

Strong Rural Communities Initiative (SRCI) Program: Challenges in Promoting Healthier Lifestyles

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ABSTRACT

Background: The Strong Rural Communities Initiative (SRCI) was created to address the health needs of rural Wisconsin communities through a multifaceted partnership that included the Medical College of Wisconsin (MCW), University of Wisconsin School of Medicine and Public Health (UWSPH), the Rural Health Development Council (RHDC), and hospitals, public health departments, and businesses in 6 rural communities in Wisconsin. The SRCI provided a broad framework of leadership to assist each of the 6 rural communities in developing and implementing new, collaborative interventions that addressed the specific health needs of the community.

Methods: Separate assessments were conducted for the communities that partnered with each respective medical school and focused on the processes of community collaboration and partnership function. Assessment approaches included formative and outcome evaluation.

Results: Each community independently reported positive outcomes associated with the partnership process and various aspects of community collaboration, including the successes and health impacts of the workplace wellness programs implemented. Assessment data also revealed challenges related to conducting effective community-academic partnerships.

Conclusions: The SRCI was established to execute statewide programs in rural communities with the goal to improve the health of people living in those communities. We have gained applicable knowledge regarding the types of challenges that exist in establishing a rural-based community research network between academic partners and community leaders.

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BACKGROUND

The Strong Rural Communities Initiative (SRCI) was established in 2004 to improve health for rural Wisconsin communities and to significantly accelerate the establishment of collaborations to champion disease prevention. The SRCI evolved from collaborative visions of 3 major organizations in Wisconsin: the Rural Health Development Council (RHDC), the Medical College of Wisconsin (MCW), and the University of Wisconsin School of Medicine and Public Health (UWSPH). Discussion among these 3 initial partners resulted in the conception of collaborative preventive health ventures, implemented through worksites, as a way to improve the health of community members and to reduce health care costs of businesses, thereby encouraging businesses to expand, remain in, or relocate to

rural communities and thus improve their economic health. This model was consistent with the recommendation of the Institute of Medicine report *Quality through Collaboration: The Future of Rural Health Care*, which suggested that rural communities must reorient their strategies from a “patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations.”¹ The SRCI model also addressed concerns about urban-rural disparities in health outcomes as reported in *Wisconsin County Health Rankings 2004* and *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* and was consistent with RHDC’s emphasis on the link between rural health and community and economic development.^{2,3}

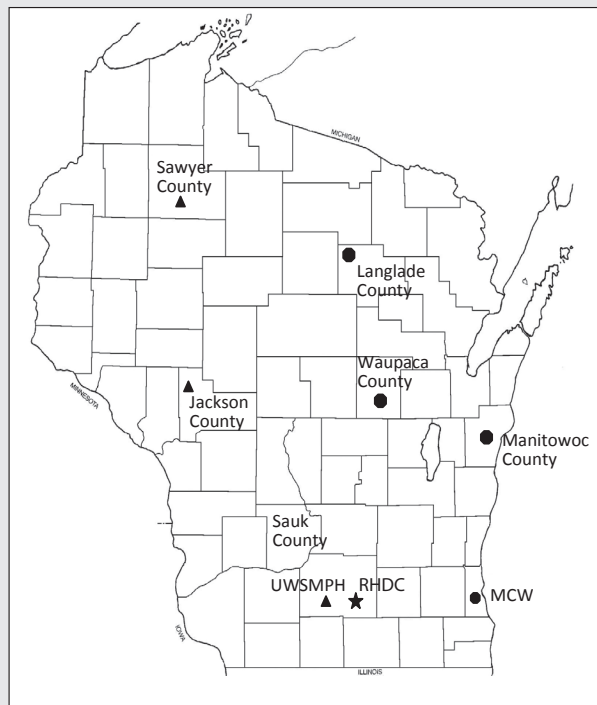


Figure 1. Map of community and academic partners in Wisconsin.

Abbreviations: MCW=Medical College of Wisconsin; UWSMPH=University of Wisconsin Madison School of Medicine and Public Health; RHDC=Rural Health Development Council.

RHDC and SRCI Program Descriptions

The RHDC brought together 2 academic partners, UWSMPH and MCW, to discuss a process that would provide funding for rural communities to initiate programs geared toward improved health outcomes. Blue Cross/Blue Shield of Wisconsin endowments were a particular funding source located at each of the state's 2 medical schools. Funds were allocated through the Healthier Wisconsin Partnership Program (HWPP) at MCW and the Wisconsin Partnership Fund for a Healthy Future (WPF) at UWSMPH.^{4,5} In late 2004, the RHDC formed a work group, comprised of RHDC volunteer members as well as other stakeholders in the statewide rural health community, to develop a proposal for the RHDC to submit to each of the medical school's funding sources.

The RHDC issued a statewide call for local community projects in 2005. The request for proposals stated "[t]he goal of the initiative is for rural communities to improve their health indicators and health status through the development of ongoing, local interventions by coalitions that include: (1) the local hospital and representatives of the medical community, (2) the county health department, and (3) representatives of other non-health-related local businesses." The RHDC work group

selected 6 communities from the 22 proposals received. Based on past working relationships and geography, it was decided that the UWSMPH would serve as the academic partner to local community projects in Jackson, Sauk, and Sawyer counties, and MCW would operate as the academic partner for Langlade, Manitowoc, and Waupaca counties. Figure 1 displays the geographical location of all partners.

In the spring of 2006, a 3-year implementation grant from HWPP was awarded to support the programs at the MCW sites. The Wisconsin Office of Rural Health (WORH) contributed funding through its Rural Hospital Flexibility Grant funds to support the programs at the UWSMPH sites for the first year, and WPF funding was awarded for the final 2 years.

Representatives of each of the 6 communities, 2 academic institutions, and the Rural Health Development Council (RHDC) created the SRCI Advisory Committee. Figure 2 illustrates the partnership framework for the SRCI Advisory Committee. Its function was to manage and direct the vision of the SRCI. The committee met bimonthly to share work in progress and provide strategic support and resources to each of the members.

Community Partners

The 6 rural community partners were given flexibility to develop and implement programs that would be of greatest benefit to their community. Table 1 provides an overview of all community programs.

METHODS

Program Assessment

The SRCI assessment focused on the process of collaboration and the perceptions of partnership functions from the perspective of participants in the collaborations. The SRCI assessment did not evaluate the impact on individual health outcomes. Some community programs did track outcomes of those participating in their interventions, but these were not standardized across all sites and therefore not evaluated by the SRCI. We deferred instead to the large body of literature documenting the known benefits of the types of health and lifestyle changes promoted by the SRCI partnerships.⁶⁻⁹ We also did not seek to address any impact of the SRCI programs on health experiences and related health insurance costs for the participating worksites. Those impacts take time to be observed and should be measured in the future.¹⁰

In keeping with the SRCI structure, separate assessments were conducted for the communities that partnered with the UWSMPH and those that partnered with the MCW. Assessment approaches were developed by the academic partners in conjunction with their respective community partners. Differences in timing of the 2 groups of projects meant that the UWSMPH

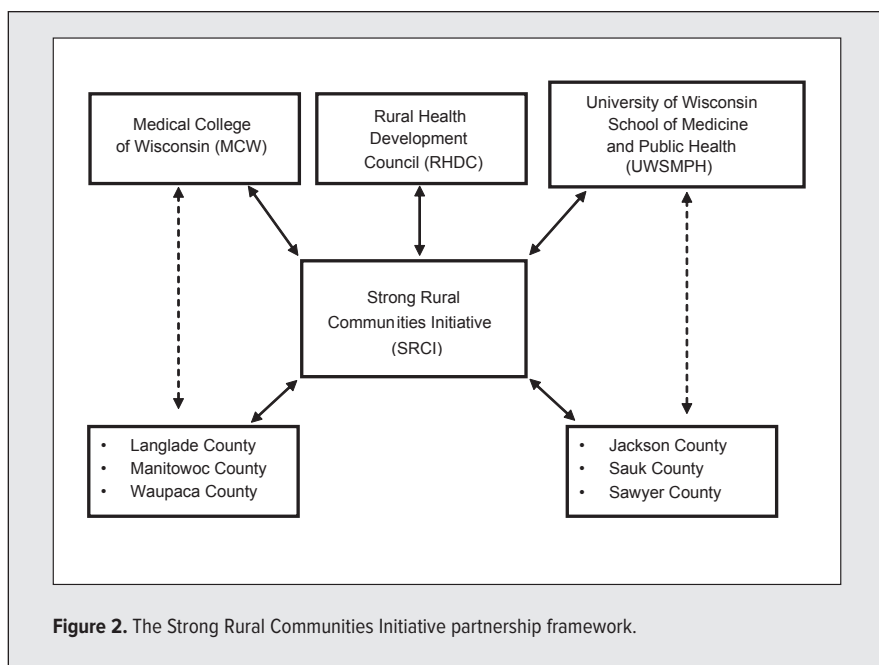
assessment was designed and conducted earlier than the MCW evaluation. This provided MCW with the opportunity to build on the UWSMPH approach and to modify that approach to reflect the needs of its community partners.

UW School of Medicine and Public Health

The assessment approach was developed as a collaborative effort of the UWSMPH, its evaluator, the Center for Health Systems Research and Analysis (CHSRA), and the 3 counties represented by UWSMPH. A formative evaluation addressed the processes, challenges, and successes experienced in developing the collaborative approach. The formative assessment was conducted using in-depth interviews with key informants in each community. Questions addressed understanding of the structure and design of the SRCI program, ways that organizations benefited from participation in the program, benefits of the program to the community, challenges encountered, and lessons learned. A total of 11 interviews were conducted. We gained additional information from participant observation at coalition meetings, including routine meetings of the SRCI Advisory Committee, meetings of individual community collaboratives, and a meeting of leaders of the 3 communities' collaborative where they shared successes, struggles, and strategies.

An outcomes evaluation was designed to reflect the collaborative nature of the project. We designed a tool that included measures that addressed impact on each of the partnering organizations—hospitals, public health departments, businesses, and the broader community—as well as the collaborative as a whole. These outcome measures were developed initially through a meeting of the 3 communities, in which appreciative inquiry was used to identify common outcomes of interest and to highlight the unique perspectives of the different partner organizations.¹¹ Additional outcomes were identified through literature review, and an outcome measurement tool was developed. A final set of 83 outcome measures, each rated for importance and for achievement, was adopted based on community partners' review of the draft tool. The outcomes tool was designed to highlight differences in perspective of the various community partners—hospitals, departments of public health, worksites, and the general public.

Data for the outcome measures was collected by a written survey in which individuals rated (a) the importance of each outcome measure to the community's health improvement pro-



gram, and (b) how well the community's program succeeded in achieving each outcome. Written surveys were mailed to key informants, using criteria provided by the evaluator. A total of 43 surveys were distributed; 29 surveys were returned. This study was reviewed and approved by the UWSMPH Institutional Review Board (IRB).

Medical College of Wisconsin

This assessment, done by MCW's Center for Healthy Communities (CHC) and the 3 counties represented by MCW, focused on various aspects of collaboration and particularly on the congruence between *importance* and *achievement* of the outcomes of collaboration. By drawing from these comparisons, we could identify areas of success (achievement levels $\geq$ importance) and areas in need of improvement (achievement levels $<$ the level of importance).

The MCW faculty began with the outcome tool developed by CHSRA and modified it to reflect the nature of its partnerships with the 3 rural counties and allow for specific statistical analyses but did not change the nature or content of the survey questions.

Forty-five surveys were sent to the rural community partners in August 2007 with the instruction that stakeholders and participants involved in local SRCI health coalitions complete the survey. The stakeholders included managers from businesses implementing an SRCI-supported worksite wellness program, hospital executives, public health workers, and other members of the health coalition leadership. Twenty-eight completed surveys were returned to the MCW for analysis.

Data were analyzed using the nonparametric Wilcoxon

Community Partner	Population of County	Number of Organizations/ Hospitals Represented	Number of Participating Businesses	Number of Programs	Program Focus
Langlade County	20,165	18	8	3	Development of worksite wellness committees, smoke-free policies implemented at workplaces, improved Health Risk Assessment (HRA) scores, weight loss challenges
Waupaca County	54,157	1	28	3	Development of worksite wellness committees, walking programs, exercise classes, healthier vending machine choices, “lunch and learn” sessions
Manitowoc County	80,641	4	18	18	Development of worksite wellness committees, improved HRA scores, smoking cessation programs, weight management programs, development of community walking trail
Jackson County	19,500	12	7	7	Development of worksite wellness committees, healthier vending machine choices, “lunch and learn” sessions, team challenges, improved health assessments, weight loss, and promote preventive care
Sauk County	55,225	8	3	13	Improved HRA scores, exercise classes/fitness memberships, nutrition counseling and classes
Sawyer County	17,117	3	6	2	Increased activity levels, increased weight loss, smoke-free policies implemented at worksites

Signed Ranks test.¹² For analytical purposes and based on results of early analyses, responses of 5 or 4 on the 5-point Likert scale were combined into 1 response category. We performed 3 separate comparisons: Achievement < Importance, Achievement > Importance, and Achievement = Importance, to identify areas of success and those in need of improvement. This study was reviewed and approved by the MCW IRB.

RESULTS

UW School of Medicine and Public Health

Each of the 3 communities based its program on an existing program of the hospital. The specific design of each program was driven in part by the contractual requirement that the program include a collaborative effort of hospitals, public health departments, and local businesses. Within these constraints, there was variation in the breadth of community representation. They also varied in the length of the health education programs offered (6 weeks to unlimited), the program location (worksite or hospital), methods of motivating individuals (competitions, incentives, group support, and accountability), and program content (information and exercise in varying combinations). Without exception, informants agreed that a combination of education and activity worked best.

Qualitative information from the interviews and participant observation revealed several common challenges. Development and implementation of the SRCI programs were more costly than anticipated. The biggest challenge was having adequate staff time to manage the project. Costs related to incentives for individual participation and repeated health risk assessments (HRAs) also were greater than expected.

Leadership was key, both for the collaborative efforts and at each worksite. Buy-in and commitment from others also was essential. Turnover in key collaborative members resulted in program discontinuities and disrupted trust relationships that had been developed over time.

Scheduling was another common challenge. In most cases, program activities took place at the worksite, usually during work hours. This presented practical challenges related to the need for participants to complete routine work activities, conflicts with other work demands, and the need for coworkers to cover for participants while they were engaged in the program.

Various approaches were used to encourage individuals to participate and remain motivated. Rewards and competitions were used to encourage participants to set and strive for personal goals. One community agreed with the importance of motivation, but expressed belief that motivation comes from within and not by external reward.

Trust was an important theme, both among members of the working collaborations and between trainers and program participants. Trust was a particular issue when trying to engage members of local minority (Native American and Hispanic) communities. This was achieved most readily when there were established personal relationships to build on and was disrupted when individuals left the community.

Collaborative members reported improved communication among the participating organizations. The effect on the business climate in the communities was unclear. Several of the participating worksites (schools, police department, county government) would be unlikely to leave the community in any case. Some of the effects that would attract businesses

Table 2. Importance and Achievement of Select Measures: University of Wisconsin School of Medicine and Public Health Partners

Leadership, Vision and Direction		
	Importance	Achievement
Leadership includes high-level, visible leaders	4.36 (4.18–4.71)	4.59 (4.45–4.71)
Leadership is open to perspectives, viewpoints, and suggestions of all participants	4.83 (4.73–5.00)	4.54 (4.36–4.70)
Partners agree on the goals of the collaborative	4.66 (4.57–4.73)	4.37 (4.33–4.43)
The collaborative has identified ways to measure progress	4.59 ^a (4.36–4.86)	4.00 (4.00–4.00)
Hospital leaders are committed to the SRCI program	4.89 (4.82–5.00)	4.72 (4.63–5.00)
Public health leaders are committed to the SRCI program	4.88 ^b (4.70–5.00)	4.28 ^c (3.89–5.00)
Leaders of participating businesses are committed to the SRCI program	4.72 (4.73–4.86)	4.08 ^b (3.33–4.33)
Resources		
	Importance	Achievement
The collaborative has adequate resources to achieve its goals	4.66 (4.64–4.71)	4.11 ^a (3.80–4.45)
The collaborative has the resources to continue when the grant funding ends	4.68 (4.50–4.86)	3.13 (3.00–3.25)
The collaborative has an effective strategy for generating resources needed to be self-supporting	4.73 (4.56–4.86)	3.29 (3.00–3.44)
Trust and Collaboration		
	Importance	Achievement
There is a high level of trust among partners	4.72 (4.71–4.73)	4.39 (4.14–4.55)
There is clear and open communication among partners	4.79 (4.77–4.82)	4.46 ^a (4.30–4.86)
Membership reflects the diversity of the community's population and organization	4.59 (4.45–4.73)	4.04 (3.70–4.29)
New members are actively recruited	4.04 (3.71–4.20)	3.64 (3.38–3.90)
There is a process for integrating new members into the group	4.22 (4.14–4.27)	3.81 (3.75–3.82)
Partners are committed to making the collaborative an on-going effort	4.69 (4.64–4.86)	3.88 (3.67–4.00)
Results		
	Importance	Achievement
The targeted issues improve as direct result of the collaborative	4.79 ^a (4.64–5.00)	4.37 ^b (4.13–4.83)
Partners feel pride in what the collaborative is achieving	4.75 (4.60–4.86)	4.41 ^c (3.89–4.71)
The collaborative is accomplishing more than the partners could accomplish individually	4.82 (4.73–4.90)	4.60 ^b (4.00–4.90)
Other businesses/worksites have asked to join the collaborative	4.60 (4.44–4.78)	3.86 ^a (3.44–4.43)
The community is more attractive to businesses as a result of the collaborative	4.04 (3.67–4.50)	3.83 (3.25–4.50)
The SRCI program improves the health of participants	4.83 (4.73–5.00)	4.33 ^c (4.11–4.86)
Employees at participating businesses are participating in the SRCI program	4.64 (4.55–4.80)	3.88 ^a (3.43–4.17)

Note: The range shows the minimum and maximum average values found among the 3 communities. Significant differences between communities were tested using F tests. Because of the small sample sizes, we highlight differences significant at $P < .20$ or less.

^a $P < .20$

^b $P < .10$

^c $P < .05$

(eg, reduced health care costs) will take time to be observed. Nonetheless, surveys completed by members of businesses/worksites reported very positive results, including increased productivity.

The survey data supported these findings and identified other issues. Given the number of outcomes measured, we show data only on select measures. (Complete data are available from the Dr Karon, the UWSMPH evaluator, upon request). The mean values of outcomes, rated both for importance and achievement, are shown in Table 2, with significant differences by community noted. Nearly all measures were rated with high levels of importance by individuals in all communities. Differences by communities were found in the importance of

having ways to measure progress and the ability to identify improvements as a direct result of the collaborative.

Measures of achievement generally were not rated as highly, although most of them also had mean values of 4.00 (on a 5-point scale) or greater. Significant differences among the communities were reported with regard to the commitment of public health and business leaders. The adequacy of resources to achieve goals and continue after grant funding generally had low rates of achievement. There were significant differences among communities in the ability to achieve their goals with current funding. All 3 of the communities reported similarly low rates of achievement related to future funding.

Measures of trust and collaboration found relatively high

rates of achievement of trust among existing partners, but low rates of achievement related to the recruitment and integration of new members into the collaborative.

Rates of achievement of several measures of results were generally high, with lower rates of achievement found in results related to participating businesses than in those related to the collaborative as a whole. Significant differences by community were found in the achievement of many of these measures of results.

Medical College of Wisconsin

In all cases where statistically significant differences were found, participants rated the importance of a specific partnership characteristic higher than their current partnership's level of achievement of that characteristic. Table 3 shows which areas of the local collaboration were in need of improved functioning (high importance, low achievement). Those areas of collaboration that needed improvement included clear, honest, and open communication; timeliness of task completion; inclusion of high-level, visible leaders; accumulation of adequate resources; measurement and achievement of long-term goals; shared decision-making; active recruitment of new, diverse members; increase policy change efforts; increase pride, awareness, and publicity of SRCI programs; increase attractiveness of community through health programs; and inclusion of participants' families in health programs.

Table 4 shows collaborative outcomes that participants felt were both important and achieved by their local partnership. These areas of strength included trust among partners; active participation among partners and acceptance of other's perspectives; clear mission and goals for the partnership; established roles for each partner; achievement of short-term goals; using outcomes to develop future efforts; sense of collaborative accomplishment; creation of new relationships; and feeling that worksite wellness programs improve health.

DISCUSSION

This is an innovative program bringing together 2 of the largest academic institutions in Wisconsin. The design of our program identified barriers to implementation of the program.

Statewide Obstacles to Implementation

The logistics of coordinating efforts between the RHDC, MCW, UWSMPH, and 6 rural communities posed several challenges to the partnership. Considering the large geographical distance between partners, simply getting meetings arranged proved to be challenging. This obstacle was resolved by a collective commitment to attend bimonthly conference calls and a yearly face-to-face meeting. Additionally, differences in the research timetable of the 2 academic institutions (and therefore the community partners) created a discrepancy in analyz-

ing and evaluating complementary phases of the project. Yet, despite differences in programmatic deadlines, the RHDC was able to serve as an intermediary between academic partners and community partners through the sharing, reporting, and dissemination of program information and results.

Another challenge was evident in the understanding and navigation of the IRB. There were systematic differences in IRB procedure between MCW and UWSMPH. Also, considering the relative novelty of community-based programs at each institution, initially there was an inherent lack of understanding on how to review community-based research. This project was the first IRB experience for many of the local community partners, and many of them encountered barriers in understanding IRB protocols. To combat this, academic partners met with IRB personnel on several occasions and resolved many issues. The community partners also were required to complete the IRB's Collaborative Institutional Training Initiative course, a web-based course for conducting human subject research, and expressed mixed feelings about the need for this process. Over time, the IRB process has become more responsive to community-based participatory research (CBPR) proposals.

Local Obstacles to Implementation

Several common challenges emerged among the 6 community partners. The rural sites varied in their histories of collaboration among the local partners, approaches to implementing the programs at the business sites, and resources available.

One overarching challenge exhibited by all 6 local community partners was overcoming scheduling conflicts. The wellness committees at sites experienced difficulties with establishing regular meeting attendance guidelines for committee members. On a smaller scale, it was also difficult to work around the various schedules of the participants. Many participants did not want to attend program-related sessions that were offered during off-work hours. Many of SRCI's community partners were able to overcome this barrier by offering wellness sessions during the workday.

Another local-level challenge centered on a lack of readiness to make healthy lifestyle behavior changes. Particularly, Jackson County and Sauk County noted that a major challenge with the project's objective to improve health status was the lack of control over an individual's lifestyle habits. Encouragement to make improvements to current lifestyle habits can be difficult to influence depending on the participant's current level of motivation to change behaviors. A select few participants reverted to habits (ie, started smoking or ignored moderation over the holidays) or were not willing to be "present" or follow the program, which affected their own results and potentially skewed the overall results.

Staff turnover within the project team and within partici-

Table 3. Importance to Partnership > Current Achievement of Partnership: Medical College of Wisconsin Partners

	Importance > Achievement
Members feel comfortable being open and honest	$P < .05$
Tasks are completed on schedule	$P < .05$
Leadership includes high-level, visible leaders	$P < .05$
Your local partnership has adequate resources (people, funds, other resources) to achieve its goals	$P < .01$
Your local partnership has identified ways to measure progress	$P < .05$
Your local partnership is achieving its long-term goals	$P < .05$
There is clear and open communication among partners	$P < .05$
Partners share decision-making responsibility	$P < .05$
Membership in your local partnership reflects the diversity of the community's population and organizations	$P < .01$
New members are actively recruited	$P < .05$
Your local partnership has a way to measure progress in achieving its desired outcomes	$P < .05$
Your local partnership has the resources necessary to continue when the current grant funding ends	$P < .001$
Your local partnership has an effective strategy for generating the resources needed to be self-supporting	$P < .001$
Partners are committed to making your local partnership an ongoing effort	$P < .05$
Outcomes of the project are being measured	$P < .05$
The targeted issues improve as a direct result of the your local partnership	$P < .05$
Other issues improve indirectly as a result of your local partnership	$P < .05$
Your local partnership has evidence of affecting public policy	$P < .05$
Outcomes of the project demonstrate the value of continuing your local partnership	$P < .05$
Partners feel pride in what your local partnership is accomplishing	$P < .05$
The public is aware of your local partnership	$P < .05$
Other businesses or worksites have asked to join the your local partnership	$P < .05$
Your local partnership is involved in promotional activities	$P < .05$
The community is more attractive to businesses as a result of your local partnership	$P < .01$
There is an increased awareness of fitness, nutrition, and other healthy lifestyle issues in the community	$P < .05$
There are new community programs focused on healthy lifestyle choices	$P < .05$
There is a sense of community pride in the Strong Rural Community Initiative program	$P < .01$
The community promotes itself as being a healthy place to live	$P < .01$
There are local policy changes to support healthy lifestyles	$P < .01$
The program improves the health of participants' families	$P < .05$

Table 4. Importance to Partnership = Current Achievement of Partnership: Medical College of Wisconsin Partners

	Importance = Achievement
The partners all have something to gain from a successful collaboration	NS
There is a high level of trust among partners	NS
Partners actively participate in meetings and provide input during discussions	NS
Leadership is open to perspectives, viewpoints, and suggestions of all participants	NS
Your local partnership has a clear mission statement	NS
Partners agree on the goals of your local partnership	NS
Your local partnership has clear goals, plans, and measures of success that provide a sense of accomplishment among partners	NS
Your local partnership is achieving its short-term goals	NS
Your local partnership includes representatives from local health care organizations, businesses, government, and residents	NS
There is a process for integrating new members into the group, giving them information about how your partnership functions and its history, and actively involving them	NS
Roles and responsibilities among partner organizations and individuals are clearly defined	NS
Your local partnership has an effective governance structure	NS
Learning generated from projects and processes can be used to enhance future efforts	NS
Partnering organizations change the way they operate as a result of this collaborative	NS
Your local partnership is accomplishing more than the partners could accomplish individually	NS
New relationships have been created among the partners	NS
Businesses involved in the your local partnership remain in the community	NS
The program improves the health of participants	NS

(NS = not statistically significant)

pating businesses also was a barrier to success for several community partners (Manitowoc County, Jackson County, Sawyer County). Turnover within participating businesses often led to decision changes regarding participation in projects, where under previous management the business had been enthusiastic about participating in SRCI-initiated programs.

Other common challenges at a local level manifested with differences in components and completion rates of HRAs, overall promotion of the project, and recognizing the “full cost” and time commitment of implementing their programs, which presented unanticipated financial restrictions.

CONCLUSION

Despite the above-mentioned challenges, the SRCI was able to bring together 2 medical schools in Wisconsin and 6 communities with 43 businesses and health partners to address health at the workplace. The collaboration created an environment of possibilities that previously did not exist, since each of the 2 medical schools did not have any significant prior history of forming this type of partnership.

The key elements of this successful collaboration included outstanding leadership, group enthusiasm and involvement; shared goals and objectives; and continuous bidirectional dialogue among community and academic partners. The SRCI agenda will be carried forward in the ongoing work of the RHDC, the WORH, and the Rural Wisconsin Health Cooperative. Participating communities also will maintain a link in the SRCI’s progress. It is our hope that the SRCI can serve as a framework for executing statewide community-academic programs that partner with the business sector.

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The Emeritus Clinical-Researcher Program

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ABSTRACT

Background: For some physicians, retirement means leaving their practice and severing ties with their institution, while others may wish to maintain a more active role within their institution. Many institutions have designed programs that enable these individuals to maintain an academic relationship and provide services to their institution.

Objectives: This manuscript provides a brief experience of the Marshfield Clinic (MC) and Marshfield Clinic Research Foundation (MCRF) recent development of an emeritus program for research and education.

Results: The program is designed to provide opportunities for physicians, clinical PhDs, dentists, and other clinicians with terminal degrees and the necessary qualifications as researchers, to continue to contribute to the MC/MCRF research mission after retirement from clinical practice. Assignment to various aspects of the program is determined by the individual's expertise, experience and institutional needs. Expectations and performance of each individual is evaluated. The infrastructure of the program was assembled by reviewing institutes that have had an emeritus program in operation and integrating the unique aspect of MC/MCRF resources.

Conclusion: Alignment of the unique skills, expertise, knowledge, and wealth of experience of emeritus faculty along institutional needs has provided added value to the institution without major financial investment.

INTRODUCTION

For some physicians, retirement means leaving practice and severing ties with their institution. However, others may have interest in maintaining a more active role within their institution by continuing to contribute intellectually. As a result, many institutions have recognized the expertise and talents

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of those nearing retirement and have designed programs that enable these individuals to maintain an academic relationship and provide beneficial services to their institution (eg, research, education, manuscript writing and editing, and mentoring).

We present herein the structure and design of our Emeritus Clinical-Researcher (ECR) Program at Marshfield Clinic Research Foundation (MCRF). The Marshfield Clinic (MC) health care system consists of over 750 physicians in 42 regional centers throughout Wisconsin, nearly 400 of whom are located at the main campus in Marshfield. MCRF is a division of MC and consists of over 200 senior, associate, and assistant scientists involved in various aspects of research. The concept of the ECR Program was 1 of 10 initiatives conceived during MC's mission

review. The review was intended to assess the state of clinician-led research and make recommendations to MC leadership on how to accomplish the goals and initiatives articulated in the MC/MCRF strategic plan. The ECR initiative was established to use the talents of distinguished physicians, PhDs, dentists, and other professionals with terminal degrees and the necessary research qualifications to continue to contribute to MC/MCRF's research mission after retirement from clinical practice.

The term "emeritus" is used to recognize retired physicians or scientists for their academic or scientific excellence and past contributions, or as an academic staff appointment title bestowed by the individual's department. Rather than sever ties with the institution, leaving the retiree "legally and academically dead,"¹ an alternate vision elucidated over 20 years ago has emerged, establishing the emeritus status as a distinguished active professional within the institution.² Currently, it is com-

mon for retiring faculty to seek emeritus status through their department to continue teaching and/or facilitate continuation of their research.

A number of universities provide support for individuals who are interested in continuing research and educational endeavors after retirement. The nature of support for emeritus faculty varies among institutions, but there are common elements. Generally, the needs of full-time faculty are favored over emeritus faculty (ie, full-time faculty are given preference in the selection of office and laboratory space and in the distribution of internal funding).³ Moreover, emeritus faculty are encouraged to seek external sources of funding for their research, and those who continue to bring in grants are treated more favorably than those who do not.^{4,5} In a deviation from this trend, the University of Southern California has established an Emeriti Research Grant program that includes an option for additional funding for undergraduate research assistants.⁶

Benefits and compensation for emeritus faculty vary across institutions. Approximately 20% of doctoral institutions provide stipends to cover travel expenses for professional activities.⁵ Appointment to emeritus status at some institutions includes provision of financial and other support to promote meaningful contributions to their respective disciplines. At Texas Tech University,⁷ emeritus faculty generally are not compensated, and the title is considered honorary. However, there are policies that allow retired faculty to receive a salary for part-time teaching.⁸ In this case, compensation is limited to between a third and a half of their most recent salary while working no more than half of full-time faculty. Many institutions also provide continuation of health benefits through their emeritus programs. Yet, while 80% of institutions in the United States allow emeritus faculty to remain eligible for health insurance through the group plans, only 58% cover the cost of the premium.⁵

Institutions manage emeritus faculty and ensure efficient resource utilization by 2 methods. The first is to make appointments for a limited period that can be renewed only at the discretion of the institution.^{4,5} In this model, the appointment to professor emeritus is for life, although use of university resources and space is delimited (eg, 3 to 5 years). Renewal is rare (approximately 7%) and is contingent on sustainment of external support by the emeritus faculty member. These programs are viewed by institutions as affiliation agreements whereby the emeritus faculty member can continue to conduct his/her research in the name of the institution but must bring in external funding to support the research. A second method is to have an indefinite appointment, subject to regular institutional review. At the University of Missouri,^{9,10} these reviews

occur on an annual basis and involve submitting a summary of activities in the areas of teaching, clinical practice, education, and research. This summary addresses only activities since the appointment or the last review, and a committee of peers evaluates these activities and provides recommendations to their respective dean and committee. The dean and review committee then determine whether the candidate's performance has been satisfactory. If performance has been unsatisfactory, a plan for improvement is implemented. If the plan fails, the appointment can then be terminated.

SELECTION OF RESEARCHER EMERITUS

Most institutions allow retiring faculty to seek emeritus status through their respective department to continue their academic and research activities. The process for obtaining an emeritus title generally involves a recommendation from the department chair and the department executive committee. At some institutions, the chancellor reviews and makes a recommendation to the board of regents,⁷ while at others the chancellor can directly confer the title.¹¹

At Oregon State University,¹² the process of clinical faculty promotion involves an examination of the candidate's performance in 4 areas. The candidate must demonstrate distinction in the areas of teaching, clinical practice, and research, as well as have a demonstrated history of service to the institution, the public, and the profession. A committee from the candidate's department prepares an evaluation of the candidate's activities. Recommendations from the candidate's peers outside the university also are solicited from those suggested by the candidate. Others are solicited by a committee of peers in the department. Based on the internal and external recommendations, the Promotion Committee and dean of the college finalize their recommendation. The provost and executive vice president then make the final decision.

The tenure selection process at Duke University Medical School¹³ involves a set of minimum criteria that must be met to qualify for a promotion, such as teaching activities and invitations to speak at national meetings, seminars, and workshops. There also is an expectation of leadership in department-level programs, as well as participation in medical student, house staff, and/or graduate student curricula. The candidate is expected to have a strong reputation regionally and/or nationally for his/her accomplishments. Participation on national boards or inclusion on national panels provides evidence of the candidate's reputation for excellence. The candidate is generally expected to have established a record of sustained funding through peer-reviewed grants and participation in clinical trials as the team leader. Bench researchers are expected to have established a national reputation through

participation in National Institutes of Health study sections or offices in professional societies. The candidate also is expected to have a minimum number of peer-reviewed publications, varying between 25 and 50 publications, with the expectation of being first or senior author on at least 40%.

MCRF'S EMERITUS CLINICAL RESEARCHER PROGRAM DESCRIPTION

The ECR Program described herein was conceptualized with aspects that add value to institutional needs. The organizing principle for the ECR Program is that it fills a purposeful need within MC/MCRF. The program should be viewed primarily as an opportunity for service—to give something back to the institution. In developing this program, we incorporated principles used at other institutions as well as in our current policies. Our system was created with requirements for contributions relative to clinical care, research, and education.

Selection

Potential candidates are selected based on a detailed description of their prior educational and research activities in each of the 4 areas listed under qualifications, their curriculum vitae, and current and pending funding support. Minimal qualifications in 1 area may be waived if the candidate is considered exceptional in other areas, especially where there is a recognized institutional need.

Qualifications

The following list of qualifications was drafted based on requirements used by institutions that have established a similar emeritus program.^{9,10,12,13}

Education. Teaching activities for an ECR might include invited lectures at national meetings, seminars, and workshops. Evidence of leadership in departmental programs and participation in medical student, house staff, and/or graduate student curricula planning and presentation are required.

Clinical Practice. ECRs are expected to be recognized regionally and/or nationally for their expertise. Participation on national board examinations or involvement in designing practice guidelines provides additional evidence of clinical excellence. Inclusion on national or international committees and membership on editorial boards of medical publications along with other markers of clinical excellence are expected.

Research. A research track record for the ECRs is essential because sustaining research is a specific goal of this program. Participation in educational programs and national or international recognition as a researcher are deemed desirable qualities. The candidate is expected to have an established record of consistent receipt of extramural funding and involvement in clinical research over his/her career and must have served

as team leader on 30% of trials. The candidate also must have demonstrated experience in designing trials and data analysis. Individuals are expected to review manuscripts and grant applications, research foci and priorities, and mentor young investigators in research and educational initiatives. Additionally, the ECRs will provide expertise in evaluation of key policy issues and administrative decisions.

Service. Demonstration of professional service may be at the local, regional, or national level, or within the community at large. Service also may occur within a clinical department or at a regional center.

Application and Selection Process

A candidate for this program submits a letter to the center director to whom the emeritus research candidate reports, outlining his/her desire for continued service in research and education, the proposed areas of continued research, and any specific responsibilities that he/she desires to undertake during an initial term. The candidate also should submit a curriculum vitae and other documents that show achievement in research, education, clinical practice, and service to MC/MCRF and the general public. The center director reviews and makes recommendations to the directors of medical research and education, who make the final decision regarding the candidate's appointment.

Responsibilities

The specific duties of an individual in this program, as well as measurable objectives for the period of appointment, are documented in a memorandum of understanding. This document is signed by the ECR, the Director of Medical Research, and the director of the center to which he/she is assigned. The range of responsibilities for this position is broad and may include the following:

- Conduct medical research as a principal investigator or co-investigator.
- Provide advice and consultation in his/her area of expertise to active research teams.
- Complete analysis of results from projects not finished before leaving clinical practice.
- Assist MC/MCRF scientists and clinicians in protocol development, review of grant proposals, publications, and other forms of scientific writing.
- Participate on the editorial board or serve as a reviewer for nationally and internationally indexed journals published at Marshfield Clinic: *Clinical Medicine and Research* and *Journal of Agromedicine*.
- In concurrence with the Director of Clinical Research, mentor new investigators in clinical research.
- Serve on standing or special institutional committees.

Term of Appointment

Appointment is for 12 months and may be renewed. A written performance evaluation is reviewed at the end of each term by the center director and by the Director of Medical Research, who is the appointing authority and makes a decision on the appointment in consultation with other members of MCRF's senior staff.

Employment Status

An ECR is a part-time Marshfield Clinic employee. The terms of employment are specified in a contract of employment that is signed by the ECR and the Director of Medical Research. Typically the amount of time and effort is limited to 0.5 full-time equivalent (FTE) or less. However, the specific level of support depends on the expertise of the individual and the program needs. The Memorandum of Understanding is an essential precursor to completion of the Contract of Employment.

Direct and Indirect Compensation

The financial compensation in this program is in keeping with the overall principle of service in filling a purposeful need. However, the ECR does receive substantial direct and indirect support including office space (may be shared) and laboratory space (as available); computer and other technology support; administrative support from the center to which he/she is assigned; and access to MCRF research administration and support offices, such as the Core Research Laboratory and Office of Research Integrity and Protections. ECRs may apply for internal research awards, are eligible to receive published research awards, and maintain an investigator research account.

PROGRAM ASSESSMENT

The emeritus program has been piloted for 3 years with 3 physician emeriti. One of these physicians is currently in his third-year term, 1 in his second-year, and 1 completed a 1-year term. Expectations for each of these positions were based on specific needs and circumstances of the MCRF, education programs, and the expertise of the individual.

Specific contributions made include mentorship in grant development to associate scientists and physician investigators, peer review and editing of grants and manuscripts, and collaboration with principal investigators on active studies. The ECRs also provided advice on research priorities, provided critical analysis of key policies, and assisted the center directors in decision-making processes and development of new research initiatives and educational programs. Other duties performed included meeting with senior personnel at pharmaceutical and biotechnology firms to evaluate research proposals and assisting with subject accrual into clinical trials.

Expanded duties included fostering skills needed to enhance the research career of young investigators by providing orientation and consultation to young investigators, residents, and students in research methodology and design of clinical trials, as well as teaching and participating in journal clubs, seminars, and educational programs. During the past 3 years, participants also have been involved in the following activities:

- Reviewing and editing manuscripts.
- Writing manuscripts that involve education and research.
- Participating in industry-sponsored clinical trials.
- Mentoring graduate students and house staff.
- Attending and presenting continuing medical education conferences.

SUMMARY

A structured ECR program at our institution (created with guidelines regarding candidate selection, requirements, expectations, and performance evaluation) is currently offered to physicians and scientists who wish to continue an affiliation and provide desired services to the institution based on expertise and experience. The program represents a compilation of information and guidelines from other institutions that have demonstrated successful programs. It is tailored to reflect the major assets and priorities of our institution and provide opportunities to qualified physicians with aspirations to continue or pursue educational and biomedical research upon retirement. Alignment of the unique skills, expertise, knowledge, and wealth of experience of the emeritus faculty along institutional needs has provided added value to the institution without major financial investment.

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