Rivalries Can Be Good

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Whether from our experience with colleges, sports events, or in the more medical world of quality of care, when faced with comparisons between "our" team and others, we tend to use scores as either validation of our work or a stimulus to improve. That is the point behind the data transparency that is a regular part of medical care delivery in the United States. The County Health Rankings, begun at the University of Wisconsin and now a collaboration between the UW Population Health Institute and the Robert Wood Johnson Foundation, have served as stimuli for communities to strive for improvement. In many cases, the program also has brought public health, the practicing community, community agencies, and elected officials together to find ways to improve a community's rank. The *WMJ* has published examples of community-driven processes to improve health that have used the Rankings as a benchmark.[1]

In this issue of the *WMJ*, Pollack and colleagues have used the Rankings to explain the overall health differences between Minnesota and Wisconsin.[2] As they note, the states share a number of similarities including size, population diversity, and climate, but find that Minnesota consistently has better measures of health outcomes than Wisconsin. Just as moving away from individual clinician measures of quality to a total clinic view helps focus on a population and smooths individual variation, moving from a county to a state helps give us a view of regions and clusters of potential problems that might not be seen looking county by county.

Their analysis showed that the most important differences are not in the medical systems or workforce but in the issues that we know affect health—educational attainment, poverty, unemployment, and behaviors, such as drinking, smoking, and obesity. Perhaps the most important data from this study are that the large cities in both states differ dramatically in their health rankings, with the Twin Cities ranking in the middle to lower third of Minnesota counties and Milwaukee being second from the bottom of Wisconsin counties.

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Maps, as a geography colleague has repeatedly told me, don't solve problems but raise questions and demand the stories behind the data. The maps in this article are striking—but need more stories and studies to explain them. Looking at the combined maps of both states, the counties that have the lowest rankings are in a swath across the northern areas of both states. While Wisconsin and Minnesota may tout the wonders of lakes and forests to attract visitors, the health data on the people who live there are less glowing. Rural poverty, demographics, education, and health behaviors and their consequences can be seen clearly in those maps.

If Minnesota and Wisconsin are rivals in health outcomes, Pollack and colleagues have clearly laid out what needs to be done for Wisconsin to be more competitive. Providing quality health care is a small part of the problem. Both states do that very well, and while there are some advantages that Minnesota has with primary care and psychiatry, in general the workforces in each state are similar. Therefore, changing the economic, educational, and cultural factors that find Wisconsin trailing in this rivalry will require political and economic solutions across the state.

Also in This Issue

In the past few years, we've seen high profile stories on Veterans Affairs (VA) services troubled by problems of access to primary

care. The VA health system does not have economic barriers for access but still struggles with patients who miss appointments, often repeatedly. Boos and colleagues describe their work at the VA Nebraska-Western Iowa Health Care System, trying to identify patients who miss appointments in an effort to improve system performance.[3] In a yearlong study, they found that the profile of patients who missed appointments in their system were young, nonwhite men who had mental health problems. These are the people who often suffer the most from recent involvement in military actions and for whom preventive measures can have the greatest effect. Targeted outreach and further studies, including interviews and focus groups would help find possible solutions to a vexing problem.

Technology can be a boon to helping continuing medical education, as demonstrated by Ross and colleagues with a highly successful simulation program for emergency physicians in neonatal resuscitation.[4] Simulation centers have been a great resource for improving skills for operating room staff, intensive care clinicians, community emergency medical technicians, and medical students. This study shows that simulation centers also can help clinicians maintain essential skills throughout a career.

Sherid and colleagues report on the profile of younger (<50) and older cohorts of patients with ischemic colitis, which has been primarily a disease of the elderly associated with disseminated arteriosclerotic disease.[5] Although the younger cohort was not large, they had a much higher level of gastrointestinal bleeding as a presenting symptom. The important lesson here is that ischemic colitis should be added to the differential in younger patients with rectal bleeding.

Schrager and colleagues discuss 4 cases of primary hyperparathyroidism and offer a review of the subject.[6] Their 4 cases from primary care clinics appeared to have some level of risk for autoimmunity as a possible complicating or etiologic factor. They also showed that, in a primary care population over a 6-year period, the rate of primary hyperparathyroidism has been fairly stable at 35 per 100,000, putting the problem into a "rare but keep it in mind" category.

Clinical trials have continued to suffer from low enrollments and low diversity of populations studied. Both threaten the value of studies and their generalizability. Some studies suggest that almost 50% of clinical trials in all fields are not able to enroll sufficient subjects by the end of the study period. Oncology networks have had similar struggles. Saphner and colleagues report on the success of a first-year program based in a large health system —Aurora Health Care—in increasing enrollment in a large number of clinical trials.[7] Just as primary practice-based research networks have added to the understanding of the incidence and management of health problems in communities as opposed to specialty-based academic health centers, improving the collaboration between well-organized health systems and academic health centers can both help more clinical trials successfully enroll patients and also get patients access to new technology and treatments. Such linkages are win-win for all involved.

Finally, Danford and colleagues report the case of a rarely seen type of diabetic-related ketoacidosis compounded by a rarely used drug and the need to keep looking for drug-related adverse consequences as a source of unexplained or unanticipated illness.[8]

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Errata

WMJ. 2016;115(3):134-138.

In "A qualitative pilot study of pediatricians' approach to childhood obesity" by Traun, et al, on page 134 the second sentence in the Introduction should read as follows: "In the United States, it is currently estimated that approximately 17% of children are obese." This correction has been made to the report online, available at https://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/115/3/134.pdf.

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