



# Health Policy

## NEWSLETTER

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### EDITORIAL

## Arthur C. Bachmeyer Memorial Lecture 2010

Each year, the American College of Healthcare Executives (ACHE) sponsors the Arthur C. Bachmeyer Memorial Address. This lecture is underwritten by the Alumni Association of the Graduate Program in Health Administration and Policy at the University of Chicago and serves as a tribute to Arthur C. Bachmeyer, MD, founder and former director of the program and a charter fellow in the ACHE. I had the privilege of delivering the 61<sup>st</sup> Annual Bachmeyer Address in Chicago this spring during the ACHE Annual Leadership Conference.

Following is an abridged version of my lunchtime comments to more than 1,500 assembled healthcare leaders from across the nation.

Good afternoon. Thank you for the privilege of addressing you here today. I am humbled to deliver the first Bachmeyer Memorial Address of a new decade. Although the previous decade could be described as one of despair, downsizing, disappointment, deceit, disillusionment, derivatives, debt and default, I refuse to be downtrodden!

As a student at the Wharton School of Business at the University of Pennsylvania, I learned from Professor William Kissick that a good luncheon address could be readily divided into three sections. One should first point with pride at specific accomplishments, view with serious alarm developments in the environment, and finally, end with hope for the future. As a result, my presentation today will point with pride, view with alarm and end with hope.

In 2002, I underwent a spinal fusion for a high grade spondylolisthesis, which was effectively shearing my left sciatic nerve. I am pointing with pride at the high level of technology that enabled me to undergo such a procedure that allows me to remain essentially pain-free. I point with pride at the skill of Dr. Todd Albert, the chair of orthopedic surgery at Thomas Jefferson University Hospital.

I also point with pride at my family, including my physician wife, my fraternal twin daughters and my son. My daughters are the products of a special invitro-like procedure called gamete intra-fallopian tube transfer or GIFTT, so I am grateful for the access to such amazing life-giving technology.

I also point with pride at my role in the November 2006 publication of the Pennsylvania Healthcare Cost Containment Council Report entitled, *Hospital Acquired Infections in Pennsylvania*. This report, the first of its kind in the world, collated and disseminated data that made hospitals in Pennsylvania accountable to the public regarding their associated HAI infection rate. Publication of this report led to front page stories in *USA Today* and *Modern Healthcare*. I am proud of the role our team played in promoting the concept that *sunshine is the best disinfectant*. While the report showed widespread unexplained clinical variation, within one year of publication of this report, HAI in Pennsylvania decreased by nearly 8½%. I am proud of the commitment we made to public accountability and to the improvements in quality and safety that have resulted.

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Finally, I'm proud of the fact that major leaders in academic medicine have written in the *Journal of the American Medical Association*<sup>1</sup> that when all is said and done, academic medicine has a single mission – to improve the health of the population. This is a watershed event that outlines the importance of the commitment we must share to improve population health.

I view with alarm a number of recent developments in our environment. The recent passage of health insurance reform ignores three of the four pillars of health reform, namely: the inability to demonstrate value for the dollars spent, the lack of care coordination, and little mention of our need to promote wellness and prevention. While it is laudable that we have extended coverage to those currently uninsured, ignoring the aforementioned pillars will create many unforeseen challenges.

I continue to view with alarm the growing burden of unexplained clinical variation in our day-to-day practice. While most clinicians do not recognize that a minority of our decisions at the bedside are based on solid evidence, the people who pay the bills clearly are cognizant of this fact. The evidence is overwhelming that autonomous decision-making without a solid evidentiary basis leads to waste and a propensity for medical error. Furthermore, nearly a decade of published work points to the fact that there is uneven adherence to the evidence when it does exist, and that the American healthcare system gets it right just about 55% of the time. This uneven adherence to the evidence is not indicative of poor doctoring but is, in part, a reflection of widespread system failure.

This widespread system failure is also chronicled in *To Err is Human*, the famous Institute of Medicine (IOM) Report published in 1999. This report made it socially acceptable to discuss the epidemic of medical error in our country. A May 2009 report in *Consumers Union* gives our healthcare industry a failing grade with regard to reducing medication error, stating that “to err is human, but to delay is deadly.” We must get beyond the conversation focused on simple things such as hand washing and penmanship and tackle the more difficult issues of systems failures that lead to error. Healthcare will never be error-free, but we must strive for care that is harm-free.

While I applaud the influx of federal monetary support for comparative effectiveness research (CER), the study of what really works in medicine, I note with alarm

that there is an explicit statutory limitation on the output of such research as the stimulus bill prohibits CER from being tied to any form of reimbursement. In short, even when we find out what does work, we will not be able to explicitly pay for it! Also, the IOM has published a list of the top 100 fertile areas for CER work. These include things like the appropriate therapy for atrial fibrillation, advances in hearing technology, and the study of fall prevention in the elderly. These are the bread and butter building blocks of primary care and it is noteworthy that the IOM enumerates these seemingly basic issues.

I also point with alarm at the growing anachronistic structure of the modern voluntary hospital medical staff. Medical staff leadership can be described by three tongue-in-cheek tenets, including, 1) “you missed three meetings, now you're president-elect of the medical staff?” 2) like the Marx brothers of old, “whatever it is, I'm against it,” and 3) a vote of 200 to 1 constitutes a “tie” in most medical staffs. There is a persistent and false view that medical executive committees, meeting one evening per month, can manage the growing quality and safety agenda.

Boards of trustees at most voluntary community hospitals remain bamboozled regarding their role in quality and safety. Recent evidence suggests that only about one-half of all not-for-profit hospitals have a board committee devoted exclusively to this key fiduciary responsibility. And finally, I point with alarm at a recent National Institute for Occupational Safety and Health Survey that notes “healthcare workers are actually experiencing increased numbers of occupational injuries and illnesses over the past decade; . . . by contrast, two of the most hazardous industries – agriculture and construction – are safer today than they were a decade ago.”<sup>2</sup>

Despite all this, I am hopeful for the future. American medical education, led by such organizations as the Institute for Healthcare Improvement, seems willing to embrace the quality and safety agenda. I am very hopeful that great medical schools like Jefferson Medical College will continue to expand their commitment to curricular reform and include such things as health policy electives, joint MD/MPH degrees, and a special focus on training medical students in improving patient safety. I view all of this as an effort to appropriately redefine professionalism.

I am heartened by the development of a new disruptive technology, namely, non-human clinical

simulation. I point with pride at the creation of the Simulation Center at Thomas Jefferson University where all new house officers are required to demonstrate their technical competencies prior to their rotations in the hospital. I am encouraged by the Association of American Medical Colleges (AAMC) demonstrating their commitment to the quality and safety curriculum by dedicating an entire issue of *Academic Medicine* (December 2009) to this important topic. We are making progress in moving this cultural boulder uphill.

Let me leave you with two closing thoughts.

High quality health care must cost less. The only way to reduce cost is to reduce waste. If we use the right drug, on the right patient, for the right indication, at the right dose, we will achieve a good outcome at a lower cost. This patient will leave the hospital sooner, will be happier, and will tell ten potential patients about the positive experience they had.

Finally, since I am speaking to a room full of leaders, I want to remind you of the admonishment from John P. Kotter, Professor of Management Science at the Harvard Business School, that “The institutionalization of leadership training is one of the key attributes of good leadership.” I want to thank you for the opportunity to address this group today and to thank the ACHE for all of the leadership training they provide to help prepare the leaders of tomorrow. Thank you and God bless you.

Well, there you have it. It was a heady experience to address a room full of healthcare leaders from across the country. My comments were very well received and many persons came to speak with me directly at the conclusion of my presentation. The Bachmeyer lecture was followed by a Fellows Forum, where I met in private with nearly 70 attendees to continue the conversation.

The Jefferson School of Population Health is committed to educating leaders for the future. If you had to point with pride, view with alarm, and end with hope for your own organization, what would you consider? ■

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**As always I am very interested in your views. You can reach me my email at: david.nash@jefferson.edu**

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# Improving the Appropriateness of Prescribing Medicine in the Elderly: A Comprehensive Approach in the Local Health Unit of Parma, Italy

Treating elderly patients can be complex because they often suffer from multiple illnesses. In addition, they are more likely than any other age group to use medications, which places them more at risk of potentially inappropriate prescribing (PIP). On average the elderly consume three times as many medications as the non-elderly and use 2 to 6 prescribed medications simultaneously.<sup>1</sup> Selecting the right medication or combination of medications for elderly patients can be challenging; age-related physiological changes and co-morbidities that often modify medication metabolism patterns and pharmacological activity can place the elderly at significant risk for medication-related issues; such as adverse drug events and prescribing errors (i.e. contraindications, excessive or duplicative medication therapy, and unrecognized interactions). Inappropriate medication prescribing has been associated with an increase in outpatient visits, hospitalization rates, and the risk of death.<sup>2</sup>

Approximately 95% of the elderly in Italy receive at least one prescription per year. Recent evidence suggests that in Emilia-Romagna, a large northern Italian region of about 4.2 million inhabitants, approximately one out of five elderly patients is exposed to inappropriate prescribing in an outpatient setting.<sup>3</sup> Since the end of 2006, researchers at Thomas Jefferson University, in collaboration with the Healthcare and Social Agency of the Emilia-Romagna Region and the Local Health Unit (LHU) of Parma, have been working on a project in the Parma LHU to improve the appropriateness of prescribing for elderly patients ( $\geq 65$  years) in the primary care setting. The Parma LHU provides outpatient health services via about 300 primary care physicians to a population of approximately 400,000 residents.

This ongoing quality improvement initiative involves several intertwined phases. In the first phase, in order to establish baseline prevalence of inappropriate prescribing in the LHU elderly population, a panel of experts was convened to develop a set of explicit

criteria on medications deemed inappropriate for older patients according to the Italian pharmaceutical market and Italian physician attitudes. The Beers criteria, widely reported in the literature, was used as a framework. The most recent set of Beers criteria, developed in 2002, defines a list of medications or medication classes that should generally be avoided in the elderly or when a specific underlying disease or condition exists.<sup>4</sup> After refining the Beers criteria to fit the Italian health care environment, the expert panel identified a total of 23 inappropriate medications and classified them as *always inappropriate* (17), *rarely appropriate* (3), and *with some indications but potentially misused* (3).

A retrospective cohort study was conducted using the medication list and the 2006 Parma LHU automated outpatient prescription data. The study revealed that of the 91,471 elderly patients, 23,662 (25.8%) received at least one prescription for any potentially inappropriate drugs. More importantly, 14,018 elderly (15.2%) were found to receive prescriptions for medications identified as *always inappropriate*. The most common inappropriate prescriptions were non-steroidal anti-inflammatory drugs, doxazosine (a-blocker), ticlopidine (antithrombotic), and amiodarone (antiarrhythmic).

In the second phase, at the end of 2007, the Parma LHU convened all primary care physicians for a series of educational sessions. The physicians were introduced to the prevalence of inappropriate prescribing in the LHU with the intention of increasing the awareness of the importance of the issue. A 21-item survey looking at the knowledge and confidence in prescribing for the elderly was also administered to the physicians. Knowledge was assessed via 7 clinical vignettes based on some of the drugs considered inappropriate for the elderly as per the list previously described. The results of the survey showed that while the majority of physicians felt confident in prescribing for the elderly, knowledge of prescribing was found inadequate.<sup>5</sup>

These findings reinforced the need for educational activities and materials for primary care physicians.

In the third phase, in late 2008, a list of alternative drugs to those judged inappropriate was developed by the expert panel. This list was the main topic of another educational session for primary care physicians held in the Parma LHU, in hopes of increasing awareness and minimizing inappropriateness in prescribing for the elderly. In 2009 local clinical leaders were recruited by the Parma LHU to present to the primary care physicians case studies on the most common inappropriate medications, in an attempt to generate interest and discussion on the topic.

An evaluation of the quality improvement initiatives is ongoing. A preliminary trend analysis compared the pre-post intervention (2006-2008) of the prevalence of inappropriate prescribing found a significant decrease from 15.2% in 2006 to 12.3% in 2008 of the elderly exposed to "always inappropriate" medications. This finding would suggest that the educational sessions may have positively affected physicians' attitudes towards improving their prescribing habits for elderly patients.

Although this finding is very promising the analysis did not include an LHU as a comparator. As soon as more recent data becomes available we will conduct a more robust study to corroborate such findings. Nevertheless, an important objective has been achieved; the project has improved communication among physicians by peer-to-peer discussion on the appropriate pharmacological treatment in the elderly. ■

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# The Value of Interdisciplinary Education: Learning Together Helps Make Care Safer

## The Need for Change

It has been more than a decade since the landmark Institute of Medicine (IOM) report, *To Err Is Human*, raised awareness of the need to improve the safety of health care. Many national agencies and organizations have devoted considerable energy to supporting quality improvement efforts. Evidence suggests that the effectiveness of these efforts has been variable. The Consumers Union gave the US healthcare system a failing grade on creating a system that prevents harm and reliably tracks progress<sup>1</sup> and Robert Wachter, a professor at the University of California, San Francisco, offered a grade of B minus in a recent *Health Affairs* article.<sup>2,3</sup> While there is disagreement on how much progress has been made, one message is clear: movement toward improving safety – and tracking success to that end – has been slow, and we are still experiencing alarming rates of error and finding deficiencies in our healthcare system.

A number of key thought leaders involved in the development of the IOM report attributed the lack of progress to “the persistence of medical ethos, institutionalized in the hierarchical structure of academic medicine and healthcare organizations, that discourage teamwork and transparency and undermines the establishment of clear systems of accountability for safe care.”<sup>4</sup>

To overcome these challenges, the Lucian Leape Institute of the National Patient Safety Foundation developed a vision for meaningful improvement in patient safety around five core concepts: transparency, care integration, patient/consumer engagement, restoration of joy and meaning in work, and medical education reform. Teamwork was a recurrent theme that emerged across all five of these core concepts. It became obvious that meaningful medical education should incorporate development of skills, behaviors and attitudes that foster teamwork and communication to improve safety. “Physicians, managers, nurses and others should work together in teams to redesign flawed processes to prevent harm. One reason this has not happened faster is that physicians have not been educated to carry out this critically important work.”<sup>4</sup>

## Moving Toward Transformational Change

With health and medical education reform high on the national agenda, we must consider the three Cs that are necessary components for an interdisciplinary team that works well together – cooperate, coordinate and communicate.<sup>5</sup>

Teamwork is not an exact science; it is learned in practice. All team members bring unique skills and experience to their work. The fundamental principles that lead to winning or successful performances are good communication, clear definition of roles and mutual respect in coordinating a strategy, and a leader who recognizes the importance of these values.

The same principles apply to health care. Most physicians are not trained to be leaders, but their decisions influence the care provided by other healthcare professionals (the clinical team).<sup>4</sup> Physician leaders must recognize and respect the role of the other team members because the collective efforts of a group are much more successful than those of an individual in achieving safety improvement.

The concept of mutual respect and strategies to incorporate the three Cs into practice must be established from the first day of medical school and be apparent throughout the educational continuum. Healthcare providers in practice must have these concepts reaffirmed through team training and continuing education opportunities. Even the process of making these opportunities available requires collaboration between educators, quality and safety improvement officers, risk managers and healthcare professionals. Some organizations have successfully created interdisciplinary educational opportunities for students and healthcare professionals; however, they remain the exception rather than the rule. It’s time to make interdisciplinary opportunities the standard in healthcare education to facilitate their use in healthcare delivery.

Patient safety leader Lucian Leape and his colleagues indicated that medical education reform was a core component of safety improvement, and that teamwork and

communication strategies should be part of the curriculum. Continuing education in the form of lectures, seminars, and fellowships are well-recognized mechanisms of delivering content to practicing health professionals and can help fill a critical knowledge gap.

One example is the collaboration between the American Hospital Association (AHA) and the National Patient Safety Foundation (NPSF). Together they sponsor a Patient Safety Leadership Fellowship (PSLF) that offers an interdisciplinary environment for learners from medicine, nursing, risk management, research and administration, in both clinical and non-clinical settings. Geared toward mid-career professionals, the Fellowship delivers key concepts in patient safety from the nationally recognized faculty and successful strategies for implementation from fellow classmates. Through leadership retreats and virtual self-study modules focused on creating a culture of safety, reliable design, leadership and complexity science, as well as disclosure, reporting and transparency, Fellows are prepared to lead improvement initiatives that have the potential to create lasting organizational change.<sup>6</sup>

The learning environment where the Fellows convene is a “gracious space,” where they feel welcomed and encouraged to learn,<sup>7</sup> affording opportunities to discuss common challenges. Through my personal experience as a member of the 2008-2009 class, I learned about the power of teamwork. The interaction with the members of my cohort allowed me to view patient safety from a variety of perspectives. The open, collaborative learning environment fostered a climate of mutual trust and respect that has helped us maintain lasting relationships as colleagues working to improve patient safety. Healthcare organizations and institutions must learn to foster this type of organizational culture in order to create an environment conducive to learning and practicing safely.

## Implications for the Future

As we work to create transformational change through interdisciplinary education, communication and coordination between

educational societies, quality and safety improvement organizations, educators and health professionals will be critical to success. By committing to the core values of “cooperate,

coordinate and communicate,” we will begin to make the improvements in health care we so urgently need. ■

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# Moving Philadelphia! Creating Healthier Communities

Thomas Jefferson University

May 11, 2010

On May 11, 2010, JSPH hosted an event entitled *Moving Philadelphia! Creating Healthier Communities* to launch the US National Physical Activity Plan. The plan was released on May 3, 2010 by an expert panel, including representation from the Centers for Disease Control and Prevention, the American College of Sports Medicine, the American Heart Association and the American Cancer Society. Philadelphia was the first city to formally endorse the plan.

The national plan focuses on prevention and wellness and is yet another example of the tremendous amount of energy being devoted to the future and how best to create healthy communities where people thrive. Clearly, physical activity is an important component of wellness, particularly in the face of rising rates of obesity and other associated chronic conditions. The program focused on physical activity and included numerous exhibitors on the campus green, as well as physical activities for children and adults – including an outdoor spinning class conducted by Jeff-IBC Wellness Center. Other participating organizations included: TJU Activities Office; TJU Center for Urban Health; Miss Amy Kids; Back on My Feet; Bicycle Ambassadors; Healthy Times; Gearing Up; and the Philadelphia Eagles.

Formal presentations were preceded by a very impressive mini-press event in which local

student health journalists (grades 4-8) from 5 schools had an opportunity to interview program speakers and ask questions about the plan and about physical activity and wellness in general. As part of the student-driven, *Healthy Times* newspaper program administered by The Food Trust, these young journalists also interviewed exhibitors and participated in the conference program. The students took notes throughout the day and developed articles for their school newspapers.

On behalf of Mayor Michael Nutter, Donald Schwarz, MD, MPH, Deputy Mayor for Health and Opportunity and Health Commissioner for the City of Philadelphia, presented a proclamation declaring May 11, 2010 Moving Philadelphia Day. In his keynote address, Dr. Schwarz discussed Philadelphia's high rate of obesity and the many hidden costs associated with obesity and chronic conditions. Dr. Schwarz noted the link between physical activity levels and the built environment, stressing that communities must be made safer and more accessible to encourage recreation.

Other noted guest speakers included Allison Kleinfelter from the National Coalition for Promoting Physical Activity and Founder and CEO of achievABILITY, who discussed the US National Physical Activity Plan in detail, and Richard Killingsworth, MPH, Senior Advisor at

Nemours Health and Prevention Services, who explored the impact of the built environment on health and wellness. Both speakers issued a call to action, not just to policy makers and decision makers, but also to local grassroots organizations and to each and every individual. The push for change must come from each of these levels in order to get the country moving.

The program concluded with a panel discussion. Panelists were Dr. Corinne Caldwell, Chair of the PA State Board of Education Wellness Committee; Ryan Oelkers, Executive Director of Cadence Cycling Foundation; Kristin Gavin, Founder of Gearing-Up; and Diane-Louise Wormley, PUFFA Project Director, Health Promotion Council. ■

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**Laura Kimberly, MSW, MBE**

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**To listen to a podcast and view slides from this program, visit: [http://jdc.jefferson.edu/moving\\_philadelphia/2010/May11](http://jdc.jefferson.edu/moving_philadelphia/2010/May11)**

**To learn more about the US National Physical Activity Plan, visit <http://www.ncppa.org/resources/plans/>.**

# FUNCTIONAL: Students taking an active role in shaping health policy

Medical school can be a demanding experience in many respects. While keeping abreast of an ever-increasing load of coursework, a medical student must learn to balance personal matters with clinical training. It requires extra energy to remain engaged with current events and therefore, as students, we sometimes feel that we will catch up with the real world after our education is completed. FUNCTIONAL (For Universal Care and Treatment In Our Nation At Last), a nearly two-year-old Jefferson Medical College (JMC) student organization, challenges students to become more politically involved. With the nature of healthcare in the US highly uncertain, we believe that students in the health professions can and should take an active role in shaping the future of the system in which we will soon be working.

Inarguably, the American health care system is in a state of crisis. For example, while the US spends nearly one sixth of its Gross Domestic Product (GDP) on health care, nearly 47 million people are uninsured.<sup>1</sup> Sixty-two percent of bankruptcies in 2007 were due to medical expenses.<sup>2</sup> Perhaps the most tragic statistic of all: over 45,000 deaths annually in the US can be attributed to a lack of health insurance.<sup>3</sup> The bottom line here is that as future physicians working within this context, we have a vested interest in creating a health care system that keeps costs down, functions efficiently, and is accessible to all.

FUNCTIONAL can trace its roots to interaction via an online Jefferson Medical College class discussion board. As they prepared to begin their first year of medical school, students Chad Vogeler (JMC 2012) and Irmina Haq (JMC 2012) discovered they shared a common interest in healthcare reform. Vogeler and Haq, now co-chairs of the group, found that there were other like-minded students in the entering class. Two months into the first year, FUNCTIONAL was recognized as an official student organization at Jefferson.

The first members of FUNCTIONAL came into the group with the same general ideas about the need for universal healthcare and, after weeks of self and peer education, adopted common goals.

The beliefs and goals of the group were – and continue to be – shaped by the current state of health care and insurance coverage in the US. Motivated by what we see as huge failures in the system, and with hope for a brighter future in healthcare, FUNCTIONAL believes in the following principles:

- Providing universal cost-effective healthcare, especially primary and preventative care, will not only lead to better health outcomes, it also will significantly reduce the cost of health care for everyone.
- The United States spends more per capita than any other nation for healthcare, and has been ranked only 37th in the world in overall health system performance.<sup>4</sup>
- Healthcare reform is absolutely critical for a financially and physically healthy America, and the current system is too unsustainable to delay reform any longer. The costs and administrative red tape of our current system make it hard for patients to access care and for health care providers to do their jobs.
- Health care is a basic human right, and it is therefore our responsibility as future healthcare professionals to advocate for universal coverage through constructive and meaningful avenues.

As a group, we are officially non-partisan and believe that a single-payer system or “Medicare for all” is an ideal solution to remedy the problems facing American health care today. However, we also are in support of health care reform that gets us closer to the goal of universal coverage. This was evident in the health care legislation recently passed in the US Congress, which was a stepping-stone in that direction. We are cautious in our support, however, as this legislation leaves millions of Americans uninsured and largely leaves our current broken system in place.

FUNCTIONAL collectively engages in political action to bring about a system of universal

health care in our country. Our organization is committed to training student advocates who are capable of affecting positive political change in the systems in which we must practice. We welcome all health professions students, not only those in medical school. We educate our peers, and give them opportunities to be involved. Our group has achieved this in a number of ways.

Since the inception of FUNCTIONAL, we have held educational discussions and movie screenings, hosted speakers and politicians on the Jefferson campus, and have coordinated lobbying efforts both online and in Harrisburg, PA and Washington, DC. Highlights of these activities included:

- An event which featured Congressman John Conyers (D-MI), author of the single-payer universal health care bill. This event was attended by over 200 people from Jefferson and the greater Philadelphia area.
- FUNCTIONAL, in conjunction with the American Medical Student Association (AMSA), organized a Pennsylvania State Lobby Day for medical students in Harrisburg. Thirteen student advocates from Jefferson participated in meetings with legislatures.
- FUNCTIONAL organized a Health Care Reform panel discussion which featured Theodore Christopher, MD, FACEP, Chair and Professor, Emergency Medicine, Thomas Jefferson University (TJU); Walter Tsou, MD, MPH, Board Advisor, Physicians for a National Health Program (PNHP), and former Health Care Commissioner of Philadelphia; and Daniel Louis, MA, Managing Director of the Center for Research in Medical Education and Health Care, TJU.

We are honored to have worked with many different organizations and individuals in the Jefferson community over the past year and a half. In the future, FUNCTIONAL group members hope to diversify our connections around campus

and collaborate with other student organizations concerned with health care reform and access. We will continue our lobbying efforts, including the annual lobby day in Harrisburg and online email campaigns. We will also continue to educate our fellow students about current health care

legislation and its effect on our future practice as physicians. Above all, FUNCTIONAL will remain a group pledged to politically empower health professions students who firmly believe that health care access in America should be a right and not a privilege, and accessible to all. ■

**Bridget Peterson**  
**Irmina Haq**

*Jefferson Medical College Class of 2012*

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## The 19th Annual Dr. Raymond C. Grandon Lecture

### Health as an Economic Strategy

*Thursday, May 6, 2010*



*From left to right: Keynote speaker, Dee W. Edington, PhD, Raymond C. Grandon, MD, David Nash, MD, MBA.*

**To view slides and listen to the podcast from this program visit: <http://jdc.jefferson.edu/hplectures/8/>**

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ATUL GAWANDE, MD, MPH, General and Endocrine Surgeon, Brigham and Women's Hospital, Associate Professor, Harvard School of Public Health, Associate Professor of Surgery, Harvard Medical School

ASHISH K. JHA, MD, Associate Professor of Health Policy and Management, Department of Health Policy and Management, Harvard School of Public Health

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# Greater Philadelphia Schweitzer Program Welcomes New Fellows

After a competitive selection process, 16 graduate students from health and human service programs in local colleges and universities have been selected as 2010-2011 Greater Philadelphia Albert Schweitzer Fellows. Honoring the legacy of Dr. Albert Schweitzer by committing to a year of service, the Fellows will devote over 3200 hours of service to local communities lacking access to adequate health services. Schweitzer Fellows continue their conventional professional training while participating in the entry-year of the Schweitzer Fellows Program. This year's newly selected group enlarges a rapidly growing network of Schweitzer Fellows for Life who are committed to supporting each other on lifelong paths of service.

The Greater Philadelphia Schweitzer Fellowship Program is proud to move forward into its 3<sup>rd</sup> year of operation. This year's Fellows represent the following academic institutions:

## **Drexel University College of Medicine**

## **Temple University School of Graduate Studies**

## **Thomas Jefferson University**

*Jefferson Medical College  
Jefferson School of Health Professions  
Jefferson School of Population Health  
Jefferson School of Pharmacy*

## **University of Medicine and Dentistry of New Jersey**

*School of Osteopathic Medicine  
Graduate School of Biomedical Science*

## **University of Pennsylvania**

*School of Medicine  
School of Dental Medicine*

With much excitement, we welcome the 2010-2011 Fellows and look forward to sharing more details about their projects and progress.

For additional information on the program, including opportunities to collaborate with a community site, and/or sponsor a Fellow, please contact Nicole C. Moore, MA, Program Director, The Greater Philadelphia Schweitzer Fellowship Program at 215-955-9995, or Nicole.Moore@jefferson.edu. You may also visit: <http://www.schweitzerfellowship.org/features/us/gp/> ■

## **Nicole C. Moore, MA**

*Program Director  
Greater Philadelphia Schweitzer Program*



*The above photo features newly inducted Schweitzer Fellows for Life and existing Schweitzer Fellows at the Annual Greater Philadelphia Schweitzer Dinner and Celebration.*

# Online Presence and Social Media: The JSPH Experience

The use of social media by organizations of all types is on the rise. According to a recent issue of *The Economist*, on average, Americans spent almost six hours surfing social networking sites in the month of October 2009. Membership on these sites is increasing: Facebook currently has over 350 million users worldwide, up from about 10 million two years earlier.<sup>1</sup> Usership of social networking sites is highest among teens and young adults, with nearly three quarters of online teens (73%) and young adults (72%) using social network sites. Among adults 30 and older, some 40% were using social networking sites in the fall of 2009.<sup>2</sup> According to a recent survey by Pearson and a survey research group at Babson, more than four out of every five professors use social media in their classes.<sup>3</sup> The leadership team at the School of Population Health recognized early the value of social networking tools to connect the Jefferson community with colleagues across the country and around the globe. The School was, therefore, an early adopter of social media and carefully cultivated a web presence reaching beyond the traditional Thomas Jefferson University website.

JSPH needed to create a completely new website to complete its transition from a department within Jefferson Medical College to a new freestanding academic entity. To coordinate JSPH's online activities and support its nascent online academic program, Dean David B. Nash convened a Digital Strategy Work Group (DSG) in 2008. The group meets regularly to discuss the evolving facets of social media and explore options that would benefit the School, its prospective students, and its network of colleagues across the nation. The group drafted a digital strategic plan outlining the use of Facebook, Twitter, YouTube, the Nash on Health Policy Blog, the JSPH web site, and Jefferson Digital Commons (JDC). As JSPH emerged as a new school with new degree programs, the digital strategy work group wanted to ensure that the School's online presence was integrated seamlessly to maximize opportunities to highlight new programs and attract students, in addition to showcasing existing research and executive education offerings. The

DSG continues to chart a course through the changing social media landscape.

## **Nash on Health Policy Blog**

One of the early initiatives of the group was to develop a blog entitled *Nash on Health Policy* (<http://nashhealthpolicy.blogspot.com/>). Initially authored solely by Dr. Nash, this was the first blog to emerge from within the Jefferson community. Dr. Nash and the work group were interested in mapping out a new approach to the blog that would keep the content current and enable more frequent postings. DSG solicited advice from an outside consultant and tackled considerations such as generating blog traffic, branding, creating content, and administering the blog. *Nash on Health Policy* was revamped in September 2009 to include postings from faculty and staff, as well as guest commentaries from selected Health Policy Forum speakers. These commentaries explore a wide range of topics related to population health, and the new incarnation of the blog offers faculty and staff an opportunity to share their unique perspectives on topics of interest with a broad community. A future goal for the blog is to conduct a more sensitive analysis of the blog's readership via Google™ Analytics, a program that generates reports and statistics about visitors to a website. The DSG is always looking for ways to engage readers in the conversation and encourage comments and opinions.

## **Facebook, YouTube, Twitter**

JSPH has an active Facebook page where faculty, staff, students, and other community members can post content and read alerts about the latest events sponsored by JSPH. This has been critical in reaching the student population and promoting academic and continuing education programs. JSPH's Facebook and YouTube pages provide opportunities to post visual media in the form of photos and short video clips. In addition, the Facebook page is linked to JSPH's Twitter account, and updates on Facebook automatically post to Twitter using a service called Ping, a network utility that links accounts and social media profiles. JSPH has experimented with live Twitter feeds from educational conferences and

special events (eg, 2010 Grandon Lecture, Future of Healthcare in Pennsylvania conference) to reach out to those who cannot attend in person.

## **Jefferson Digital Commons**

Jefferson Digital Commons (JDC) is a repository designed to showcase the work of departments, faculty, and students. JSPH uses JDC to post publications such as the *Health Policy Newsletter*, and the *Prescriptions for Excellence Newsletter*. Additionally, visitors will find *Health Policy Forum* podcasts; audio and video recordings of conferences and other educational programs, and related slide sets. All JDC items and publications can be easily located through a Google™ search. Academic and Instructional Support and Resources (AISR) works closely with JSPH to help connect and interface JDC postings with other social media postings. Recently, AISR assisted JSPH by posting Health Policy Forum podcasts to iTunes University. This will allow JSPH programs to reach another audience while creating a synthesis of information between JDC, the JSPH website, and other social media venues.

## **Future Directions: Social Media Policy**

The DSG recently explored and analyzed social media policies of various institutions. Some of the considerations for educational institutions when crafting a policy on social media use include: disclaimers, copyright, procedures and guidelines, use of personal information, and appropriate content. The group is currently developing social media policy and procedures that could potentially be shared throughout the University. The Group will continue to explore new ways to improve the School's visibility online and generate interest in its academic and professional continuing education programs. ■

**Laura Kimberly, MBE, MSW**  
**Lisa Chosed, MA**  
**Emily Frelick, MS**

*Jefferson School of Population Health*

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1. The Economist. A special report on social networking. A world of connections. [http://www.economist.com/specialreports/displaystory.cfm?story\\_id=15351002](http://www.economist.com/specialreports/displaystory.cfm?story_id=15351002). January 28, 2010. Accessed March 26, 2010.
2. Social Media & Mobile Internet Use Among Teens and Young Adults. Amanda Lenhart, Kristen Purcell, Aaron Smith and Kathryn Zickuhr 2010 Pew Internet & American Life Project. [http://pewinternet.org/Reports/2010/Social Media and Young Adults.aspx](http://pewinternet.org/Reports/2010/Social%20Media%20and%20Young%20Adults.aspx). Accessed June 14, 2010.
3. Pearson Social Media Survey, 2010 <http://www.slideshare.net/PearsonLearningSolutions/pearson-socialmediasurvey2010>. Accessed June 14, 2010.

# JSPH at International Society for Pharmacoeconomic and Outcomes Research (ISPOR)

May 15-19, 2010

Atlanta, Georgia

## Poster Presentations

**Ceccarelli M, Maio V, Slaubagh L, Rabinowitz C, Diamond J.**  
Statin use and the risk of colorectal cancer: A population-based cohort study.

**Jutkowitz E, Pizzi LT, Meltzer M.**  
Comparison of cost of allopurinol vs febuxostat as a first line treatment for gout

**Jutkowitz E, Carniol P.**  
Return on investment of ablative fractional lasers.

**Lee EH, Jutkowitz E, Parasuraman S, Derk C, Pizzi LT.**  
Injection site reaction questionnaire: An Adequate tool for measuring injection site reactions.

**Mohandas A, Thomson E, Goldfarb, NI.**  
Advancing the evidence base for orthotics and prosthetics.

**Pizzi LT, Lee EH, Thompson E, Berman B.**  
Medication therapy quality: A review of measures and conceptual framework to align physicians and pharmacists.

**Hagan M, Lee EH, Arikian S, Pizzi LT.**  
Comparative effectiveness index: A conceptual approach to comparative effectiveness research.

**McAna JF, Couto J, Goldfarb NI.**  
Clinical and economic impact of a program combining comprehensive lipid profiling with a heart disease treatment protocol.

**Slabaugh L, Maio V, Abouzaid S, Templin M.**  
Prevalence and predictors of polypharmacy amongst elderly patients: A population-based cohort study.

## Podium Presentations

**Jutkowitz E, Gitlin L, Pizzi LT.**  
Evaluating willingness to pay thresholds for a dementia caregiving intervention.

*Eric Jutkowitz, post-baccalaureate fellow at Jefferson School of Population Health (JSPH), was awarded Best New Investigator, Podium Research Presentation at the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) 15th Annual International Meeting.*



## Want a Quick Response? There's an app for that!

QR codes, or quick response codes, make printed material interactive hardlinking the printed piece with the internet. QR codes allow the mobile phone user to obtain information anytime, anywhere in seconds. Most phone companies offer the QR code reader either free or at a very low cost at their App Store. Try it out free by going to <http://www.mobile-barcodes.com/qr-code-software/> to download the reader for your phone. Install the software and give it a try.

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Use your SmartPhone (mobile phone with camera and web access) to keep up with new developments at JSPH...go online now to apply, sign up for a virtual open house, or learn about our new PhD program!

[www.jefferson.edu/population\\_health/](http://www.jefferson.edu/population_health/)

# Health Policy Forums

## How Pennsylvania's Budget Shapes Service Delivery

**Kenneth J. Braithwaite, II**

Senior Vice President, The Hospital and Healthsystem Association of Pennsylvania (HAP)  
Regional Executive, Delaware Valley Health Care Council of HAP

**Laval Miller**

Executive Director, Pennsylvania Health Law Project

March 10, 2010

This Health Policy Forum provided an overview of PA's state budget and its impact on health care service delivery and its populations. Kenneth Braithwaite of the Delaware Valley Health Care Council of HAP, and Laval Miller, Executive Director of the Pennsylvania Health Law Project, described the many challenges of balancing costs with serving those in need.

The speakers described the various programs in Pennsylvania's health care safety net which includes Medical Assistance for those with low incomes; the Children's Health Insurance Program (CHIP); and adultBasic Health Insurance.

Medical Assistance provides physical and behavioral health coverage for 2.1 million people in PA and services 450,000 people with disabilities and 300,000 seniors. It is characterized by a range of services which can be costly. Within the past two years the number of PA residents who are eligible for Medicaid increased significantly.

The options for maintaining and expanding this program while containing costs pose difficult and limited options.

CHIP, which actually began in PA, has been a very popular, well supported program. It provides comprehensive coverage such as behavioral, drug, vision and dental. It is subsidized below 300% of the federal poverty level with at-cost premiums of \$221 per child per month. CHIP has experienced a significant increase in enrollment within the past 7 years.

As a program for the uninsured, adultBasic is a state-only program designed for adults who meet specific criteria. It is subsidized below 200% of the federal poverty level at \$36 [per person] per month. This program does not cover prescription drugs or behavioral health services. Due to the increasing demand for services and an increase in the number of uninsured people, the waiting list for this particular program has doubled within the past 2 years.

The speakers also discussed issues of costs for caring for the uninsured and its effect on cost shifting, margins, and utilization within hospitals and health care systems. They describe the dynamics between insurers and providers and the disruption that ultimately ensues for the consumers. Nowhere is this more evident than the staggering number (19) of obstetric (OB) facility closures in Southeastern PA since 1997. Unfortunately, OB services are often viewed as a community service due to the small amount of revenue they provide.

The speakers emphasized the concern over cuts to hospital Medical Assistance in the proposed 2010-2011 and budget the impact of a changing administration.

**For information on the Pennsylvania Health Law Project visit: <http://www.phlp.org/>**

**For information on the Delaware Valley Healthcare Council of HAP visit: <http://www.dvhc.org/>**

## Consumer Health Informatics and Healthcare Disparities

**Michael Christopher Gibbons, MD, MPH**

Associate Director, Johns Hopkins Urban Health Institute  
Assistant Professor, Johns Hopkins School of Medicine and School of Public Health

April 14, 2010

Health care disparities are generally viewed to be related to societal, socio-cultural, behavioral, economic, environmental, and biologic factors. Dr. Gibbons discussed these issues at a recent Health Policy Forum and examined how technology might be used to address these disparities.

Dr. Gibbons set the framework for this presentation by describing current converging trends such as: the prevalence of chronic disease; increasing longevity and the burgeoning senior population; rising health care costs; and ingrained health care disparities. He emphasized that socio-behavioral

and environmental factors are increasingly recognized as significant determinants of health and health outcomes. Dr. Gibbons raised the point that it is impossible to characterize health or disease by only one type of analysis, nor is it possible to characterize disparities in this way.

Dr. Gibbons described how information technology-based approaches may offer significant promise in gaining a more comprehensive understanding of disparity pathogenesis. He went on to describe a new basic research model of *socio-behavioral*

*phenotypes* comprised of groups of individual and population level factors that coexist and thought or known to act cooperatively and influence health outcomes among specific populations. He also discussed *populovigilance*, which is the science of collecting, monitoring, and evaluating data from defined populations on the adverse effects of disparate health care, environmental hazards, behavior and policies.

Dr. Gibbons defines Consumer Health Informatics (CHI) as any electronic tool, technology or electronic application designed to interact directly

with consumers with or without the presence of a healthcare professional, that provides or uses individualized information and provides the consumer with individualized assistance to help better manage their health and healthcare. Types of CHI tools include interactive web-based applications; educational websites; non-web-based computer feedback applications; personal monitoring; health risk assessments; patient decision aids; text messaging; and discussion/chat groups.

Although preliminary evidence suggests that CHI applications may improve certain adult clinical

health outcomes, the role of these applications among children and other priority populations have not been thoroughly evaluated.

Dr. Gibbons raised the idea of digital disparities. Although the digital divide is changing, he discusses how differences in technology access, utilization patterns, and preferences among subgroups can lead to differential health benefits if they are not examined and understood. He further explained that this type of relationship to the technological environment might lead to an increase in disparities for those who are disenfranchised or not understood.

Dr. Gibbons has a vision for the future of disparities in which clinicians and researchers understand all the social, environmental, and biological factors that contribute to ill health. It is hoped that one day health risks can be managed before they become diseases and before patients ever need to go to the hospital. He would like to see clinical interventions that can be easily delivered and customized and health information that is always accessible for providers and patients.

## Changing Social Environments to Promote Health: Evidence, Opportunities and Challenges

**Karen Glanz, PhD, MPH**

*George A. Weiss University Professor  
School of Nursing and School of Medicine  
University of Pennsylvania*

*May 12, 2010*

Much has been written recently about the challenge of addressing rising rates of obesity in the United States, and the outlook tends to be gloomy. Well-intentioned interventions may enjoy isolated, short-term success, yet behavioral change with staying power seems elusive. However, Karen Glanz, PhD, MPH, offered a note of hope at a recent Health Policy Forum. She discussed her work, which strives to make connections between academia and the community, and to measure the impact of evidence-based interventions. She began by noting that the national vision for health, articulated in the Healthy

People 2020 goals, includes an emphasis on creating social and physical environments that improve health for all, and she referenced Frieden's health impact pyramid as a helpful model for examining population health issues.<sup>1</sup>

Dr. Glanz advocates for a social ecological approach to health promotion. She pointed to several examples which have had a positive impact in the sphere of community and health system environmental interventions, and in legislation, regulation, and enforcement. In particular, Dr. Glanz discussed the

success of tobacco control initiatives and was hopeful that our experiences with tobacco may help point us in the right direction as we develop strategies to address obesity.

She ended by reminding the audience that although randomized control trials are seen as the gold standard, natural experiments can also offer valuable insights. In addition, it is critical to reach out to disadvantaged populations and develop more practical tools and interventions.

### REFERENCE

1. Frieden TR. A framework for public health action: The health impact pyramid. *Am J Public Health*. 2010; 100(4): 590-595.

## Physician Leadership and Medical Group Performance: A National Study

*Louisa Baxter, MB, Msc, MRCP (UK)*

*Commonwealth Fund Harkness Fellow in Health Care Policy and Practice  
Jefferson School of Population Health*

*June 9, 2009*

JSPH was particularly excited and proud of Dr. Louisa Baxter as she closed the most recent Health Policy Forum season with a very insightful presentation. Dr. Baxter is a Commonwealth Fund Harkness Fellow who has been an active and integral addition to JSPH this past academic year. Harkness Fellows are part of a highly selective

group of health services researchers and clinicians from across the globe who come to the US for one year to conduct research and study health care policy and practice. Dr. Baxter is a 3<sup>rd</sup> generation National Health Service (NHS) employee from the UK with an impressive array of experiences and qualifications.

Dr. Baxter began her presentation by providing a historical overview of NHS in the UK. She outlined the key drivers that led to the impetus for this innovative system. The core principles to this day include the system's ability to meet the needs of everyone, provide care free of charge at the point

*Continued on page 14*

of delivery, and provide services that are based on need, not ability to pay. NHS employs over 1.7 million people; 50% of the workforce is clinically qualified. Approximately 140 patients are seen weekly per general practitioner and there are 40,000 general practitioners.

Dr. Baxter's research study is designed to explore the relationship between the culture of small medical practices (SMP) and practice structural characteristics regarding key elements of patient-centered medical home implementation in the US. Additionally the study explores the understanding of physicians in SMPs of the patient-centered

medical home model. Dr. Baxter described her survey-based methodology and discussed the preliminary findings. Themes that emerged from her research revealed the following: tensions between local, state, and federal policy goals and the capability of group practitioners to implement; a huge variation in understanding the implementation of the medical home model; and payment reform as a key factor in increasing buy-in for the patient-centered medical home model at the provider and payer level. A number of implications and pending questions exist for further analysis. For example, how can the patient-centered medical home respond to the

increased demand for care, given the shortage of primary care providers?

The Forum participants had a rare opportunity to view a newly released video in which Dr. Baxter interviewed a number of national leaders, health policy experts, politicians, and front-line clinicians in a candid discussion of current practice, reform and policy concerns facing the US.

**Health Policy Forum podcasts can be downloaded by visiting:**  
<http://jdc.jefferson.edu/hpforum/>

## Upcoming Health Policy Forums - Fall 2010

### Addressing Population Health through Interdisciplinary Collaborations

September 8, 2010

**Tim Gibbs**

*Executive Director*

*Delaware Academy of Medicine*

### Turning Dialogue Into Data: Leveraging Patient and Physician Insights for Behavioral Change

October 13, 2010

**Carolyn Choh Fleming, MBA**

*Professor of Marketing*

*Department of Pharmaceutical Marketing*

*Saint Joseph's University*

### Breaking the Language Barrier: Health Care Quality, Efficiency and Savings through Professional Medical Interpretation

November 10, 2010

**Louis Provenzano**

*President and COO*

*Language Line Services*

### Location for Health Policy Forums:

**Bluemle Life Science Building, Room 101**  
233 South 10th Street (10th and Locust Street)  
Philadelphia, PA 19107

**Time: 8:30 am – 9:30 am**

**For more information call:  
(215) 955-6969**

## JSPH Publications

Sarsour K, Morin C, **Foley K**, Kalsekar A, Walsh J. Association of insomnia severity and comorbid medical and psychiatric Disorders in a health plan-based sample. *Sleep Medicine*. 2010; 11(1):69-74

**Foley KA**, Wang P, Barber B, Long S, Bagalman E, Wagner V, Song X, Zhao Z. Clinical and economic impact of severe infusion reaction in patients with colorectal cancer treated with cetuximab. *Annals of Oncology*. Epublication. January 25, 2010.

**Foley KA**, Sarsour K, Kalsekar A, Walsh JK. Subtypes of sleep disturbance: Associations among symptoms, comorbidities, treatment and medical Costs. *Behavioral sleep medicine*. 2010; 8(2):90-104.

Meadows ES, Johnston SS, Cao Z, **Foley KA**, Pohl GM, Johnston JA, Ramsey SD. Illness-associated productivity costs among women with employer-sponsored insurance and newly diagnosed breast cancer. *J Occup & Environ Med*. 2010; 52(4): 415-420.

**Nash DB**. A Brit's perspective on the U.S. Healthcare system. *Medpage Today*. March 1, 2010. <http://www.medpagetoday.com/Columns/18736>. Accessed June 15, 2010.

**Nash DB**, Braithwaite KJ. The impact of Medicaid underfunding. *Medpage Today*. April 7, 2010. <http://www.medpagetoday.com/Columns/19431>. Accessed June 15, 2010.

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Nguyen G, Hsu L, Kue KN, Nguyen T, **Yuen E**. Partnering to collect health services and public health data in hard-to-reach communities: A community-based participatory research approach for collecting community health data. *Progress in Community Health Partnerships: Research, Education, and Action*. 2010;4(2): 115-119.

## JSPH Presentations

**Berman B**. Update on Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). Presented at: The 11<sup>th</sup> Annual Billing and Coding Symposium, Philadelphia, PA, May 7, 2010.

**Berman B**, Bagley D, Weiner P, **Thomson E**, Lepchuk B, **Abouzaid S**. Anxiety and pain associated with urologic office procedures. Poster presented at: Association of PeriOperative Registered Nurses (AORN) 54<sup>th</sup> Congress, Denver, CO, March 13-18, 2010.

**Berman B**, **Goldfarb N**. Developing and testing ambulatory quality measure. Application to nursing sensitive measures. Presented at: Ambulatory Care Registered Nurse Performance Measurement Conference, Philadelphia, PA, March 1, 2010.

**Goldfarb N**. Pay-for-Performance. Implications and opportunities for nurses. Presented at: Ambulatory Care Registered Nurse Performance Measurement Conference, Philadelphia, PA, March 2, 2010.

**Goldfarb N**. Implementing Pay-for-Performance in ambulatory care. Presented at: American Heart Association, QCOR 2010 (Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke), Washington, DC. May 12-14, 2010.

**Pracilio VPP**, **Berman B**, Craig E, and **Goldfarb N**. Physician practice patient safety assessment: A model for team-based patient safety improvement. Presented at: The 12th Annual NPSF Patient Safety Congress, Florida, May 17-19, 2010.

**Simmons R**. Public health advocacy: Making effective visits to Capitol Hill. Presented at: The National Public Health Education Advocacy Summit, Washington, DC, March 6, 2010.

**Simmons R**. Teaching cultural humility and competence: Lessons learned from developing and teaching a multi-disciplinary online hybrid course for public health and health professions students. Presented at: The Association of Teaching Prevention and Research Annual Meeting, Washington, DC, March 25, 2010.

**Simmons R**. Developing future public health leaders: Experiential advocacy training on Capitol Hill. Presented at: The Association of Teaching Prevention and Research Annual Meeting, Washington, DC, March 27, 2010.

**Simmons R**. The impact on prevention and public health of the 2010 health reform law: How it can make a difference in our public health and health care system. Presented at: The Southern Delaware Medical Society Lecture Series, BayHealth Medical Center, Dover, Delaware, April 27, 2010.

# Health Policy NEWSLETTER

Jefferson School of Population Health  
Thomas Jefferson University  
1015 Walnut Street, Suite 115  
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