

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the 1972 Annual Review of Mary Hitchcock Memorial Hospital:

Dr. Jarrett Folley, MHMH's chief of staff, was quoted as saying: "I would foresee an extension of things done in the outpatient area . . . with [a] closer relationship with health agencies in other communities to provide continuing care. We will be trying to determine the role of our physicians in the broadening health-care system, particularly how they may better complement other physicians and hospitals throughout northern New England."



99

Number of employees today in the DHMC Office of Care Management, which coordinates patients' care not only during but after their hospital stays

Waitless environment is good for mental health

Just imagine: A mental-health clinic with no appointments and no waiting lists. Patients could stop in any time to see a counselor or a psychiatrist. The concept isn't imaginary, however. It's real and it works, says Dr. Andrew Pomerantz, chief of mental health at the DMS-affiliated VA Medical Center in White River Junction, Vt.

Model: His team developed a new model of delivering mental-health care within the White River VA's primary-care clinic. Known as the Primary Mental Health-Care (PMHC) Clinic, it has been well received by the nearly 13,000 veterans and their families who visit the primary-care clinic each year; 99% of patients who used the PMHC during its first year (2004-05) rated overall care there as good to excellent. Patient ratings have stayed high ever since.

In the quarter before the PMHC opened, patients waited an average of 33 days to see a mental-health specialist and were often reluctant to continue treatment due to the stigma associated with seeking mental-health care. In the first quarter after the clinic opened, waiting time had been reduced to an average of just 19 minutes, and lost productivity due to no-shows was eliminated.

The model has won two national awards: the American Psychiatric Association 2005 Psychiatric Services Achievement Award and the Veterans Health

Administration 2006 Advanced Clinic Access Award.

Patients who come to the PMHC see both a psychologist (or a licensed counselor) and a psychiatrist on their first visit. "The full spectrum [of care] is there," says Pomerantz. "You're seeing people skilled in both the psychological treatments and the psychiatric treatments."

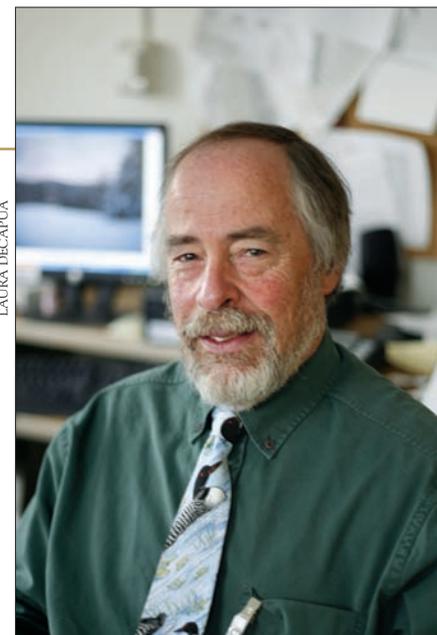
And having the new clinic in a primary-care setting helps avoid stigma. "You come in the primary-care clinic without being branded as a mental-health patient or a psychiatric patient," points out counselor Brady Cole, a cofounder of the PMHC. Its presence within primary care also fosters regular consultations between primary-care doctors and mental-health staff.

And since it's an open-access clinic, patients can visit any time, regardless of the severity of their illness. "What's different with this is that everybody gets in," says Pomerantz.

A patient new to the clinic first fills out self-report tests on a touchpad; the tests assess depression, anxiety, PTSD, and overall physical and mental functioning, as well as a suicide risk. Next the patient meets a psychologist or counselor who takes a psychosocial history, then a psychiatrist who does a mental-status exam and diagnostic assessment.

Finally, the patient, psychologist, and psychiatrist, plus possibly the patient's primary-care physician, meet together to dis-

LAURA DECAPUA



Pomerantz's model has won two awards.

cuss a treatment plan. About 75% of patients stay within the PMHC for care or return to their primary-caregiver, while 25% are referred for specialized mental-health care. The PMHC starts with an assumption that "the patient is okay," says Pomerantz, but something in his or her life needs to be addressed. "Our job is to focus on the [patient's] chief complaint," he adds.

Access: Running the clinic on an open-access basis can be a chore, notes Pomerantz, though 90% of the time the patient flow is fairly even. If five people show up at once, "we manage it," he says. "If one of them has that suicide question highlighted, we'll take care of that first. We'll adapt. Maybe I'll do everything. Maybe they'll only see me and not the therapist and I'll touch on the things that the therapist would normally do. In some situations, maybe we'll both see the person together."

The main thing, says Pomerantz, is "you need to learn to let the patient set the agenda."

MATTHEW C. WIENCKE

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the 1984 Dartmouth Medical School admissions viewbook:

Dr. Allen Dietrich said his objectives as a faculty member were “to establish a personal research agenda on preventive health care, to develop a strong family practice and primary-care clinical thread throughout the four years of the DMS curriculum, and to build a model family practice center. . . . I believe it is one of Dartmouth’s obligations to teach its medical students . . . a person-oriented approach to medical care, not just a disease-, procedure-, or organ system-oriented approach.”



2007

Year Dietrich was named to the U.S. Preventive Services Task Force, a national panel of experts in preventive and primary care

Trustees call for a doubleheader at DHMC

The Roman Republic did it. Hewlett-Packard did it. Goldman Sachs did it. Now Dartmouth-Hitchcock Medical Center is doing it—proving that two heads are better than one.

Structure: A new co-leadership structure for DHMC—to be known as the Office of the Presidents—was endorsed by the relevant Boards of Trustees two months ago, and Nancy Formella, R.N., M.S.N., was named president of Mary Hitchcock Memorial Hospital and of the Dartmouth-Hitchcock Alliance. Formella had been in that role in an acting capacity since the retirement last year of long-time MHMH-DHA president James Varnum. And the shared presidential structure—a collaboration between Formella and Dr. Thomas Colacchio, president of the Dartmouth-Hitchcock Clinic and a professor of surgery at DMS—had also been in place unofficially for the past year.

DHMC is following in the footsteps of companies like Hewlett-Packard, Goldman Sachs, Intel, TIAA-CREF, and other enterprises that have made shared leadership work. Even the early Republic of Rome thrived for 400 years with consuls and other magistrates who served as co-leaders. But DHMC may be one of the first academic medical centers to function in this way. “We’re kind of leading the way,” says Formella. “For us right now, this is the right thing for the organization.”

Experts who study management systems have found that

co-leadership works best when the people at the top have complementary skills. Formella and Colacchio fit that mold.

Colacchio, who joined the DMS faculty in 1981, combines administrative duties with a day and a half in the clinic, so he “understands the clinical practice from a physician’s point of view,” says Formella. “And my background as a nurse is in care provision, and being a manager and an executive in a hospital. So, together, that’s a pretty powerful package—that kind of clinical depth of knowledge with administrative knowledge.”

Process: Their personal characteristics are complementary, too. “I would say my strengths are very much in the arena of building relationships and inviting conversation and group process kinds of things,” says Formella. And “Tom’s strengths are in sifting through a lot of information and a lot of data and getting to the conclusion and being more direct in the decision-making.”

The co-equal nature of the leadership structure

was underscored by the Trustees’ announcement that Formella and Colacchio will be paid the same salary—\$600,000 each. The Trustees said they were impressed by what the two leaders have accomplished so far, citing “the remarkable progress made by Dartmouth-Hitchcock over the past 12 months in its financial performance and in the setting of a set of ambitious priorities for the future.”

Formella sees challenges ahead, however. “This is an organization that is wedded to the status quo,” she points out.

“We’re not where we need to be or where we want to be, and we haven’t been particularly passionate about changing it.”

Until now. Under Formella and Colacchio’s leadership, DHMC is taking a systematic look at all its processes and functions. “Things like patient ac-

The shared structure has been in place unofficially for the past year.



Colacchio and Formella now officially lead the lineup at DHMC.



TEA-TOTALER: A DMS study of the correlation between tea consumption and skin cancer incidence found that subjects who drank two or more cups of tea a day had a 65% lower risk of squamous cell carcinoma. Lemon boosted the effect.

cess, how do we make appointments, what's really our commitment to getting patients in here in a timely way?" says Formella. She anticipates improving information technology, performance reviews, and clinical and administrative systems.

"We've been an organization that has been good at launching a project, and we don't hold our own feet to the fire," she adds. "We're designing these improvement projects in a way that—the best way I can say it is—will hold our own feet to the fire—[by developing] metrics and . . . building accountability."

Formella—who has more than 30 years of experience as a staff nurse, a clinical nurse specialist, and a nursing executive—came to DHMC as senior nurse executive in 1999. She had previously worked for a national consulting firm for three years and before that held leadership positions in Mayo system hospitals for 15 years.

Magnet: In 2003 she led the effort to obtain Magnet status in nursing for DHMC. In 2004 she was named Nurse Leader of the Year by the New Hampshire Nurses' Association. And in 2005 she was honored for Nursing Management Excellence by the New Hampshire Organization of Nurse Leaders. She holds a B.S.N. from the University of Iowa and an M.S.N. from Marquette University.

"It is so humbling to be asked to take on this role at this time in this organization's history," says Formella. "It is just very, very gratifying."

Laura Stephenson Carter

Too much coursework? Try some hair of the dog!

For medical students whose "chief complaint" is intense coursework, a proven cure seems to be more courses. Courses, that is, that they've designed or on subjects that they've chosen.

Electives organized by students let them "follow their passions and not lose parts of themselves" to the rigor of medical school, says Dr. Joseph O'Donnell, senior advising dean. And students are often "way ahead on societal trends," he adds, so it's not unusual for elective subjects to later be absorbed into the formal curriculum.

Kalindi Trietley, the director of learning and disability services, coordinates these "enrichment" electives. She says the program allows DMS to be sensitive to "pockets of interest that aren't big enough for a course but [are] very valid." There are more than 30 current offerings, on topics from wilderness medicine to medical Spanish. The program, now 10 years old, includes both student- and faculty-initiated courses; each is overseen by a faculty member.

Two electives offered last term—Medical Anthropology and the Art and Craft of Medicine—offer a window on why and how such courses come to be.

Katherine Ratzan's interest in medical anthropology dates from some courses she took before coming to DMS. "I thought others might find the perspective from that field . . . refreshing," she says. She set up six lectures;

one, "Asian Medical Systems in Interaction with Biomedicine," was given jointly by a U.S. physician and a Tibetan physician. "Students discussed the idea that science itself is culturally mediated," Ratzan says, "and this must be kept in mind when interacting with patients who do not hold the same set of beliefs."

The art elective had its genesis when Daniel Kaser took a one-year leave from DMS to pursue his interest in art (see dartmed.dartmouth.edu/fall06/html/student_notebook.php). This experience reinforced his belief in the importance of art in healing. Upon his return to DMS, he organized a course combining studio work with classes led by an educator at Dartmouth's Hood Museum of Art. "Students are encouraged not only to draw, but to talk about what they have drawn," Kaser says. "Further, we look at objects in the Hood galleries . . . and discuss what we see. This practice of observation and oral presentation is critical to medical encounters."

Wake: O'Donnell likens such electives to "letting a thousand flowers bloom." He sees them as part of the constant renewal of the formal curriculum. For example, he says, international health is a subject on which "the institution is coming along" in the wake of student interest.

See <http://dms.dartmouth.edu/admin/olads/enrichment.shtml> for more about the enrichment electives.

James DiClerico

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A reminder of the pace of change, and of timeless truths, from the Spring 1987 issue of this magazine:

In an article titled "Pernicious Weed," Dr. A. Stuart Hanson, DMS '60, wrote: "As an internist specializing in pulmonary disease, I had begun to realize [10 years previously] that I was making my living from the end results of cigarette smoking. My mentors in pulmonary disease had trained at tuberculosis sanatoriums . . . but what I was seeing now, in my own practice, was a new set of pulmonary diseases that were in large part caused by tobacco."



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Mentions since then in the magazine of tobacco's effects or of smoking cessation

1992

Year DMS students began a tobacco-education initiative in local schools