



Health Policy

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GUEST EDITORIAL

Health Reform: Will It Improve Our Nation's Health?

It has been over a year since the Patient Protection and Affordable Care Act (PPACA) passed Congress and was signed by the President.¹ Throughout the year, we've heard a wide range of views as to its economic and political benefits and costs to our health system. As a result of the changeover to Republican control of the House of Representatives after the mid-term elections, there have been multiple efforts to repeal, change, or de-fund many provisions of the new law. Although the law itself will not likely be repealed within the near future, the appropriations for many components of the new law will be hotly contested. The impact of those debates on the actual implementation and enforcement of the new law is unclear.

From my view, the continuing debate over the new law seldom addresses the significant changes in policy that support prevention and health promotion programs and services. It is understandable that people are concerned about the governmental costs of implementing the new law and the impact on costs for private sector health care products and services. The cost of repealing the law is estimated to result in a net increase of federal budget deficits of \$230 billion, whereas the PPACA has been estimated to reduce the federal deficit by \$132 billion.² More importantly, repealing the new law will not address the underlying reasons for the high cost of US health care. Although the recession held down health care costs in 2009, estimated costs are expected to increase from \$2.5

trillion (17.3% of GDP) in 2009 to \$4.5 trillion (19.3% of GDP) by 2019.³ This year the first of the *baby boomers* (those born between 1946-1964) will reach age 65 and become eligible for Medicare. The growth of our aging population (65 years and older) has been significant – from 35 million in 2000, to an estimated 40 million in 2010, and a projected 55 million in 2020 – a 36% increase this coming decade.⁴ How will the nation be able to provide health for its citizens? To quote Helen Darling, President of the National Business Group on Health, during the debate on health care reform, “*We are at a point where it is impossible to do nothing.*”

It is important to examine the five major themes of the PPACA, which include the following:⁵

- *Expanding health care insurance coverage*, including rebuilding the primary care workforce and resources for community health centers
- *Adding new consumer protections and options*, including a ban on denials for pre-existing conditions and banning insurance lifetime dollar limits
- *Making health care more affordable*, including an emphasis on preventive care and the elimination of cost sharing (co-pays and deductibles), closing the “donut hole” for the Medicare Part D prescription drug

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plan, and creating insurance exchanges that include tax credits for small businesses

- *Providing quality improvement measures* including demonstration projects, enhancing continuity and integration of care through medical homes and accountable care organizations (ACOs), and expanding value-based purchasing
- *Investing in prevention and expanding public health programs, policies and incentives*, giving all Americans the opportunity to lead healthier lives

Will the implementation of the PPACA improve our nation's health?

According to The Commonwealth Fund, by 2019, 32 million Americans or 95% of legal residents who are not currently insured, will have insurance.⁶

From a public health and prevention perspective, the 2010 PPACA's intent is to improve the health of our nation. In their summary article in the *New England Journal of Medicine* last fall, Health and Human Services Secretary Kathleen Sebelius and Assistant Secretary for Health Howard Koh summarized the numerous prevention components of the PPACA.⁷ "Many of the major titles in the law ... advance a prevention theme ...

As a result, we believe the act will reinvigorate public health on behalf of individuals, worksites, community, and the nation at large ..."⁷ Some examples include:

- Creation of a national prevention and public health fund
- Promotion of evidence-based clinical and community preventive services and removal of economic barriers to obtain those services
- Improvement of health care in medically underserved areas through the use of community health workers
- Development of community projects to reduce childhood obesity;
- Establishment of a national Diabetes Prevention and Care program targeting those at high risk
- Provision of incentives to increase the number of students choosing health care and public health as career choices, including loan repayments and scholarships
- Training of mid-career public health and allied health professionals and fellowship

- training in such areas as epidemiology, informatics, lab sciences, etc.

Will these preventive measures safeguard the public's health? Some argue that while improving state and local capacity, the changes may not be transformative enough to respond to public needs.⁸ Will these and other future cost-saving prevention provisions of the PPACA improve health and reduce costs? The jury is still out on that question. Although many view these preventive measures as contributing to the improvement of our nation's health, whether they will reduce health care costs given the uncertainties of the cost-saving efficacy of prevention and the inertia associated with individual decisions concerning prevention is uncertain.⁹

A fundamental question that has been raised throughout history since the inception of the Social Security Act in the 1930s is, "should access to health care and opportunities for good health be a *right or a privilege*?" The vast majority of the world's nations have defined health as a right of its citizenry. The 2010 PPACA has attempted, to some degree, to address that fundamental question. The answer may be determined over the next decade.

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Johnson & Johnson Health Care Systems Collaborates With JSPH on Surgical Safety Resource

The Safe Surgery Initiative is an online resource developed to help educate patients about ways they can reduce their risk of surgical site infections (SSI), a major source of postoperative illness. Developed for use by providers, health plans and employers, this resource offers ready-to-use materials in English and Spanish that can be customized with the organization's logo. The resource also includes clinician educational tools for clinicians regarding best practices.

For more information, or to access this resource, visit www.safesurgeryinitiative.com

AMSA's 3rd Annual Patient Safety and Quality Leadership Institute

Future leaders of healthcare quality and safety gathered at the Thomas Jefferson University campus on January 14, 2011 for the Third Annual Patient Safety and Quality Leadership Institute (PSQLI), a three-day leadership development program sponsored by the American Medical Student Association. This is Jefferson School of Population Health's (JSPH) second time as the academic anchor and host for this innovative program. The purpose of the PSQLI is to create a student-driven national forum to educate students on patient safety and quality improvement and, through a train-the-trainer approach, develop leaders of quality who will return to local institutions as change agents and peer-educators. The dynamic curriculum employs didactics, simulation, case-based learning, and facilitated small-group sessions. Participants apply with a proposed quality improvement or curricular development project, and develop and refine their project over the course of the program, with plans to implement the project at their school or teaching hospital. National experts in healthcare, medical education, patient safety, and healthcare improvement participated in the discussion including (Table 1).

The PSQLI is a direct response to the National Patient Safety Foundation report, *Unmet Needs*:

Teaching Physicians to Provide Safe Patient Care, which was developed by a roundtable gathering of stakeholders in medical education and patient safety and released in early 2010¹. The report addresses the inadequacy of medical schools and teaching hospitals in facilitating a basic knowledge of patient safety tenets and helping students develop skills needed to deliver safe patient care. As of 2008, only 10.4% of US medical degree-granting schools reported any patient safety curricula.² Interestingly, out of the reported curricula, a majority provide only one lecture during the entire four years of schooling, according to Dr. Ginzburg. Various sessions of the PSQLI targeted recommendations of the *Unmet Needs* report, including four main domains of quality and safety: (1) role of education, (2) science of quality improvement and patient safety, (3) systems design, and (4) project development. Many of the students are leveraging the *Unmet Needs* report to steer changes at their institutions, through the creation of electives or pathways, longitudinal integration of quality and safety into core curricula, and clinical quality improvement interventions.

This year, AMSA and JSPH teamed up with the Institute for Healthcare Improvement (IHI) to open the previously medical student-focused

Table 1 - PSQLI Faculty

David B. Nash MD, MBA Dean, JSPH

David E. Longnecker, MD, Director of Health Care Affairs at the Association of American Medical Colleges

Richard Shannon, MD, Chair of Internal Medicine at University of Pennsylvania

Jennifer Myers, MD, Patient Safety Officer at the Hospital of the University of Pennsylvania

Samara Ginzburg, MD, Assistant Dean for Medical Education at Hofstra North Shore – LIJ School of Medicine.

Baber Ghauri, MD, Medical Director, Simulation Medicine; Patient Safety Officer, Abington Memorial Hospital

Katherine Berg, MD, MPH, Associate Professor of Medicine; Co-Director, University Skills and Simulation Center (USSC), TJU.

Dale Berg, MD, Professor of Medicine, Co-Director, UCSSC, TJU

John J. Duffy, RN, MSN, CCRN, Assistant Professor, JSHP

Peter M. Fleischut, MD, Department of Anesthesiology, NY Presbyterian Hospital-Weill Cornell Medical College

Lee Ann Riesenber, PhD, RN, Director, Medical Education & Outcomes, Christiana Care Health System

Rangari Ramanugam, PhD, Associate Professor, Owen Graduate School of Management, Vanderbilt University

Michael Appel, MD, North American Safety Education Group



Back row (left to right): Aaron Sin, Mark Royo, Caleb Cheng, Bjørn Bakke, Mohammad Ali Khoshnevisan, Anthony Gifuni, Joshua Weinstock, John Brockman, Jo Inge Myhre, Boris Rozenfeld

Front row (left to right): Alexis Skoufalos, Valerie Pracilio, Reshman Ramachandran, Heidi Charvet, Aliye Runyan, Jamie Davies, Alyssa Sadowski, David B. Nash, Marina Zeltser, Minda Aguhob, Leah Marcotte, Kavita Patel, Jennifer Noble, Sara Omar, Natasha Sharda

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Matt Lewis, of the Leading Change Group, speaks to PSQLI attendees at the Celebrating Improvement Leadership reception co-sponsored by the IHI Open School.

program to all health professions. Through its monumental campaigns and networks, the Institute for Healthcare Improvement has been a key driver of quality improvement in the United States. The organization recently formed a student division, the IHI Open School, and has established Open School chapters of health profession students in over 40 countries. The collaboration between PSQLI and IHI has allowed the program to reach a wider audience of students from all health professions, to foster the inter-professional teamwork that is at the core of patient safety.

This year's institute attracted over 40 participants nationally and internationally, with varied backgrounds that included medical, pre-medical, pharmacy, nursing, public health, healthcare management, and residents. This is double the number of students that were in

attendance the previous year. Over its three year history, the PSQLI has graduated over 90 students, representing forty-five schools, twenty-two states, and five countries.

A unique component of the program is that participants were able to engage in simulation training at Jefferson's state-of-the-art simulation facility. This was made possible through the joint efforts of Drs. Dale and Katherine Berg, Co-directors of the University Clinical Skills and Simulation Center at Jefferson and Baber Ghauri, MD, Medical Director of Simulation Training at Abington Memorial Hospital. Simulation in healthcare has traditionally focused on teaching procedural skills such as venipuncture, intubation, and the physical exam, among others. More recently, however, the use of simulation to teach teamwork, situational awareness, and communication

and interpersonal skills is gaining momentum. Coming from the opposite sides of the simulation training spectrum, Drs. Dale and Katherine Berg and Dr. Ghauri collaborated together to use state-of-the-art simulation equipment and technology to highlight the importance and utility of team training in improving patient care. Following the simulation scenario, the three faculty members engaged the participants in a debriefing session to discuss successes and failures of communication and developed solutions for breakdowns in team dynamics.

At the completion of the program, many participants departed with a sense of urgency and excitement to return to their respective institutions and become agents of change. For one of the participants, the institute "refined [his] perspective and had given [him] a better direction," and for another, the weekend was "simply the most encouraging experience of [his] medical school adventure." Many participants believe this program has affected their career choices. One student reported, "it has made patient safety a priority, which is something that isn't emphasized" and another commented that "I am more sure now than ever that this is what I want to do." The program coordinators are reviewing participant feedback in an effort to improve the program for yet the next PSQLI in the 2011-2012 academic year. ■

If you are interested in participating as a student, faculty member, or program coordinator in the future, please contact Marina Zeltser at zeltser.marina@gmail.com.

Boris Rozenfeld

4th Year Medical Student, Drexel University College of Medicine

Marina Zeltser

4th Year Medical Student, Robert Wood Johnson Medical School

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Pitfalls and Problems Abound: A medical student shares a family experience with the health care system

“Man, that doctor was an ass!” my mom shouted as he walked out the door. He didn’t even bother explaining what was going on with grandma. At this point, we have been at my grandmother’s bedside for twenty days. She was originally admitted for pneumonia.

Our job as the medically savvy members of the family was to sit in the hospital waiting for doctors to come by to receive the latest update. But this task became insurmountable when we discovered that each doctor who walked in the door was saying something different. Each had a different concern and priority for my grandmother’s ailment. One would say it’s her failing liver, the other would say that her breathing is still the biggest problem; the next would say that she was perfectly fine and would be sent home soon.

She was transferred four times to different rooms. Her IV was supposed to be changed but, amidst her transfers, it never got done. The next day that we visited my grandmother she appeared confused. It turned out that there was a mix-up on her order for lactulose and she had not been given it for 3 days. The following day my grandmother was left in her rehabilitation chair for an hour and a half, screaming and writhing in pain, because her patient alert was left on the floor where she couldn’t reach it. She had been bedridden for 3 weeks and, at that point, severe atrophy had set in. The therapist, rushing

from room to room, left her in an overstretched position and didn’t return. My mom walked into the room to the sight of her 71-year-old mother screaming in pain.

The list of system failures was endless throughout this 4-week experience. The suffering caused by misdiagnoses, lack of communication, and inefficiencies almost cost my grandmother her life. This happened recently, at a prominent hospital in New York. But it is not a unique story. It is happening everywhere, every day in America.

As a fourth year medical student I have studied patient safety and quality improvement, and was helpless to prevent most of these inefficiencies. Even with an intimate understanding of the interworking elements of our health care system, my complaints were mildly answered, my concerns disregarded, and my frustrations were not acknowledged. We have a long way to go before we address these issues that cost lives, decrease trust, and create a culture of neglect. As medical students, we are observers of various health care systems. We go from one hospital to the next, only staying long enough to understand it and then move on. We see some processes that work great and some that are appalling.

How can we stand by as students, family members, and health care professionals and watch our patients be subjected to such a system of inadequacy? It becomes a moral imperative

for us to act! We are in prime position to call out our medical institutions for supporting such movements but not acting on them in the classroom. Our medical education system isn’t creating a culture of patient safety and systems change; it’s currently maintaining course of a hubris profession with a gilded façade of patient care.

The cries from our patients agonizing due to our system’s inadequacies can no longer be met with a deaf ear. We need to own up to our archaic customs and move forward, acknowledging our patients’ dire need for health care delivery redesign. We need to create opportunities for others to hear and see the impact of our failed system, and recognize the feasibility of the way forward and our responsibility for due diligence. We need to amplify the voices of our suffering patients. When we are taking our board exams we need to be confronted by a failing system. During our daily case studies we need to see how system failure leads to death. We need to bring back that impassioned image that brought us through the doors of our profession, and allow it to express itself by saving lives in a whole new way. ■

Sadly, Cole’s grandmother recently passed away.

Cole Zanetti

*4th year student at Texas College of Osteopathic Medicine
AMSA Patient Safety and Quality Leadership Institute Attendee*

The Jefferson Scale of Empathy (JSE): An Update

Empathy is an essential component of the physician-patient relationship that is linked to positive clinical outcomes.¹ A decade ago, we developed the Jefferson Scale of Empathy (JSE) in response to a need for a psychometrically sound instrument to measure empathy in the context of medical education and patient care.²

Three versions of the JSE are available for administration to 1) physicians and other health providers, 2) medical students, and 3) students in the health professions other than medicine.

The three versions are similar in content, with slight modifications in wording of some of the items to maintain face/content validity for the target populations. Other researchers have consulted with us and modified the scale for administration to groups such as pediatric nurses, psychotherapists, clinical social workers, counselors, dentists, veterinarians, ministers/priests, and leaders/supervisors.

The JSE has received substantial national and international attention. To date, we have received

658 inquiries about the JSE from researchers in the United States and abroad. The JSE has been translated into 38 languages and used in 54 countries worldwide including in Europe, Middle East, Africa, Asia, North America, South America, and Australia and New Zealand.

In several current studies at academic medical centers, the JSE is used as the major research instrument. For example, researchers at the Cleveland Clinic are examining the short- and long-term effects of narrative skills training on

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JSE scores in staff physicians (funded by the American Board of Internal Medicine). Another study at the Cleveland Clinic examines the development of empathy during osteopathic medical education (funded by the American Osteopathic Association). The American Medical Association sponsored a longitudinal study with 14 medical schools (as part of the Innovative Strategies for Transforming the Education of Physicians), to examine relationships between the medical education learning environment and JSE scores. With the collaboration of the Parma (Italy) Health Authority, 240 primary care physicians with over 280,000 adult patients have completed the JSE to study the relationship between empathy and patient compliance. (This is an ongoing study, not currently published.)

Selected highlights of published findings:

- **Gender** – Women scored significantly higher than men on the JSE in medical school, residency, and practice.
- **Clinical Competence** – High scorers on the JSE received higher global ratings of clinical competence in six third-year core clerkships.
- **Long-Term Predictive Validity** – Scores on the JSE in third year of medical school can help predict residency program directors' ratings of empathic skills three years later (at the completion of the first residency year).
- **Specialty Choice** – Medical students and physicians who scored higher on the JSE were more likely to choose “people-oriented” specialties (e.g., primary care, psychiatry) than “technology/procedure-oriented” specialties (e.g., hospital-based specialties such as anesthesiology, pathology, and radiology, and surgery/surgical subspecialties).
- **Peer Nomination** – Third-year medical students who scored higher on the JSE were

more likely than low scorers to be nominated by their classmates on professionalism attributes.

- **Empathy and Objective Structured Clinical Examination (OSCE)** – Scores of the JSE were significantly associated with simulated patients' ratings of students' empathy in OSCE stations.³
- **Decline in Empathy** – Scores of the JSE decline in the third year of medical school, and in nursing students who were exposed to patient care.⁴
- **Preventing Decline in Empathy** – Shadowing patients by emergency medicine residents in emergency room for a short period of time prevented decline in empathy among participating residents.
- **Enhancement of Empathy** – We observed a significant increase in the mean scores of the JSE as a result of participation in a workshop in which medical and pharmacy students (at Midwestern University) watched a variation of the “Aging Game” (unpublished, study in progress).
- **Empathy Versus Sympathy** – Empathic and sympathetic orientations toward patient care are two different measurable entities. This differentiation is important because empathy (defined as predominantly a cognitive attribute), and sympathy (as an affective entity) have different consequences in patient care.^{2,4}
- **Patient Perceptions** – Scores of the JSE were associated with patients' perceptions of physician empathy among family medicine residents.
- **Patient Outcomes** – Family medicine physicians who scored higher on the JSE were more likely than their lower scoring colleagues to have good outcomes among their patients with diabetes.¹

Our empathy studies have been frequently cited in professional publications; Jefferson Medical College is now considered the headquarters for research on empathy in the health professions education and practice.

As the country moves to implement health system reforms aimed at improving quality of care while controlling costs, we believe that our studies of empathy have important implications for medical education and patient care. The availability of the JSE has provided the opportunity to examine clinical outcomes and other correlates of empathy in medical education and the practice of medicine. ■

Mohammadreza Hojat, PhD
Daniel Z. Louis, MS
Kaye Maxwell, BS
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Center for Research in Medical Education and Health Care

Readers of the *Health Policy Newsletter* who would like to include the JSE in their research or quality improvement activities are encouraged to contact Kaye Maxwell at: kaye.maxwell@jefferson.edu.

A complete list of 25 publications describing the development, psychometrics, and applications of the JSE is available from the authors.

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8th Annual Interclerkship Day: Improving Patient Safety

January 3, 2011

The 8th Annual Interclerkship Day on Improving Patient Safety was a unique opportunity for Jefferson Medical College's (JMC) 3rd year students to increase their awareness about medical error and patient safety, while benefiting from lessons learned from the aviation model of crew resource management and its application to medicine. The program was moderated by David B. Nash, MD, MBA, Dean of the Jefferson School of Population Health (JSPH), and sponsored by the Office of the Dean of JMC and JSPH.

John J. Nance, JD is an internationally known aviation expert who served as the keynote speaker. Nance is a founding board member of the National Patient Safety Foundation; a former airline pilot; and an ABC News broadcast analyst on aviation. He presented convincing evidence demonstrating how medicine can use crew resource management (CRM) principles from the airline industry to improve patient safety and increase professionalism. He discussed the importance of communication and the creation of an environment and culture that allows the most junior team member to participate and speak up if something is amiss. Ideally, this type of environment will foster a team and a culture

where all team members are committed to improving patient safety.

The application of CRM via medical simulation was presented by Kenneth J. Abrams, MD, MBA, Senior VP of Clinical Operations and Chief Quality Officer at New York's North Shore Long Island Jewish Health System (NSLIJ). Dr. Abrams shared training scenarios that replicate situations in multiple medical environments, including a critical care unit, emergency department, and operating room. At NSLIJ, residency teams battle in Sim Wars, a patient simulation competition that reinforces teamwork and positive clinical outcomes.

Geno Merli, MD, FACP, Senior VP and Chief Medical Officer of Thomas Jefferson University Hospital (TJUH), provided an intriguing luncheon presentation on various quality and safety initiatives underway at TJUH. The major areas of focus he discussed included readmissions, medical safety and infection control where he outlined improvements made over time. The students had the opportunity to hear firsthand, the perspective of a CMO and gain greater insight into the role and its responsibilities.

Valerie D. Weber, MD, Chair of Clinical Services at The Commonwealth Medical College, used case studies to explore patient safety issues and solutions through leadership strategies. Supporting the theme of the day, she stressed the characteristics and skills needed to become a leader in quality and safety and encouraged the students to take an active role early on their professional journey.

The day concluded with a lively and interactive session on the importance of skillful communication in challenging scenarios. Jason Baxter, MD, MSCP, Assistant Professor in the Division of Maternal-Fetal Medicine at Jefferson, set the stage for students to see and experience methods for delivering bad news to patients and families. He helped to characterize the elements of a successful encounter with patients and families through the use of case scenarios, and student involvement in role-plays. The audience observed important skills, actions, language, and non-verbal cues which enhance the provider-patient encounter and lead to patient satisfaction. ■

School of Population Health to Host Summer Global Health Academy @ Jefferson

Registration Deadline: 4/22/2011

Our world is small. And it's getting smaller. We are all connected in some way: the Internet, travel, trade, politics, commerce, banking, the environment. Our personal health and the health of populations worldwide are all affected by globalization.

The Global Health Academy, an initiative of the Jefferson School of Population Health, is an intensive summer education program designed specifically for high school students interested in international affairs who wish to explore this field at the global level through the perspective of population health.

Students in the Global Health Academy @ Jefferson will participate in an in-depth exploration of major challenges to global health – infectious diseases, natural disasters, water shortages – and the international resources, agencies and technologies that respond to them. They will also investigate the social, political, economic, scientific and ethical aspects of these challenges. Each day will provide discussion and interaction with global health experts, and hands-on activities and field trips. Students will be introduced to volunteer opportunities and career options in the field that align with their own academic and personal interests. ■

The program runs from June 27 to July 22, 2011.

The application deadline is April 22, 2011.

Application fee: \$25

Program fee: \$1,600

For further information call: (215) 503-0174 or visit: http://www.jefferson.edu/population_health/gha.cfm

The Use of Archival Data to Inform Health Policy

This article provides an introductory overview of the origins, benefits, and applications of archival data for informing health policy.

In contrast to investigation that relies on data collected for a specific research project, scientific inquiry using archival data relies upon data that have already been collected. Researchers may seek the archival data that best fit their research question, adapt their research question to the data they have on hand, or choose to combine both methods.¹ However, aligning the relevant research question and the available data often poses a challenge.

Archival data collected as part of *longitudinal research studies* has been used to inform health policy. For instance, decades of information collected from participants in the classic Framingham Heart Study (1948) provided a wealth of information that has been made available to researchers through archived sources.² More recently, Christakis and Fowler analyzed longitudinal data collected as part of the Framingham Study to describe the increase in rates of obesity among large social networks.³ Following in part from the contributions of Christakis and Fowler, there are empirically supported recommendations for developing effective programs aimed at using social networks to reduce the obesity epidemic.⁴

Analyses of archival data from *cross-sectional studies* have also been used to inform health policy. Cross-sectional data are derived from the study of groups of individuals at the same point in time. Ellaway, Macintyre, and Bonnefoy conducted secondary analyses of the Large Analysis and Review of European Housing and Health Status (LARES) Survey,

an international cross-sectional survey administered in Europe.⁵ In part, their results provided empirical support that environmental factors, such as green space, should be included in health policies aimed at promoting physical activity to decrease rates of obesity.

Efforts to store and make available archival data for research also extend to *administrative data*, i.e., pieces of information collected as part of the routine operations of a business or agency. In 1998, The University of Pennsylvania established the *Neighborhood Information System (NIS)*, which makes available in one central repository a vast amount of information routinely gathered for operational or business purposes by public or private agencies. Hillier and colleagues have analyzed these data from multiple administrative sources to inform public policy initiatives regarding housing abandonment in large urban cities such as Philadelphia, PA.⁶

Administrative medical claims data are often used to compare outcomes of interventions. For example, they may be analyzed to determine cost effectiveness, differences in the intensity of care among different patient populations, or both.

Recently, the Einstein Center for Urban Health Policy and Research analyzed inpatient data from persons with diabetes mellitus to better understand the percent of admissions associated with diabetes, and the most common complications in this patient population. This information may be useful in planning the allocation of hospital services and in directing programs aimed at reducing medical complications. Importantly, this

information is readily available for analysis and offers comparable or better rates of follow up without the resource demands of primary data collection.^{7,8} One caveat – the reliability of these data appears to decrease for elements that less directly relate to the primary purpose of the data collection. For instance, the reliability of secondary diagnoses may be lower than for primary diagnoses.⁷

Despite the challenges described above, analysis of archival data from administrative sources has substantial benefits. Typically gathered through processes that present no more than minimal risk to participants, these data may provide information about vulnerable populations such as prisoners, the elderly, and children – information that can be particularly difficult to obtain elsewhere.

Dialog among researchers and policymakers in conjunction with advancements in technology, such as the Internet and personal computers, during the last several decades have coincided with increased accessibility and variety in archival data. Archival data analyses offer significant ethical and feasibility benefits. Results from these studies are directly applicable to illuminating the most prominent health policy issues; developing effective public health interventions; and developing administrative policies related specific health issues.

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Research Analyst

Einstein Center for Urban Health Policy and Research

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New Global Health Fellowship Links Jefferson and Sierra Leone

Sierra Leone, located in West Africa, is still recovering from the devastating repercussions of a civil war that ended in 2002. It is one of the poorest countries in the world, and ranks near the very bottom of the United Nations Development Index. The health care system is fragile at best, and Sierra Leone's population health statistics are grim. Average life expectancy at birth is 39 years for males and 42 for females;¹ one in 8 women die from giving birth;² and the under-five mortality rate is the worst in the world.³ The country's total expenditure on health is only 3.5% of GDP.⁴

For several years the Department of Emergency Medicine (DEM) at Thomas Jefferson University & Hospitals has been building collaborations with physicians and institutions worldwide. Emergency Medicine lends itself to such global work due to its flexible shift schedules, a clinical foundation that is broad, and an understanding of the issues that surround the hospital and healthcare system as a whole. As part of the department's long-term growth strategy, we felt that it was important to develop international projects that faculty, residents and other staff could participate in. However, our belief is that sustainable development cannot be achieved in isolation from work in only one specialty or discipline. Sustainable development requires improvements in local governing structures, in financing, and in education. Hence, we decided to focus on the broader field of global health. The goal of all our department's global health initiatives is broad-based, collaborative development with an emphasis on education and long-term goals.

We developed ties with Global Action Foundation (GAF), a US-based non-governmental organization with a local partner, Wellbody, in Sierra Leone. Dr. Bailor Barrie, a

Sierra Leonean physician and co-founder of GAF, visited Jefferson in April 2010; in turn, we visited Sierra Leone in October 2010. With assistance from Dr. Barrie, we conducted a preliminary survey of the local healthcare infrastructure and capacity. We also spent time teaching ultrasound and other clinical skills at a clinic he established in the Kono District (the setting for the movie *Blood Diamond*). Originally founded to serve amputee victims from the war, it now serves as a general clinic and urgent care center for the region. One of our most alarming observations of the health care system was the absence of an adequate healthcare workforce. The physician shortage is severe, with only 1 doctor per 50,000 people. If you were to imagine this statistic applied to Philadelphia, there would only be 29 physicians to serve the city's entire population.

Our growing work in Sierra Leone provided the impetus for establishing the first post-residency Global Health Fellowship program for physicians in Philadelphia, beginning July 2011. The program is a joint effort between the Department of Emergency Medicine and the School of Population Health. In addition to pursuing a Master of Public Health (MPH) degree, the Fellow will be placed in Sierra Leone for field training, where s/he will conduct ethnographic public health investigations within the Kono District. Additionally, DEM faculty will seek to work with local hospitals and the medical school in Sierra Leone to improve the quality of healthcare and mechanisms for healthcare delivery in Sierra Leone. The goal of the fellowship is to supplement the existing broad clinical skill-set of emergency medicine physicians with a knowledge and understanding of key issues and challenges in global health development. The program will focus on an interdisciplinary

and systems-based approach to healthcare development that includes consideration of economic, political, cultural and social issues, providing the Fellow with a broad set of skills that can be used in the future to work in the field at a micro or macro level.

One cannot ignore the clear benefits of such a project and training program to both the Jefferson community and to the people of Sierra Leone. Locally at Jefferson, the presence of a Global Health Fellowship increases collaboration between departments (DEM and the Dept. of Family & Community Medicine's Center for Refugee Health) and schools (the Medical College and the School of Population Health), while also providing a strong academic impetus to advance the development of the field of global health. For Sierra Leone, our program will focus on developing local capacity, while providing guidance for improving local systems. No longer will it be about patients waiting six months for the next "Western" doctor to show up in town, but about increasing their confidence in their own healthcare providers and providing improved care to all patients. ■

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Health Policy Forums

Transformative Technology Applications in Healthcare

Peter Raymond

*Founder and Chief Innovator
Human Condition*

December 8, 2010

The fall season of the Health Policy Forums concluded with a stimulating look at technology in health care and stretched our imaginations to the fullest. Our future-focused speaker, Peter Raymond, provided Forum participants with an overview of Human Condition's health care-related solutions. Human Condition is an innovative company committed to improving health care and educational experiences through the development of emerging technologies and communication toolsets.

Mr. Raymond's perspective and philosophy of technology is very practical and population health-oriented. He believes in a plethora of possibilities and examines how technologies may interact with various spaces, organizations, companies, and industries. Simply put, Raymond believes "anything is possible." He described recent trends in technology and emphasized the uptick in "applications" as the primary trend. He believes we have the capacity to build better applications, improve packaging, and use tools together more effectively.

The designer of the world's first fully immersive heart simulator, Raymond humbly described how simulation technology can serve to help clinicians

as well as patients. Heart failure is difficult to diagnose in its early stages, and the design of the simulator helps cardiologists distinguish the disease at different stages and classes of heart failure. The simulator not only helps to increase the likelihood of an earlier diagnosis, it provides the clinician with a better understanding of and empathy for the patient's experiences. It is important to mention that the venue for this simulator is a pod (*HeartFXpod*) which in its most expansive format has been a 5 pod traveling exhibit.

Human Condition has also designed simulators for Multiple Sclerosis (MS) and Restless Leg Syndrome (RLS). The MS simulator has been used by a variety of clinicians and patients to better grasp the sensation of losing balance. The RLS simulator is actually a custom-made sensory boot created to give clinicians a first-hand experience with the varying range of symptoms associated with RLS.

Another important product of Human Condition is the Walk-Up Medical Clinic, a modular state-of-the-art clinic that can be deployed in airports, grocery stores, and pharmacies. Currently in trials in 5 states, this ADA and HIPAA-compliant

clinic is fully equipped with registration systems, digital communications, and secure temperature-controlled storage.

The reader at this point may wonder, when does Peter Raymond sleep? The work of Raymond and the Human Condition does not have an end point. With the help of a video presentation, Raymond went on to discuss *Clinics Rising*, a project about which he feels quite passionate. *Clinics Rising* is a multimedia project designed to reveal the complexities of current global health issues through firsthand narratives of patients and providers. The first program of *Clinics Rising* focused on the various health care challenges and socio-environmental dynamics in northern Rwanda.

Forum participants walked away from this presentation inspired and energized to ponder new ideas as they look to the future. ■

For more information on Human Condition visit: <http://www.hcxdesign.com/>

To learn more about Clinics Rising visit: <http://www.hcxdesign.com/clinics-rising/>

Public Health Law Research: Making the Case for Laws to Improve Health

Scott Burris, JD

*Professor of Law, Temple University Beasley School of Law
Director, Center for Health Law, Policy and Practice*

February 9, 2011

An eager standing room-only audience filled the space at February's Health Policy Forum to listen to Scott Burris, JD, Professor of Law at Temple University. Mr. Burris is the Director of the Center for Law, Policy, and Practice at Temple and Director of the Public Health Law Research program of the Robert Wood Johnson Foundation. Public Health Law Research (PHLR) is a five-year initiative aimed at promoting regulatory, legal, and policy solutions to improve public health nation-wide. Focused on expanding the field of public health law research, PHLR funds studies that provide evidence about how law can be used to improve population health.

PHLR is making evidence more accessible to policy-makers and the public.

Mr. Burris is well known for his work in HIV policy, and his forum presentation drew upon that expertise to provide a historical frame of reference to the arena of law, policy, and public health. Reflecting back to the earlier time period of the HIV epidemic, reporting requirements were a big topic of discussion, even prior to the widespread availability of HIV testing. Although law was identified as a possible influence on HIV testing in 1983, the first serious studies on its influence occurred in 1995. Similarly, laws related

to injection drug users and the availability of needle exchange programs raised complex issues, and were not researched rigorously until 1995.

Mr. Burris describes public health law research as, "the scientific study of the relation of law and legal practices to population health."¹ Mr. Burris discussed the different categories or fields within public health law research: interventional law, infrastructure law, and incidental law. Interventional laws are laws that intend to influence health outcomes or mediators (e.g., smoking bans). Infrastructural laws are laws that establish the

powers, duties, and structure of public health agencies (e.g., state and local infrastructure laws that affect population health outcomes). Incidental laws are laws that originally may have been adopted for reasons unrelated to public health, but ultimately have resulted in an unintended public health impact. The example Mr. Burris referred to was a study that explored land use zones and walkability.

The specifics of research design, data sets, and coding laws were also discussed. Mr. Burris explained some of the challenges involved with conducting this type of research, including the logistics of coding laws across numerous variables.

Burris encouraged the audience to get involved and take advantage of the resources of the Public Health Law Research program. The program offers free

educational tools online, and it recently posted a Call for Proposals for both short- and long-term studies. ■

For more information on the Public Health Law Research program visit: www.phlr.org.

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

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Main Line Health Offers Unique Educational Model for Outreach to Community Youth: The Annenberg High School Science Symposium

Major changes in healthcare affect everything from economics to ethics, and therefore it is more important than ever to expose the next generation to science and medicine. The Annenberg High School Science Symposium is Main Line Health's (MLH) effort to offer high school students an early opportunity to learn about these issues. Started in 2004, when the Annenberg Center for Medical Education at Lankenau Medical Center defined "outreach to the community" as part of its mission, the Annenberg High School Science Symposium was established to inspire the interest of high school students in science, medicine, and healthcare.

In the past seven years, the number of participating schools has grown from four to 15.* The students, representing public and private schools from Philadelphia and the western suburbs, participate in four spring symposia at each of the MLH System's acute care hospitals: Bryn Mawr, Paoli, and Riddle Hospitals and Lankenau Medical Center.

Each year, in late fall, the high school science groups convene to choose their topic of interest. This year's 15 research or discovery topics include bipolar disorder, stem cell research, biotechnological applications in the treatment of diabetes, women in crisis in Sudan and Haiti, endostatin, Alzheimer's disease, robotic surgery, and gastric bypass.

The Annenberg Center staff arranges for a qualified mentor to meet with the student groups to discuss their topics, and to advise them on how to direct the research.

In December, the school groups gather at the Annenberg Conference Center for telecast of a live

surgery. This element is added to whet the students' appetite for science and medicine; it is usually a laparoscopic cholecystectomy performed by Lankenau surgeon Jonathan Gefen, MD. Suzanne Comer, MLH Manager of Academic Affairs and principal organizer of the symposia, explains, "The surgical telecast and the science lecture which precedes it emphasize three educational values fundamentally important for high school students contemplating a career in healthcare. Review of the anatomy and physiology of the bile ducts prior to the telecast demonstrates to the students (1) **the importance of learning basic science in high school**; emphasis on laparoscopic surgery as a recent development in medicine demonstrates (2) **the importance of being 'life long learners'**; and when students recognize the beauty and privilege of looking into another person's body, they gain (3) **an appreciation of the privilege implicit in being a healthcare worker.**"

The culmination of the program occurs in March, when the students go to one of Main Line Health's four acute care hospitals where they present their project to three other high school groups, parents and families. Each presentation must include an element of the creative arts to help explain scientific principles. At the conclusion, the students are questioned by "honorary judges" (Main Line Health- and community-experts in medicine or science), whose questions challenge the students to discuss extemporaneously the social and ethical implications of their projects.

According to its originator and director, Dr. Barry Mann, Chief Academic Officer of MLH, by including a creative component, the Annenberg High School Science Symposium provides a science discovery model that is different from other high school

science competitions. "Whereas other programs pit school against school and reward the knowledge-based performance of individual students," he says, "the Annenberg High School Science Symposium emphasizes *teamwork, collaboration, and creativity* – the true underpinnings of scientific discovery."

Some previous participants, who are now medical students and have returned as honorary judges, provide anecdotal testimony to the program's success. More formal surveys are underway to assess educational and motivational impact.

"This program embodies our commitment at Main Line Health to our community," says Jack Lynch, CEO of Main Line Health. "This investment provides students with an opportunity to have a special learning experience at our institutions in which both the scientific and ethical aspects of healthcare are explored."

* The 15 high schools participating in the Annenberg High School Science Symposium are: Barrack Hebrew Academy, Conestoga, Episcopal Academy, Friends' Central, Garnet Valley, Great Valley, Abraham Lincoln, Lower Merion, Malvern Preparatory, Marple Newtown, Merion Mercy, Penncrest, Radnor, Upper Darby, and George Washington.

Joel Port

*Vice President, Planning and Business Development
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Nan Myers

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Book Review

Nudge: Improving Decisions about Health, Wealth, and Happiness

Richard H. Thaler and Cass R. Sunstein

Penguin Group: New York, originally published in 2008, revised and expanded version 2009

The field of behavioral economics has emerged in recent years as a framework for understanding the choices we make in “actual economic life.”¹ This book examines some of the principles used in behavioral economics to understand and influence behaviors. As the title implies, Nudge is about getting people to act in their own best interests. Depending on one’s view about who decides what is in someone else’s best interest, you may or may not agree with this book. I found it a welcome [and painless] introduction to some of the current thinking around the use of incentives – what the authors call “nudges” – to encourage behaviors aimed at making us healthier, happier, and perhaps even wealthier. There are so many ways in which incentives are currently being tested for use in promoting health and wellbeing² that this book should be of high interest to anyone interested in behavioral change at an individual, community, or population level. The authors use humor throughout the book to address their key points; to show that everyday life provides the best examples of how ‘nudging’ works; and to keep the reader engaged. And it works!

Richard Thaler is Professor of Behavioral Science and Economics and Director of the Center for Decision Research at the University of Chicago, and Cass Sunstein is Professor of Law at Harvard Law School. Together they [playfully] take the reader through examples of how some decisions can be made easier – and, ostensibly, better – by structuring choices. They pose thought-provoking options to improve the current status of areas such as Social Security, organ donation, malpractice insurance, education, and marriage. You don’t need to know a thing about economics or behavioral economics to understand this humorous, but serious book.

The premise of the book – and this is so relevant to those of us working in public health – is that there is evidence that structuring choices can be done in ways that: 1) allow or preserve an individual’s right to choose and 2) can also lead to positive outcomes. They cite many interesting and (some) famous experiments in psychology and the behavioral sciences to illustrate their points. Their lead-off example of ‘nudging’ is to rearrange a school cafeteria so that healthier foods are seen first by students, or are easier to reach than less healthy foods. [Nudging, as they quote a William Safire column in the *New York Times* (October 8, 2000) is “to push mildly or poke gently in the ribs, especially with the elbow; to alert, remind, or mildly warn another.” They contrast it with ‘noodge’ which Safire notes is “a Yiddishism; a noun meaning pest, annoying nag, persistent complainer.” They want to nudge without noodging, though it seems to me that nudging towards change is somewhat more intentionally directed than a gentle poke.]

Three terms that are used through the book are “choice architect,” “Libertarian paternalism” and “default options.” A “choice architect” is someone who has “the responsibility for organizing the context in which people make decisions.” (p.3) Many of us in healthcare, public health, health policy are “choice architects” who design opportunities and test structural changes to promote access to care, improve informed decision making, decrease likelihood of poor treatment choices, etc. Thaler and Sunstein coin the term “Libertarian paternalism” which combines a respect for choice with a desire to influence peoples’ behaviors “in order to make their lives longer, healthier, and better.” (p.5) The term ‘soft paternalism’,³ used in ethics, shares many of those characteristics;

where clinicians endeavor to steer patients towards decisions they think are in their best interest while engaging them in an informed decisionmaking process. The “default option” is what people do in a more or less automatic mode; identifying opportunities to move people from a status quo or “moving the default option” is the strategy used in the nudge to move toward a desired outcome. For example, to improve healthier eating, moving the candy from the check-out line in the supermarket to a back aisle might decrease the “mindless” purchasing of sweets that takes place while waiting for grocery purchases to be rung up.

The main chapters are “Money,” “Health,” and “Freedom.” Other chapters discuss “mininudges” and “bonus nudges” where they describe a number of creative suggestions and projects that use ‘nudging.’ There is even a website, <http://www.nudges.org>, for those interested in submitting their own nudges. The applications to public health and health policy will be apparent to the interested reader. This is a book that provides an accessible introduction to behavioral economics, and their application of concepts borrowed from psychology, marketing, communication, and other disciplines, to better understand how we make decisions and how we might make better ones. ■

Reviewed by Etienne Phipps, PhD

Director, Einstein Center for Urban Health Policy and Research

Albert Einstein Healthcare Network

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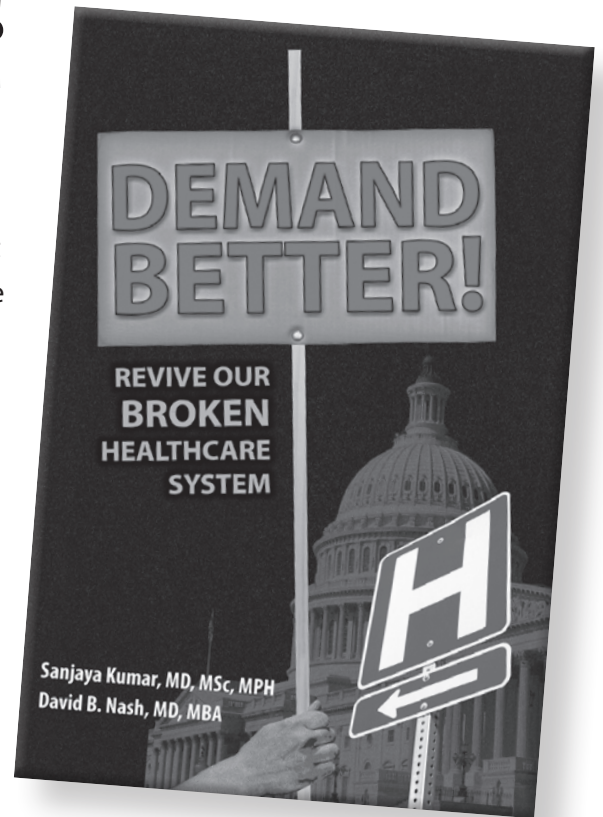
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Much of the healthcare debate is centered on cost - the skyrocketing cost of direct patient care, the cost to insure millions of currently uninsured people, the administrative costs that eat up a large chunk of every healthcare dollar, the cost of defensive medicine to avert malpractice lawsuits. How can it be that we spend more than \$700 billion each year on medical care that fails to improve patients' health and often harms them?

The problems are cultural. We "know," for example, that modern medicine is largely backed up by solid science. We boast that our delivery system is superior because we offer access to more and newer services than any other country. We've focused a great deal on safety improvement over the past decade. Our physicians and hospitals are paid to deliver the right care. Our medical schools are the envy of the world. All of this we know.

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About The Authors



Sanjaya Kumar, MD, MSc, MPH

Sanjaya Kumar, MD, MSc, MPH is Founder, Chief Medical Officer and Chief Technical Officer of Quantros, Inc., a leader in web-based healthcare data management and decision support solutions to further patient safety and quality. Today, more than 2,200 healthcare facilities in the USA use Quantros applications to drive improvements in quality of care delivered, patient safety initiatives and compliance programs. In 1997, he founded

Quantros, Inc. and introduced an automated self-auditing and compliance management tool to the healthcare industry. Solutions for patient quality, safety, risk management and surveillance soon followed.

Dr. Kumar serves on numerous quality improvement committees, task forces and working groups. Dr. Kumar has been widely published in peer reviewed medical journals and is the author of *Fatal Care: Survive in the U.S. Health System*.

Dr. Kumar earned his medical degree at the University of Benin and received postgraduate medical training in the UK. Dr. Kumar received a Master of Science degree in Health Planning and Financing from the London School of Economics and Political Science. Dr. Kumar also earned a MPH in Epidemiology from the University of Massachusetts.



David B. Nash, MD, MBA

David B. Nash, MD, MBA is the Founding Dean of the Jefferson School of Population Health on the campus of Thomas Jefferson University in Philadelphia.

Dr. Nash is a board certified internist who is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement.

He is a consultant in both the public and private sectors. In December 2009, he was named to the Board of Directors for Humana Inc., one of the largest publicly traded health and supplemental benefits companies. He recently was appointed to the Board of Main Line Health – a four hospital system in suburban Philadelphia, PA.

Dr. Nash received his BA in economics (Phi Beta Kappa) from Vassar College; his MD from the University of Rochester School of Medicine and his MBA in Health Administration (with honors) from the Wharton School, where he was a former Robert Wood Johnson Foundation Clinical Scholar.



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