POLICY FORUM

Data as the Foundation for Health Policy

Introduction

Ever since the North Carolina Medical Society transferred publication of the NCMJ to the North Carolina Institute of Medicine and The Duke Endowment, the journal has been focused on health policy analysis and debate. Years ago, former US Surgeon General Julius Richmond and North Carolina’s own Milt Kottlechuck proposed that the best public policy was a blend of data, strategy, and will. Thus the NCMJ’s health policy analysis and debate has always employed scholarly references to inform strategies and to build a will to action informed by data.

Our scientific editors, John W. Williams and George L. Jackson, further the journal’s tradition of clinical scholarship by receiving and vetting papers from North Carolina scholars. Scores of virtually anonymous reviewers have for years reviewed and critiqued submissions, returning the work to the authors for clarifications and edits until the best papers were accepted for publication. (Every year we name and thank those reviewers for their time and effort. See page 4 of this issue for the most recent listing.)

In this issue, we focus exclusively on recent research that has been conducted in North Carolina. For example, an article by Fleming and colleagues describes Operation Medicine Drop, a powerful response to increased deaths due to unintentional poisoning [1]. In addition to quantifying the amount of medication collected by this drug take-back program, Fleming and colleagues also echo some of the concerns discussed by Varnell in the NCMJ’s May/June 2013 issue on chronic pain [2]. In this area, the data is clear and the strategy is obvious: Judicious prescribing, cautious dispensing, and controlled disposal of pain medication could curtail this epidemic.

In another article in the current issue, Van Doren and coauthors remind us that, although substance misuse is epidemic in scope, most emergency departments see relatively few cases [3]. Specifically, emergency department encounters due to mental health or substance misuse make up 6.4% of all emergency department encounters in Orange County and only 2.4% of encounters in Wake County [3]. Unfortunately, our frontline emergency departments can only treat the consequences of substance misuse, not the cause.

Research also shows us that infectious diseases continue to be all too prevalent in our state. Mined data from Wake Forest Baptist Health in Forsyth County shows that capture-recapture analysis yields an estimated influenza A(H1N1)pdm09 disease burden that is 8-fold higher than the disease burden estimated by physician-ordered testing alone [4]. Rather than more testing, the authors argue for greater awareness of the prevalence of influenza. Even more than awareness, another obvious conclusion is to improve immunization efforts.

In another study in this issue, Bryant and colleagues found that tuberculosis contact investigations were more rapid and thorough when they were performed by experienced nurse investigators, highlighting the need for retention of public health staff and effective knowledge transfer from one generation to the next [5]. The state tracks the staffing and experience of personnel in our local health departments, measuring both capacity and need. Currently, experienced staff members are aging, and a new generation of expertise needs to be developed. These issues were also treated in our January/February 2014 issue on education of health professionals and in the September/October 2013 issue on respiratory diseases.

Studies in the current issue also look at environmental exposures. In one article, Johnston and colleagues examine the possible mercury exposure associated with consumption of fish from North Carolina’s
Haw River Basin [6]. Unfortunately, they found that fishers’ knowledge of the risk of mercury exposure was not associated with decreased consumption of high-mercury fish, which suggests the need for additional outreach and education efforts. Public policy can protect when there is a challenge to detect and prevent.

Another environmental exposure that can adversely affect North Carolinians is childhood trauma. Adverse childhood experiences are known to be associated with poor outcomes, but current classifications of disability are insensitive to survey tools and definitions of physical, mental, and emotional disability. Nonetheless, Austin and coauthors examined the effect of adverse childhood exposures among persons with disabilities and found that life course experiences are as powerful as toxic environmental exposures [7]. Indeed, social determinants of health are environmental exposures with far-reaching consequences for individuals and society. For more on this emerging science, see the NCMJ’s January/February 2013 issue on implementing Bright Futures guidelines for well-child care.

Exploring the topics addressed in our July/August 2013 issue on health care reform, Swan and Foley looked at the impact of the Patient Protection and Affordable Care Act on North Carolina’s free clinics [8]. Adoption of electronic health records is a mixed blessing for some, but it is a step in the right direction for free clinics seeking to document patient care. However, reductions in volunteerism and funding for free clinics are real risks if the community believes that the Affordable Care Act automatically provides access to care for all populations. In addition, the number of insured individuals is now increasing faster than the supply of providers.

Recalling the NCMJ’s July/August 2014 issue on cancer in North Carolina, the article in the current issue by Zullig and colleagues reminds us that health disparities—between rural and urban, men and women, minority and white—are problems not only nationally but also within our state [9]. The authors describe methods that cancer researchers can employ to search for selection bias in access to cancer treatment.

Finally, several issues of the NCMJ have dealt with training, staffing, innovation, team-based health care, and quality improvement. In the current issue, Kalich and coauthors describe the time-consuming yet critical effort of medication reconciliation and the value of reviewing and adjusting not only cardiac medications but also anticoagulants and insulin [10].

We know that science informs best practice. This issue of the journal reminds us that science and best practice inform public policy debate and response. With our commitment to both research and the practical application thereof, you will find the NCMJ wherever data, strategy, and will intersect with practice, health policy analysis, and debate.  

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