

Systems Change and Local Alliances to Address Community Challenges

John J. Frey III, MD, Medical Editor

In the past few decades, public policy and family and patient advocacy have increased the visibility of mental health problems in our communities. One of the effects of the Affordable Care Act (ACA) has been to insist on what is often termed “parity” for mental health services within insurance plans and programs. Simply put, mental health services—with particular emphasis on substance abuse—are no longer add-ons or marginal services but should be central to patient care. Payment has been a formidable obstacle to dealing with one of the most challenging aspects of community health and one of the most difficult daily problems for primary care clinicians. Even though common sense says that prevention should save money and lives, the costs and savings of increasing mental health services are still not clear 4 years after the ACA went into effect.¹

Even with financial changes, lack of access to mental health services continues to plague patients. Much of the responsibility for managing mental health problems falls to primary care clinicians, where models of collaborative behavioral health allow patients to receive both counselling and medical management for the majority of their problems at the point of primary care service.² However, the management of severe depression and schizophrenia is often challenging beyond the capability of most nonpsychiatrists and requires substantial social services for patients.

Molfenter and colleagues describe a systems approach to organizing county-level human services and community and contracted mental health agencies with a quality improve-

ment strategy for decreasing psychiatric readmissions. Their change model demonstrated substantial decreases in 30-day readmissions in targeted counties in the state over a 4-year period.³ Their model encouraged counties to choose from a variety of approaches that best fit the mix of needs and resources. All but 2 of

Molfenter’s study did to address community-wide health problems rather than compete with each other for market share. One nationally recognized recent example of communities and health systems collaborating for success was the city of Milwaukee winning the White House Healthy Communities Challenge in 2015

Encouraging student self-reflection and self-assessment rather than leaving it up to their busy teachers and the Dean’s office seems like a step forward in adult learning and good preparation for the rest of their lives.

the 23 participating counties showed year-to-year decreases in readmissions.

While participation was voluntary, counties with the highest readmission rates were encouraged to participate. Their process and their results show how data from state hospitals and the public health department can help frame the problem while reliance on local partnerships and actions found appropriate solutions. One of the suggestions for making the ACA more successful in improving access and controlling costs is to encourage state experimentation that recognizes regional differences in everything from resources to culture. One wishes that regional health systems could act as collaboratively as the counties in

for the largest increase in percentage of eligible people enrolled in the insurance exchange of the Affordable Care Act of any large city in America.⁴ Competition has a place, but collaboration can get a lot more done.

Another alliance that might improve long-term health is outlined in the article from Traun and colleagues,⁵ where they interviewed pediatricians about attitudes and approaches to children and adolescents who were overweight or obese. While physicians felt they were adept at recognizing at-risk children and were aware of the clinical tools and patient education in their offices, they acknowledged that more work with families and community resources would help them and their patients be more success-

ful at weight control. Certainly the county-level data on childhood obesity is available, and pediatricians might take a similar approach as the mental health community to increase countywide collaborations between clinicians and what Traun and colleagues call “meaningful community connections with local organizations and advocates” in addressing an issue that we know is as much social as biomedical. Systems change will be necessary for success here, too.

A brief report by Morris et al reviews a survey of physicians statewide who raise some concerns about the value of electronic health records in documenting obesity and obesity management—primarily having sufficient time to do it.⁶ While respondents knew of office- and hospital-based ways of educating patients about obesity, they admitted that they felt discouraged about whether they would make a difference. While the survey had a low return rate, it likely reflects the frustration clinicians feel and the lack of clear evidence-based interventions for obesity in their patients—a problem over which they have little control.

The Infamous Letter

The “dean’s letter” (which now goes by a much longer and more descriptive title) is the first of a long list of letters that others will write for us and about us during our professional careers. Job references, promotions, awards, and other life changes require some type of personal view of who we are and whether we are qualified for what we have applied or for what we have been nominated. My generation’s evaluations and letters were secretly written and transmitted. On one of my clinical rotations, I remember the chief of service greeting me with, “Frey, oh yes, I have heard of you ...” and not in a complimentary tone, either. So, it is quite a breakthrough for students not only to see, but to contribute to their letter in an experiment at the Medical College of Wisconsin by Holloway and colleagues.⁷ The Dean’s office used the student contributions to the Unique Characteristics section of their letter to construct the final draft. I am sure the deans could separate chutzpah from the overly modest. Encouraging student self-reflection and self-assessment rather than

leaving it up to their busy teachers and the Dean’s office seems like a step forward in adult learning and good preparation for the rest of their lives.

A brief report by Adsit and colleagues⁸ found that more than half of the cancer clinics in a statewide survey did not address smoking cessation with patients. Most, but not all, assessed smoking at each visit. These data are surprisingly consistent with national data showing that 40% of cancer clinics do not offer treatment for smokers. Fortunately, the investigators offered, and all clinics accepted, a plan for academic detailing of tobacco cessation programs with the hope that it will increase their counseling and interventions with patients.

Finally, 2 surgical case reports highlight both unexpected and highly problematic conditions that should be considered in patients with usual presentations of coronary artery disease⁹ or in patients whose liver transplant is functioning less well than expected.¹⁰ In the first instance, the patient had lived almost twice as long as the norm for patients with his risk factors and his anatomical findings for a coronary anomaly. He should consider himself very fortunate, since others with the same anomaly were described in autopsies. In the case of liver transplants, which are increasing across the country, screening patients for portal steals prior to transplant should change the surgical approaches and decrease the risk of a failed transplant. With the high costs of transplant surgery and medical management, increasing success rates will be better on many fronts.

...

Editor’s Note: *The WMJ is fortunate to welcome Sarina Schrager, MD, as associate medical editor, as well as 3 new members to the journal editorial board. Doctor Schrager, who has served on the editorial board since 2008, is a professor of Family Medicine at the University of Wisconsin School of Medicine and Public Health. Vijay Aswani, MD, PhD, is an internist/pediatrician with Marshfield Clinic; William J. Hueston, MD, is a family physician and senior associate dean for academic affairs at the Medical College of Wisconsin; and Richard H. Strauss, MD, is a pediatric intensivist with Gundersen Health System in La Crosse. With the increasing interest in the*

journal and the increasing number of manuscripts we have been seeing, we welcome their involvement.

REFERENCES

1. Jacob V, Qu S, Chattopadhyay S, et al. Community Preventive Services Task Force. Legislations and policies to expand mental health and substance abuse benefits in health insurance plans: a community guide systematic economic review. *J Ment Health Policy Econ.* 2015;18(1):39-48.
2. Baird M, Blount A, Brungardt S, et al. The development of joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med.* 2014;12(2):183.
3. Molfenter T, Connor T, Ford JH, Hyatt J, Zimmerman D. Reducing psychiatric inpatient readmissions using an organizational change model. *WMJ.* 2016;115(3):122-128.
4. The White House. Office of the Press Secretary. Fact Sheet: Announcing the Winner of the Healthy Communities Challenge [news release]. February 12, 2016. <https://www.whitehouse.gov/the-press-office/2016/02/12/fact-sheet-announcing-winner-healthy-communities-challenge>. Accessed May 10, 2016.
5. Traun BD, Flood TL, Meinen A, Daniels M, Remington P. A qualitative pilot study of pediatricians’ approach to childhood obesity. *WMJ.* 2016;115(3):134-139.
6. Morris GL, Chapman K, Nelson D, Fink J, Walker R, Cisler R. Physician use of electronic health record in obesity management. *WMJ.* 2016;115(3):140-142.
7. Holloway R, Domack A, Treat R, De Roo K. Results of student-generated ‘unique characteristics’ on the Medical Student Performance Evaluation. *WMJ.* 2016;115(3):129-133.
8. Adsit R, Wisinski K, Mattison R, Bailey H, Fiore M. Survey of baseline tobacco cessation clinical practices and receptivity to academic detailing. *WMJ.* 2016;115(3):143-146.
9. Austin BK, Shah MS. High-risk variant of a rare coronary anomaly. *WMJ.* 2016;115(3):151-153.
10. Dua A, McElroy L, Wochinski A, Hong JC, Cronin DC. Portal steal syndrome after full-size deceased donor liver transplantation. *WMJ.* 2016;115(3):147-150.

WMJ

Let us hear from you

If an article strikes a chord or you have something on your mind related to medicine, we want to hear from you. Submit your letter via e-mail to wmj@wimed.org or send it to *WMJ* Letters, 330 E Lakeside St, Madison, WI 53715.

advancing the art & science of medicine in the midwest

WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

© 2016 Board of Regents of the University of Wisconsin System and The Medical College of Wisconsin, Inc.

Visit www.wmjonline.org to learn more.