning opportunities.

The addition of the Master of Public Health Program was roundly applauded by respondents. Several suggested this program be expanded in ways that would contribute to development of the state’s public health workforce. One way to do this is to offer opportunities for “distance learning.”

Support for the Master of Public Health Program

Respondents saw the program as an effective tool to address the shrinking public health workforce.

We need to develop better distance education pieces, particularly for our MPH program. So, workforce development should be another priority in the next five-year plan. So we’ve started an MPH program, which is great or could become great right out of school. But if we want to train the workforce and if we want our own faculty to really begin to believe in that part of an integrated school of public health, we need to develop training programs that are not for full-time students.

I would like it in writing in the next five-year plan...that the MPH will be delivered at a distance.

Develop a distance MPH, which somebody working out in the field could take, rather than having to be a full-time student.

The “graying of the public health community”

Several respondents addressed the aging of the state’s public health workforce and questioned whether there was sufficient interest to fill the impending vacancies.

We know in the healthcare field that we’re facing some real shortages in some critical areas in both the medical side and also in the public health side. I’m watching the aging of the governmental health side. We call it the graying in the public health community.

We are going to have a whole generation of local public health officers retiring over the next five or ten years, and I’m not so sure we have a sufficient interest to fill those vacancies over time. On the medical side, everyone knows about the nursing shortage and the pharmacist shortage and the med tech shortage.

… maintain, sustain and create a competent public health workforce, particularly with the demographics of the public health workforce in Wisconsin. The average person’s like 55 years old.

This respondent noted the deficiency in Spanish-speaking health care workers.

The biggest problem for our population is simply the lack of qualified physicians and health professionals that speak Spanish.
Under-funded public health in Wisconsin

Related to public health workforce development was the acknowledgement that public health projects, in general, are under-funded. The WPP could do more to draw attention to the situation.

I think something WPP could do is help policymakers understand how under-funded public health in Wisconsin is, and how risky it is to under-fund public health in Wisconsin…The Population Health Institute puts out the county health report cards and now recently put out the state health report card…and I think even more could be done in that regard. We rank pretty low as a state in funding governmental public health, quite low. The UW could help argue for change in that regard.
Publicize the WPP’s Mission and Accomplishments

The Partnership Program needs to publicize its mission and its accomplishments to the public and across the University campus.

A strategic planning effort should include a communication plan. This was duly noted by several respondents that suggested the Partnership Program needs to do more to publicize its mission and its accomplishments. Respondents were speaking not only about informing the public, but also about improving communication within the new School and across University departments.

Promote the Program’s accomplishments

A priority for several respondents was the promotion of the Program’s mission and its accomplishments.

The WPP needs to tell more stories, and there are a lot of good stories to tell, about the accomplishments and the impact that the programs they’ve funded are having.

I think that we need to work on our public persona. I don’t think people know what the Partnership Program is all about. I don’t think faculty know what it’s about… I don’t think other schools or colleges know about it. I think the public has no knowledge of it, nor do they have a deep knowledge of the impact it’s had… Well, I think they need an organized, strategic process of education and publicity, absolutely.

The Comprehensive Cancer Center, to one respondent’s thinking, might serve as a model for the WPP.

The Cancer Center, which has spent years developing, has a real eye for public education and awareness that gets out in front on this issue….

If you asked ten people have you ever heard of the Comprehensive Cancer Center, most of them would say yes… Yet, from the OAC side of it I think we’ve heavily invested in virtually every county in the State of Wisconsin, without exception…. I mean, you look at dots that show where we have created partnerships. Well, I think every one of those partnerships needs to have an element of publicity associated with it so the communities know what the heck’s going on.

Faculty, department chairs and the Dean should all take responsibility for communicating the Program’s goals and accomplishments.

A big thing is communicating better to faculty about the transformation and what it means, what will happen, what will it look like when it’s more developed. And it has to be multi-modal. Faculty have to hear it from their department chairs, from the Dean, from their colleagues. It has to be repeated again and again in all kinds of ways, and the Partnership has to find ways to keep pushing the communication part of it ahead.
Take advantage of professional conferences

One respondent suggested that the WPP use prominent health care professional conferences to publicize its mission and accomplishments.

They can utilize the conferences that various groups run like Wisconsin Hospital Association or like the Wisconsin Public Health Association, the Wisconsin Nurses Association, the Wisconsin Association of Local Health Departments and Boards and various groups that have statewide events where they bring together their membership from across the state, all of whom are working to improve community health. They should utilize those venues to showcase some of the grants that they funded and to disseminate better knowledge of the opportunity to apply, and to really demonstrate the impact they’re having through those programs...There’s a number of different groups that have venues that they could use to either distribute something in writing or, better yet, perhaps do some exhibits, showcasing, and maybe some poster sessions.

And whatever the vehicle, the WPP could stand to adopt a sound-byte approach to publicizing its accomplishments.

I would encourage them to be more vigilant in their on-going communication. They should say, ‘These are things we have done. These are the results we have achieved. These are the things that are better in Wisconsin because of what we have done. If you have suggestions or concerns this is how you can contact us.’ The things that I think might help are things that are shorter. Long, annual reports are easy to not pay attention to. But a short piece, maybe the model should be USA Today, which certainly communicates short concepts frequently. I’ve seen too many organizations that are concerned about making sure you get the whole picture and it’s almost like the complete gets in the way of the good. I would encourage them to think about short hitting, ‘These are four things that we did this last month.’