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GUEST EDITORIAL

The 2011 ACGME Program Requirements: A New Model for Quality and Safety

On June 23, 2010, the Accreditation Council for Graduate Medical Education (ACGME) posted on its web site new program requirements for residency training in the United States.[1] These guidelines were highly anticipated by the academic medical community since they contained the duty hour regulations that would likely frame the work schedules of house staff for the next decade. This expectancy was heightened by the release in 2008 of the Institute of Medicine (IOM) Report – "Resident Duty Hours: Enhancing Sleep, Supervision and Safety."[2] This report raised concerns that the ACGME 2003 duty hour regulations did not go far enough to ensure the safety of patients and residents. Specifically, the IOM identified research models that found safety gains from more restrictive shift lengths, and highlighted other industries that have aggressively regulated hours at work and at rest.

The recommendations of the IOM were met with cynicism focused on the economic costs of such restrictive schedules and the potential negative impact on training as residents spent less time in clinical settings and more time off duty. Many were also concerned that a decrease in shift length meant a necessary increase in patient "handovers" or "sign-outs" that might have a negative effect on patient safety.

The new ACGME guidelines will go into effect on July 1, 2011. Specific changes to resident duty hours affect all years of post-graduate training. The 2003 requirements allowed for shifts of 24 hours plus an additional 6 hours for educational activities and patient sign-out. This effectively resulted in residents at all levels working for periods up to 30 consecutive hours. The new guidelines are more restrictive and are differentiated for level of training. For PGY-I residents (interns), duty periods may no longer exceed 16 total hours. For PGY-II residents and above, the new limit is 24 total hours, and it is strongly suggested that this time period include opportunity for "strategic napping" between the hours of 10 pm and 8 am. These upper-level residents will now be allowed only an additional 4 hours for patient transitions, instead of the 6 hours in the previous iteration of the duty hour requirements. Time off between duty periods is also stipulated by the ACGME requirements. Similar to the earlier regulations, residents must have at least 8 hours off between work periods, and "should have 10 hours off." A new component stipulates that these work-free intervals must be greater than 14 hours for upper year residents following any 24-hour shift. The total limit of 80 hours per week is similar to the 2003 regulations. A new caveat requires all moonlighting activities of residents to be counted against this limit. This stipulation addressed a frequent concern that sleep deprivation of residents was also influenced by activities some individuals pursued outside of

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their appointed training programs. Other work rules have remained stable between the two sets of regulations; these include the requirements for call no more frequently than every third night and one day free from duty each week.

While the duty hour requirements have generated the most attention, it is important not to lose sight of several other new stipulations that are intended to improve the safety of patient care in a training environment. To best understand their impact, I believe one should re-examine the death of Libby Zion.[3] Ms. Zion's case is perhaps the best publicized example of an adverse clinical advent, and undoubtedly one of the most important events in the timeline of the examined interface between graduate medical education and patient safety.

In 1984, Ms. Zion presented to the emergency room of a large teaching hospital in New York. Her initial complaints included a fever, agitation and abnormal limb movements. She was noted to be taking phenelzine, a monoamine oxidase inhibitor, for treatment of depression. She was evaluated by both a PGY-I and PGY-II resident in the emergency room, who discussed their findings with the attending physician by phone. She was given the admission diagnosis of "viral syndrome with hysterical symptoms." To alleviate her shaking, the residents prescribed meperidine, a narcotic frequently used for its alleviating effect on rigors typically associated with a fever. The intern and resident left her bedside at about 3am. The intern proceeded to provide care for some of the other 40 patients she was responsible for, and the resident went to sleep in a call room. When Ms. Zion became even more agitated, hospital staff called the intern twice. Following one call, the nurses were given an order to restrain the patient. Subsequently, the intern placed a new verbal order to administer haloperidol, a potent neuroleptic intended to sedate Ms. Zion. At no point did either house officer return to her bedside to directly re-evaluate her. At 6:30 am, her temperature was found to be 107° F. Despite emergency cooling measures, she suffered a cardiac arrest, and could not be resuscitated.

In retrospect, it is evident that several points in the care of Ms. Zion were problematic. These include medication choices that created drug-drug interactions, erroneous judgments about her presenting diagnosis, and the inability of the residents to return to see her as she developed complications. As an educator and administrator, I would ask different questions. Do we believe that a PGY-I in 1984, without modern decision support tools, would reliably recognize drug-drug interactions? What factors prevented the residents from returning to re-evaluate the patient? Why was the supervising attending not called when the patient's status was obviously deteriorating? Most importantly, how much of a role did fatigue really play in this scenario? In other words, would transferring this patient's care to a well rested resident have resulted in a different outcome? I believe that the answer to the final question is definitively "no." Thus, it is important to acknowledge the new safety initiatives mandated by the ACGME, as they are likely to fill important safety gaps beyond those created by physician fatigue.

The first of these initiatives is outlined within the physician core competencies as a domain within the category of "Systems-Based Practice."[1] Here it is stipulated that residents "must systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement."[1] This competency statement further dictates that residents "work in interprofessional teams to enhance patient safety and improve patient care quality" and also that they "participate in identifying system errors and implementing potential systems solutions." Later, within the newly re-named competency of "Professionalism, Personal Responsibility, and Patient Safety," this is again emphasized. Here it is stated that the program director must ensure that residents are "integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs." Finally, the ACGME adds "Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the monitoring of their patient care performance improvement indicators."

As a set, these requirements will ensure that residency programs go further to involve residents and faculty in safety and quality efforts. The current ACGME requirements are easily satisfied with conferences, and programs most often use the "Morbidity and Mortality" format to do so. The new requirements will require training programs to go beyond these traditional sessions in examining patient safety and quality, and make certain that residents are active participants in the process. Creating multidisciplinary efforts will be a new paradigm for many programs, and the monitoring and use of performance indicators for residents will likely be a larger challenge for others.

Another new focus has been placed on resident sign-outs or handovers. The ACGME refers to these vital activities as "transitions of care." As in previous iterations, the new guidelines ask that programs create clinical schedules that minimize these transitions. However, it is now further specified that there be "structured hand-over processes to facilitate continuity and safety***" and that programs ensure that "residents are competent in communicating with team members" in the handover process***. These new features will again require training programs to develop systems and solutions that are beyond the current norms. Evaluating the competence of residents in these activities will be a special challenge.

Finally, the ACGME has formally outlined supervision models for residents. The new requirements define these levels as "Direct," "Indirect" or "Oversight." They further outline that PGY-I residents be directly supervised or indirectly supervised, with the latter model allowable only if the supervisor is immediately available. While this intensified need for supervision will be a shift for some programs, it is likely the single most important safety measure to be adopted. In simple terms, it will no longer be acceptable for the least experienced team members to make critical decisions without the input of senior residents and faculty. The goal here is to lessen the likelihood of a PGY-I learning of a flawed decision only during teaching rounds that occur hours after the clinical events that ensued.

In summary, the new ACGME requirements go beyond the well publicized ones intended to ensure residents are less fatigued. Further additions emphasize quality and safety with the strongest position this organization has ever taken on this issue. This will not be a seamless transition. These new guidelines must be implemented in a time of economic uncertainty for many teaching hospitals. Institutions may not yet have information systems that easily provide the data required to meet these regulations. The idea of multidisciplinary processes is a novel one for many specialties. The evolutionary process will require program leaders to elicit guidance from faculty and hospital personnel who have not been actively engaged in the past. Moreover, these models for safety and quality will require new educational efforts to guide faculty and residents in the appropriate use of safety and quality principles.

In our institution, there are opportunities for residents and faculty to pursue formal coursework

in this domain. Specifically, the Jefferson School of Population Health offers certificate and degree programs in Healthcare Quality and Safety. Even more accessible are planned online courses that will allow even those residents with limited time to learn more about these critical issues. This will be an exciting time for champions of safety and quality. They will not just witness, but certainly participate in the positive evolution of the graduate medical training environment. Moreover, it is hoped that these efforts will create a new generation of physicians, who all become such champions. ■

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New Health Insurance Exchanges Expected to Address the Health Care Iron Triangle

Expanding access to health care is a primary goal of the Patient Protection and Affordable Care Act (PPACA), the landmark health reform legislation enacted in March 2010. Based in part on the reform model ratified by Massachusetts in 2006, this federal policy enterprise expands access to coverage using four main mechanisms: an individual mandate; expanding Medicaid eligibility; reconfiguring of commercial health insurance market rules; and establishing state-based health insurance exchanges (Exchange) that are set to open for business by 2014.[1]

Modeled after Stanford economist Alain Enthoven's theory of managed competition,[2] Exchanges are structured marketplaces where insurers compete on quality and value. Certain individuals will access premium subsidies and employees are offered a choice of health benefit designs, health insurance carriers, and provider networks. For small businesses in particular, Exchanges offer additional value beyond providing employees with choice. Typically, the small business owner works directly with their health plan to solve claims issues and enroll new employees into the insurance arrangement, among other administrative tasks. But in an Exchange, "back-office" administration of health benefits lies with the Exchange, a dynamic that promotes economic development by empowering employers to focus more resources on achieving their business goals rather than on health care.

Exchanges though, are expected to be more than merely a health insurance distribution apparatus. Policymakers envision Exchanges aggressively addressing the two other vertices of the iron triangle of health care – cost and quality – by serving as a vehicle through which states drive homegrown health reform efforts. Vermont's ongoing effort to introduce a single-payer health care system by leveraging their Exchange as the single point of entry for most health care in the state is a worthy example.[3]

To be certified by and subsequently offered in an Exchange, a qualified health plan (QHP) must satisfy not only traditional insurance regulatory requirements such as provider network adequacy and financial solvency, but myriad quality criteria as well. These include publicly reporting patient experience survey data and meeting minimum criteria on clinical and patient performance measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.[4] Certified health plans must also implement a quality improvement strategy that leverages, "quality reporting, effective case management, medication and care compliance initiatives" and medical home models.[5] Other initiatives related to reducing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness and health promotion activities must also be undertaken by QHPs.[6] Beginning in 2015, most hospitals in each QHP's provider network will be required to utilize a patient safety evaluation system and have in place a comprehensive hospital discharge program that seeks to address the issue of transitions of care.[7]

One central decision transferred to each state under PPACA is whether to devise and implement its own Exchange.[8] For example, deferring this responsibility to the federal government could further complicate Pennsylvania's already complex health care and insurance systems, disrupt coordination with other state-based health programs, and discourage stakeholders from engaging in collaborative efforts that seek to improve patient outcomes. Principally citing a desire to keep health care truly a local endeavor, the majority of states, including Pennsylvania, will likely establish their own Exchange. The final report of the Pennsylvania Health Care Reform Advisory Committee – a multi-stakeholder workgroup – recommends that the state establish its own Exchange, and that this new marketplace be structured as an independent public authority or a regulated non-profit entity and compete in the marketplace as an active purchaser, a model whereby it actively negotiates with health plans to garner high-value plans for its individual and small employer constituents.[9]

Making these recommendations a reality requires a change in state law by the General Assembly. Anthony M. Deluca, the Democratic Chair of the House of Representatives' Insurance Committee, is sponsoring H. 627, a bill that

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would establish the Pennsylvania Health Insurance Exchange and provide it with the powers and duties necessary to carry out its mandates.[10] As of the submission of this article, H. 627 was awaiting action by the House Insurance Committee.

Although the federal reform law focuses principally on expanding access, the states and private sector actors must not lose focus on the imperative to control costs and improve quality. While framed as bodies designed to address health care access issues, Exchanges more notably hold great promise in promoting visionary efforts aimed at mitigating costs and elevating quality. Indeed, qualifying these new marketplace arrangements simply as insurance delivery mechanisms will likely cause states to fall short of achieving the dual goals of better health and affordable care for all. In addition to streamlining health benefits administration and simplifying the health insurance shopping experience, Exchanges will endure as entities that accelerate the adoption of proven effective innovative care systems that lead to improved outcomes, lower costs, and greater overall value. ■

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Promoting a Culture of Change in a Patient-Centered Medical Home

The model of primary care in the United States is changing at a rapid pace. There are new expectations of primary care providers, namely the ability to focus on multiple issues during ever shorter visits, while simultaneously fostering a collaborative and enriching relationship with patients, many of whom are experiencing an increase in health-related risks and stressors. The increasing list of demands has led to frustration for clinical providers and patients, and underscores the need for new models of care that can adapt to improve the quality of care, contain costs, and improve the interaction between patients and providers. Healthcare systems that emphasize a robust primary care component have more comprehensive, better quality, and equitable care at lower cost.[1] These high-performing practices are often linked to the development and implementation of the Patient-Centered Medical Home (PCMH) model.

Key concepts being tested by the American Academy of Family Physicians (AAFP), along with other national agencies, include changing the context in which we take care of patients; moving from a systems-centered or physician-centered approach to a patient-centered approach, the Patient-Centered Medical Home. The National Committee for Quality Assurance (NCQA) defines a PCMH as "a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship."[2] The basic tenets of a PCMH include: access to care, strong relationship with a personal physician, team-based care approach, shared decision making, improved information sharing, the use of electronic health records, and care coordination and management.

Jefferson Family Medicine Associates (JFMA) achieved NCQA recognition as a Level 3 PCMH several years ago, and has adopted and fully implemented nearly all of the components of the PCMH model. This change and implementation is an ongoing process that requires dedication from all members of the care team. Creating an office culture that is open to change, communication, and collaboration is vital to continuing our journey in this process.

The process of change is not without bumps along the road. "Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign."[3] The PCMH model challenges each individual to change their identities and the way they view patient care. As a practice transforms, it is common to have periods of "change fatigue,"[1,4] whose symptoms include: "unresolved tension and conflict, burnout and turnover, and both passive and active resistance to further change."[4] In the face of change, we often see inconsistent motivation from physician providers and pushback from staff members that see any change as an increased workload without clear benefits to them. Change fatigue may be encountered by any practice and, if ignored, may lead to delayed progress or even reverting back to the more-comfortable, albeit less-efficient, norm.

The National Demonstration Project (NDP) is a group-randomized clinical trial of 36 independent clinical practices, examining the implementation of the PCMH model of care. The outcomes studied in this project have included patient experience, provider and staff experience, patient outcomes, and

quality of care. The NDP has defined the ability of a practice to weather the processes of change as the "adaptive reserve factor."[3,4,5,7] Adaptive reserve includes: "healthy relationship infrastructure, aligned management model, and facilitative leadership."[4] "High-functioning teams with strong adaptive reserve have been characterized as having positive communication patterns; low levels of conflict; and high levels of collaboration, coordination, cooperation, and participation."[6] Those teams that had a high adaptive reserve fared better during the implementation phases of the PCMH transformation.

The care team at JFMA includes physicians, nurse practitioners, registered nurses, medical assistants, and students from many clinical disciplines. Although JFMA was not one of the practices included in the NDP, we have observed many of the same challenges that were presented in the NDP, and have had intermittent periods of "change fatigue." In developing our new model of care, we have focused on empowering staff members to fully participate in the patients' care by: having standing orders; participating in the quality care initiatives and patient education; linking quality scores to compensation; involving team members in the planning stages of change initiatives prior to implementation; and actively seeking feedback from all levels of providers along the implementation/transformation process.

Our patients are already seeing the benefits of our changes, with increased access to care through the open access scheduling system, and timely follow-up of laboratory and radiology testing. Accessing test results immediately through our computer system, and more accurate and faster prescription management through e-scripting, is another advantage. Additionally, efficient and complete medical records with our electronic health records link patient records across primary care and specialty care. Patients have expressed that they feel more comfortable knowing that their charts are more readily available and that their primary care provider has access to notes and treatment plans from the specialists within the Jefferson health system. We have recently started to implement our Care Management Team, whose goal is to track, outreach to, and advocate for our most at-risk patients. Although this program is at the early stages of implementation, we have seen an increase in patients who both make and keep their appointments after being discharged from the hospital, providing us with the opportunity to review any outstanding orders and medication changes that were instituted during their hospital stay. We are hoping to see that this program translates into a decrease in hospital readmission and healthier outcomes for our patients.

As we work to implement the necessary changes, we will focus on improving our adaptive reserve by working to improve our communication and support. In our effort to function as "facilitative leaders" we are attempting to foster a safe and supportive office culture that empowers staff to identify and suggest new ideas as well as discuss what is not currently working. As we look to further implement, revise, and enhance our own PCMH at JFMA, we will continue to focus on staff and team development, while promoting a culture of change in our practice. The transformation process is an ongoing endeavor and requires stamina and dedication of all the members of the care team. It will prove to be a challenge worth mastering. ■

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College Within The College (CwiC) at Jefferson Medical College – Population Health

The development of programmatic tracks providing students with academic opportunities outside of the traditional medical curriculum represents a national trend in medical education.[1,2] Education for clinicians traditionally focuses on the medical condition(s) acutely affecting individuals and fails to incorporate principles of population health and prevention that are necessary to achieve a greater impact on our nation's health. Similar to health care reform, medical education reform requires fundamental redesign. Education for medical students needs to expand beyond the traditional biomedical focus and integrate new skills and approaches that support the health of populations. In doing so, educational reform will play a key role in transforming the nation's health care delivery system and in improving the health of the nation. CwiC-PH at Jefferson is a major effort to fundamentally redesign the structure and content of medical education.

With support from the Senior leadership of Jefferson Medical College, the College Within the College (CwiC) Scholarly Concentrations Program began in the Fall of 2010 with two areas of concentration - *Clinical Translational Research* and *Population Health* (emphasizing Public Health, Global Health and Community Medicine). The *Population Health* area of concentration, with leadership from the Jefferson Medical College Department of Family and Community Medicine and the Jefferson School of Population Health, began in February 2011 with its first cohort of 28 first-year medical students. Thirty-five mentors from multiple University Departments and Schools were selected and assigned to CwiC-PH students.

A 2010 HRSA Interdisciplinary and Interprofessional Joint Graduate Degree (IPCDDP) five-year grant ($1.25 million) to the Department of Family and Community Medicine supports the development of a dual degree program – either an MD/MPH or MD/Master of Science in Chronic Disease Management – and builds on the CwiC-PH program.

Over five years, CwiC and IPCDDP Leadership, Mentorship, Curriculum and Evaluation Teams will work with at least 175 medical students and link a significant number of them to a dual degree program.

The CwiC-PH and IPCDDP address the critical need to redesign the nation's care system to meet the mandates of the Institute of Medicine to provide care that is safe, effective, efficient, and timely, and is delivered by patient-centered interprofessional teams of health professionals. An expanded and robust primary care system, which works actively and effectively with patients, communities, and populations to address existing and emerging health concerns, is vital to ensuring the health of the American public in the 21st century. Nonetheless, medicine continues to suffer from a lack of young leaders with the specific skills and perspective to drive needed change.

The mission of CwiC-PH and the IPCDDP is to provide outstanding training in clinical care and innovative education in population and public health in order to prepare leaders to serve as future change agents working to improve the health of Americans, especially its most vulnerable and underserved populations**.** To accomplish this mission**,** the longitudinal CwiC Population Health (PH) components that augment the traditional curriculum include:

Year 1 – enhanced population health components of Introduction to Clinical Medicine (ICM)I, participation in community health initiatives, assignment of CwiC faculty mentors, and twice-monthly seminars emphasizing an Introduction to Public Health.

Summer – Bridging the Gaps, Family & Community Medicine Assistantship, Global initiatives, community service programs.

Year 2 – case studies in ICM II, ongoing advising for MD/MPH, and twice-monthly seminars emphasizing application of the Social and Behavioral Foundations of Public Health.

Year 3 – Ongoing advising, enhanced clerkship experiences, community electives, and Capstone planning.

Year 4 – Two electives such as Refugee Health, Medical Partnerships and Homelessness, Global Health, Health Advocacy, and completion of a Capstone Project, which may take the form of research papers, conference presentations, curriculum modules, policy analysis, or other scholarly work.

The CwiC-PH curriculum addresses the recommendations of an interdisciplinary panel of experts who developed objectives for a *Clinical Prevention and Population Health Curriculum Framework for Health Professions*.[3] These objectives, not traditionally stressed in the current medical school curriculum, include:

1. Assessing the health status of populations using available data (e.g., public health surveillance data, vital statistics, registries, surveys, electronic health records and health plan claims data).

2. Discussing the role of socioeconomic, environmental, cultural, and other population-level determinants of health on the health status and health care of individuals and populations.

3. Integrating emerging information on individuals' biologic and genetic risk with population-level factors when deciding upon prevention and treatment options.

4. Appraising the quality of the evidence of peer-reviewed medical and public health literature and its implications at patient and population levels.

5. Applying primary and secondary prevention strategies that improve the health of individuals and populations.

6. Identifying community assets and resources to improve the health of individuals and populations.

In addition to longitudinal mentorship and enhanced curriculum, benefits to students enrolled in the CwiC-PH program include: discussion of their concentration work in students' Dean's Letters; a certificate upon completion of the program; and 15 credits applied to the MPH program at Jefferson, thus saving additional tuition costs, and allowing students to obtain a joint degree in five years.

CwiC-PH is ideal for those students interested in: a career in academic medicine and population health; community-based research in future practice; health equity and social justice; improving quality and cost of care; engaging with communities – locally and globally; and achievement beyond the traditional curriculum.

A baseline assessment of student demographics and knowledge, attitudes and skills related to Population Health was conducted. Additional evaluation strategies have been developed to track student changes over time and provide feedback for curriculum modification for subsequent cohorts, These measures include: student and mentor satisfaction; the JMC Longitudinal study; the AAMC graduate questionnaire; attrition rates; publications and presentations; and comparison to non-participants in CwiC - specialty choice, match results, and future academic career.

CwiC-PH will be organizing further learning opportunities, including an online discussion board, regular journal/book club discussions, and building on lessons learned from the first cohort. ■

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Greater Philadelphia Schweitzer Program Welcomes New Fellows

The Albert Schweitzer Fellowship (ASF) is thrilled to announce the selection of the new cohort of Greater Philadelphia Schweitzer Fellows. After a competitive selection process, 15 graduate students from among the area's best health and human service schools have been awarded 2011-2012 Greater Philadelphia Albert Schweitzer Fellowship positions.

Over the next year, these students will join approximately 260 other 2011-2012 Schweitzer Fellows across the country in conceptualizing and carrying out service projects that address the unmet health needs of underserved individuals and communities while developing lifelong leadership skills.

Schweitzer Fellows continue their conventional professional training while participating in the entry year of the Schweitzer Fellowship Program. This year's newly selected group continues to diversify the rapidly growing network of Schweitzer Fellows who are committed to supporting each other on lifelong paths of service.

As anticipated, the Greater Philadelphia Schweitzer Fellowship Program moves forward into its 5th year of operation.
This year's fellows represent the following Colleges and Universities:

Drexel University
College of Medicine

Temple University
School of Graduate Studies
School of Medicine

Thomas Jefferson University
Jefferson Medical College
Jefferson School of Pharmacy
Jefferson School of Population Health

University of Medicine and Dentistry of New Jersey
School of Osteopathic Medicine
School of Nursing

University of Pennsylvania
School of Medicine
School of Social Policy and Practice

With much excitement, we welcome the 2011-2012 fellows and encourage you to visit the national website for more details about their projects and progress. http://www.schweitzerfellowship.org/features/us/gp/ ■

For further information on the program, including opportunities to sponsor a Fellow, please contact Nicole C. Moore, MA, Program Director of The Greater Philadelphia Schweitzer Fellowship Program at 215-955-9995, or Nicole.Moore@jefferson.edu.

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National Tobacco Control Leader Speaks at Jefferson

March 25, 2011

Rosie Henson, MSSW, MPH, Senior Advisor to the Assistant Secretary for Health at the Department of Health and Human Services (DHHS), gave a special presentation at Jefferson as part of the ***Get Healthy Philly*** Tobacco Policy and Control Speaker Series sponsored by the Philadelphia Department of Public Health. Ms. Henson oversees the National Tobacco Control Strategy of DHHS.

For many years Ms. Henson directed the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health (OSH) where she launched the state-based National Network of Tobacco Cessation Quitlines, which provided access to telephone counseling and follow-up for all US smoking. She also played a pivotal role in leading the CDC's efforts to establish youth tobacco surveillance activity globally. During her tenure with the CDC, Ms. Henson directed multiple disease prevention and health promotion programs.

Ms. Henson provided a concise overview of the historical context of tobacco control and the current state of tobacco use in the US. She discussed several initiatives and challenges in the effort to curtail cigarette smoking. Ms. Henson emphasized youth-targeted mass media campaigns as one of the most effective interventions to reduce tobacco use. Other evidence-based interventions include smoke-free laws; accessible and affordable tobacco cessation options; increase in the retail price of tobacco products; and restriction of tobacco advertising and promotion.

Simon McNabb, Senior Policy Advisor to the CDC's Office on Smoking and Health, added to Ms. Henson's discussion by outlining current and future activities developed by the HHS Tobacco Control Strategic Plan. For example, one strategy, "Lead By Example" focuses on the implementation of model tobacco control policies that would include expansion of coverage for tobacco cessation benefits in Medicaid and Medicare.

Rosie Henson, Senior Advisor to the Assistant Secretary for Health, US Department of Health and Human Services

Another strategy, "Improve the Public Health: Accelerate State and Community Control Efforts," builds on the American Recovery and Reinvestment Act (ARRA) by expanding evidence-based tobacco control programs and developing a coordinated cessation strategy.

Ms. Henson is very optimistic about the future and is particularly impressed with the leadership and public health initiatives of the City of Philadelphia. ■

To download a copy of *Ending the Tobacco Epidemic, A Tobacco Control Strategic Action Plan for the US Department of Health and Human Services*, visit: http://www.hhs.gov/ash/initiatives/tobacco/tobaccostrategicplan2010.pdf

To learn more about *Get Healthy Philly's* tobacco policy and control program visit: http://www.phila.gov/health/Commissioner/Tobacco.html

JSPH Unveils Applied Health Economics Program

The Jefferson School of Population Health (JSPH) announces the launch of its Master of Science in Applied Health Economics and Outcomes Research (MS-AHEOR).

Applied Health Economics and Outcomes Research is an academic discipline that focuses on whether or not a product or service benefits patients. It establishes efficacy of the product or service, then compares its effectiveness to other interventions, and finally considers its incremental cost efficiency. AHEOR is increasingly important and necessary as rising health care costs continue to challenge the stability of the nation's economy. Costs continue to rise despite evidence that additional spending is not associated with attractive incremental value in outcomes, costs or quality.

For further information on the program, call (215) 503-0174, or visit http://www.jefferson.edu/population_health/ahe/aheindex.cfm

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Carolyn M. Clancy, MD, Director, Agency for Healthcare Research and Quality

Richard H. L. Corder, FACHE, MHA, Assistant Vice President, RMF Strategies

Allan M. Korn, MD, Senior Vice President, Chief Medical Officer, Office of Clinical Affairs, Blue Cross and Blue Shield Association

Rick May, MD, Vice President, Accelerated Clinical Excellence Team, HealthGrades: Guiding Americans to Their Best Health™

Michael L. Millenson, President, Health Quality Advisors LLC, Mervin Shalowitz, M.D. Visiting Scholar, Kellogg School of Management, Northwestern University, Author, *Demanding Medical Excellence: Doctors and Accountability in the Information Age*

Diane C. Pinakiewicz, MBA, President, National Patient Safety Foundation

Marc Roberts, PhD, Professor of Political Economy, Department of Health Policy and Management, Department of Global Health and Population, Harvard School of Public Health

Jed Weissberg, MD, Senior Vice President, Hospitals, Quality and Care Delivery Excellence, Kaiser Foundation Health Plan and Hospitals, Kaiser Permanente

Colloquium Co Chairs:

Kathleen Goonan, MD, Chief Executive Officer, Goonan Performance Strategies, LLC, Associate in Health Policy, Massachusetts General Hospital

David B. Nash, MD, MBA, FACP, Dean, Jefferson School of Population Health, Dr. Raymond C. and Doris N. Grandon Professor of Health Policy, Thomas Jefferson University

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The Use of Social Media by Graduate Health Science Students: The Thomas Jefferson University Experience

The popularity of the Internet has led to increased usage of social media networking sites, which are becoming today's meeting halls and community centers. The US government has recently developed a website with policies and guidelines on social media.[1] This website highlights the growing arena of social networking for agencies by broadening collaboration and communication to users. A recent survey by the Neilsen Media Group found that social networks and blogs accounted for one in every four and a half minutes people spent online worldwide.[2] In this study, individuals spent on average 6 hours in the month of April 2010 using social media versus 3 hours and 31 minutes the previous year.

With the awareness that traditional 4-year college students were heavy users of social networking, the Office of Institutional Research developed an online survey to investigate the media preferences of Jefferson students. The purpose was to gauge their level of activity on social media sites, and to evaluate how they responded to advertisements on those sites. Respondents included 644 first-year students and 413 graduating students from Jefferson programs in biotechnology, couple and family therapy, medicine, nursing, occupational therapy, physical therapy, public health, radiologic and imaging sciences and pharmacy. Descriptive statistics were computed for each group and are presented below.

Online media was identified as the primary source of information by the largest percentage of respondents, for all the age groups. Sixty-four percent responded that they made decisions based on advertisements they see on online media, higher than any other type of media listed, followed by journals (59%) and television (55%). Facebook was used by 77% of the students. This included: 91% of students aged 18-25; 78% of students aged 26-35; 53% of students 36-45; and 33% of students aged 46 and above, showing that as age increases, the amount of Facebook usage decreases. The majority of students reported not using Facebook or Twitter's advertisements to gather more information for educational programs.

Eighty percent of graduating students reported using Facebook and, of those, 75% reported that they planned to use it to connect with fellow alumni. Only 18% of students reported using LinkedIn. Some of the reasons listed were connecting with employers, networking opportunities, keeping in touch with alumni and past professional colleagues, getting letters of recommendations, and being informed about job opportunities. When they were asked "Are there any other social networking sites that you currently use or plan to use for your professional career?" there were very few responses. Those mentioned included: Professional Association Sites, Professional Listservs, University Career Center website (Simplicity.com), and MySpace.

The results indicate that an overwhelming majority of Jefferson students prefer to get their information online, which is similar to findings by the national surveys of traditional 4 year students.[3] Further, Facebook is used heavily by students of all ages and there is much less use of other social networking sites, such as Twitter, MySpace, or LinkedIn.

Understanding social media usage has several implications for higher education and the health professions. Social media has been shown to improve student skills in technology and creativity, as well as their communication skills by facilitating access to new and diverse ideas of people they wouldn't be able to meet in person. Social networking online rather than face-to-face allows students to quickly make and keep connections, which is important in the fast paced, diverse world of the Health Professions. Implementing social media on a wide scale at Jefferson would result in more technologically savvy individuals and would serve as another avenue for communication. More importantly, it can draw traffic to the University, department, or program's traditional websites or blogs. It is a low-cost, viral way of getting the word out about school events and programming, and can be used to keep students informed of new classes, special lectures, holiday hours, special events, and even emergency notices.

A unique opportunity in social networking may present itself for university administrators if they are willing to think creatively. Above all this platform is about being social, allowing students a virtual meeting space to connect with alumni, establish school pride, announce reunions, sporting events, talk about group projects, interact with the diverse groups from across the world which will have profound social/emotional benefits to students. Research in this arena should continue into the future to measure not only student, but faculty, and administrative interest and usage in these to ensure the Jefferson keeps pace with emerging technological trends. ■

Carolyn Giordano, PhD
Senior Research Analyst
Office of Institutional Research
Thomas Jefferson University

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National Public Health Week Luncheon and Town Hall Meeting Reinventing Health in One of America's Poorest Communities: Camden, NJ

Jeffrey Brenner, MD

Panelists: Kathy Jackson, MSN; Ana Aningalan, MSW; Kelly Craig, MSW; Jessica Cordero

April 5, 2011

How best to provide care to the neediest population has proven to be a significant challenge to clinicians, hospital administrators, government officials, health plans, and policy analysts. The Affordable Care Act provides the impetus to make it a priority, but efforts to date have been sporadic and continue to lag far behind. Those working to develop innovative practice models need look no further than Camden, where the Camden Coalition of Healthcare Providers, under the leadership of Jeffrey Brenner, MD, has made significant strides.

On April 5, 2011, the Jefferson School of Population Health celebrated National Public Health Week with an open Town Hall meeting and luncheon. The standing room only audience learned first-hand what Dr. Brenner and his team of social workers, nurses, and health coaches have accomplished in Camden.

The Camden Coalition of Healthcare Providers began as a breakfast meeting where practitioners compared notes on local challenges. Over the last 9 years it has grown into a community organization that joins together the 3 main hospitals – Cooper University Hospital, Our Lady of Lourdes Medical Center, and Virtua Health – with physicians, nurses, case workers, and health coaches. The team uses data analysis and word of mouth to identify the most burdensome patients, seeking them out to provide assistance with access to services, scheduling, transportation, and even housing.

Dr. Brenner himself has spent the last 11 years on the front line, providing care and treating the most indigent patients who have a spectrum of complex health and psychosocial problems. He tired of observing the common pattern of patients utilizing the emergency room as a source of primary care, moving through the system like a revolving door. He has dedicated painstaking time, poring over countless data, to identify Camden's neediest population and develop a coordinated plan to provide them with appropriate primary care.

As we seek to meet the needs of our sickest patients in a cost-effective way, it is important to note the example of Camden. According to Dr. Brenner and his team, caring for this impoverished and disenfranchised population requires understanding: 1) how to locate them, 2) how to motivate them, and 3) how to provide wrap-around services (such as mental health services, housing, and transportation) that have a direct impact on health outcomes.

In these days of health reform there is no single solution to fostering wellness. The dedication and hard work illustrated by Dr. Brenner and his team offer a model of care for problem-solving some of the greatest challenges in public health today. ■

Preventing Jewish Genetic Diseases in Philadelphia and Nationally

It is estimated that each person is a carrier for approximately five to 15 recessive mutations in his or her genes. Since all of our genes come in pairs – one from our mother and one from our father – a mutation in one copy is compensated for by the other copy. Therefore, a carrier for a recessive genetic disease is a healthy person. There are usually no outward signs of one's carrier status. However, if a carrier for a recessive disease mates with someone who is also a carrier for **the same** recessive disease, then there is a 1 in 4 chance, with each pregnancy, of having a child affected with that disease.[1] Too often, people find out they are carriers only after a child is born with a rare recessive disease.

There are many ethnic groups at higher risk for certain genetic diseases. This may be due to intermarriage, geographic isolation, or – as is the case for African Americans, who are at higher risk for Sickle Cell disease – carrier status offered protection against acquired diseases more common in their geographical location. Jews of Eastern European descent, known as "Ashkenazi Jews," are at increased risk to be carriers for several genetic diseases, many of which are also found in the general population. These diseases are severe and many are life-threatening. **One in five** Ashkenazi Jews is a carrier for at least one of **18** diseases[2] for which carrier screening is recommended in the Ashkenazi Jewish population (Table 1).

There are no cures for any of these diseases. Many lead to early death or shortened lifespans, and require rigorous daily medical management. Only one of these diseases, Gaucher disease, has an effective treatment. However, they can all be prevented through carrier screening prior to pregnancy (pre-conception screening). Medically accurate screening is available with a simple blood test.

Screening programs have been initiated across the country in order to reduce the probability of babies being born with any of these life-threatening and preventable Jewish genetic diseases (JGD). The Victor Center for the Prevention of Jewish Genetic Diseases was founded in 2002 by Albert Einstein Health Care Network in partnership with Lois Victor, a mother who lost two children to a Jewish genetic disease. The Victor Center partners with college campuses, clergy, healthcare professionals

Continued on page 12

Table 1

Genetic Diseases Associated with Ashkenazi Jews

Bloom Syndrome

Canavan Disease

Cystic Fibrosis

Dihydrolipoamide Dehydrogenase Deficiency

Familial Dysautonomia

Familial Hyperinsulinism

Fanconi Anemia Type C

Gaucher Disease

Glycogen Storage Disease Type 1A

Joubert Syndrome

Maple Syrup Urine Disease

Mucolipidosis IV

Nemaline Myopathy

Niemann-Pick Disease Type A

Spinal Muscular Atrophy

Tay-Sachs Disease

Usher Syndrome Type IF

Usher Syndrome Type III

and communities to build awareness, educate and provide ongoing access to comprehensive genetic education, counseling and screening services.

Since the Victor Center was founded in Philadelphia, Centers have been established at The Floating Hospital for Children in Boston and at the University of Miami Miller School of Medicine. Partnerships are underway in cities throughout the United States including Atlanta, Pittsburgh, Minneapolis, Tulsa and Omaha.

The screening program of the Victor Center is modeled on the community-based screening movement for Tay-Sachs disease. During the 1970s, Jewish and medical communities galvanized around screening for Tay-Sachs disease and created a powerful grassroots movement that eventually became standard medical practice. As a result, the number of Ashkenazi Jewish babies born with Tay-Sachs disease has decreased by more than 90%.[3] However, many additional diseases have been identified as having significant carrier frequency in the Ashkenazi Jewish population since Tay-Sachs screening was started. The Victor Center is working to raise awareness amongst physicians of the availability and need for screening for all 18 diseases through outreach to physician practices, and providing education at conferences held by major medical organizations (e.g., the National Society of Genetic Counselors, American College of Medical Genetics and the American College of Obstetrics and Gynecology).

The Victor Center approach focuses on prevention as a fundamental component of social change. While research continues to search for a cure for devastating inheritable diseases such as Tay-Sachs, Canavan, Familial Dysautonomia and others, the best way to ensure that couples have the greatest number of reproductive options and that Jewish children are born free of these diseases, is to educate our young adults about the diseases and enable them to know their carrier status. There are only two ways to find out if you are a carrier: through a simple blood test or by having an affected child. Education and awareness must be followed by screening if we are to have any success in eradicating these diseases.

The Victor Center is currently involved in several major projects, including: a pilot education and screening campaign in Atlanta with the support of the Marcus Foundation; development of a webinar to teach Rabbis how to discuss JGDs with their congregations and young couples; working with OB/GYN practices to create a toolkit for educating both doctors and patients about Jewish genetic diseases; creating a guide to ensure appropriate screening; and launching a video featuring Matisyahu, a Jewish reggae rapper, educating people about Jewish genetic diseases.

The Victor Center recently completed a three-year project focused on raising awareness of Jewish genetic diseases on college campuses. With funding from the Centers for Disease Control and Prevention (CDC), the Victor Center hired a social marketing company to conduct research on the best practices for educating college students about Jewish genetic diseases and to empower students to create a comprehensive awareness campaign on college campus. The guide and campaign materials, known as the "1 in 5" campaign, were field tested at six campuses across the country last spring. These materials are currently being rolled out at campuses nationwide. The Victor Center plans to undertake a similar social marketing process to identify and create the best practices for educating young professionals. ■

Shoshana Rosen
Outreach Manager

Faye Shapiro, MS, CGC
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Victor Center for the Prevention of Jewish Genetic Diseases
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For more information about the Victor Center for the Prevention of Jewish Genetic Diseases, contact Faye Shapiro at shapirof@einstein.edu.

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Health Policy Forums

The Role of Innovation in Value-Based Healthcare Delivery

Christopher McFadden
Managing Director
Health Evolution Partners

March 9, 2011

Christopher McFadden, managing director of Health Evolution Partners, offered a unique perspective on innovation in health care delivery at a recent forum. Health Evolution Partners (HEP) is a healthcare-focused private equity firm based in San Francisco. Founded by David J. Brailer, MD, PhD, the former National Coordinator of the Office of Health Information Technology, HEP invests in commercial-stage companies and medical product sectors. HEP seeks to invest in companies that increase the effectiveness, efficiency, and quality of healthcare delivery.

Mr. McFadden introduced the audience to the concept of innovation and provided a framework in which to explore the various touch points of innovation such as suppliers, payers, and providers. Innovation in general, refers to the introduction of a new idea, service, process or product designed to improve treatment, diagnosis, prevention, education, and research with the long-term goals of improving quality, safety, outcomes, efficiency and costs.[1]

McFadden explained how the costs of delivering health care are unsustainably high and crowd vulnerable populations. Some of the contributing factors driving cost include: low productivity (cost/quality of many delivery systems); ineffective alignment of incentives; low levels of market transparency; and rampant free-rider effect. Innovation is often the healthcare market response to under-performance.

The healthcare system obviously has very complex systemic needs which pose major challenges when it comes to innovation. Some of the major challenges include: increasing clinical efficiency; reducing frictional costs; improving stakeholder alignment; increasing accountability; and improving the coordination of care. The advent of accountable care organizations creates a new landscape that does not quite fit into the traditional framework of innovation.

McFadden summarized his presentation by describing some of the most critical themes related to the future of innovation. He stressed the need for bold novel solutions, and strong, creative, collaborative clinical and operating leadership.

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Betting on Bending the Cost Curve

Mark Pauly, PhD
Bendheim Professor and Professor of Health Care Management, Business and Public Policy, Insurance and Risk Management and Economics
The Wharton School

April 13, 2011

The April Forum speaker was Dr. Mark Pauly from The Wharton School of the University of Pennsylvania. His topic, "Betting on Bending the Health Care Cost Curve," has been addressed by others who promise cheap, easy answers to our cost problems in health care. In contrast, Dr. Pauly emphasized the both the difficulty of bending the cost curve, and the trade-offs that our society will have to make in dealing with unaffordable medical costs.

Even if there are no easy ways to slowing the rise in health care costs, some methods are better than others. Dr. Pauly emphasized that we are in a car "…headed at 90 miles an hour towards a brick wall." In other words, we definitely will stop, but hitting the wall is the worst way to stop. Turning the wheel or applying the brakes is preferable.

It may take a genuine crisis to provoke action. The most successful methods in the past—HMOs and cost sharing—have been too unpopular to remain in place. Dr. Pauly emphasized the importance of eliminating waste, but as a starting point rather than a solution to all the problems with costliness of health care.

Dr. Pauly also highlighted the benefit of policies that work in unforeseen circumstances. We should not simply implement policies that only work if everything goes according to plan. This perspective is what led him to focus on the "Cadillac tax." If it works as intended, it will bend the cost curve. If it fails to control spending, it will automatically eliminate the tax-favored status of health insurance for the most expensive plans.

Dr. Pauly was less optimistic about other options for bending the cost curve. The success of Geisinger and Kaiser Permanente demonstrate that integrated delivery models can be successful, but there may be a limit to the number of physician-leaders available to run them. The biggest reason for pessimism is that many

Continued on page 13

Accountable Care Organizations (ACOs) are being formed by hospitals, which tend to function on the model of expensive care for sickest people. Preventative care and wellness provide great opportunities to improve health, but they may not necessarily save money.

Dr. Pauly was the most skeptical of the promise of insurance market reform to save costs. His research suggests that there is little money to be squeezed out of the private insurance system, and that any savings will come at the cost of choice that consumers seem to value.

In conclusion, Dr. Pauly discussed Medicare costs and other public programs. While private sector cost growth is a problem, it does not generate the same kinds of distortions as public programs do. That means that many people, especially those with generous private health benefits, may be able to keep what they have. However, it also means that everyone, especially those in Medicare, will be asked to give up what they hope to get—the high technology treatments of the future. That is the price to be paid for the subsidies for lower-income health insurance included in the Affordable Care Act. Dr. Pauly emphasized that this is a painful trade-off to get a real solution to our health care financing problems.

The Changing Landscape of Health Services Research and Policy

Erin Holve, PhD, MPH, MPP
Director, AcademyHealth

May 11, 2011

AcademyHealth's mission is to advance health care decision making through health services research. As reform legislation continues to unfold, this mission is critical to understanding how to best utilize available resources to maximize the health of the entire population.

At a recent forum, Dr. Erin Holve discussed how data can be transformed into innovation in health care, emphasizing that researchers can make meaningful contributions to policy through their work. AcademyHealth seeks to support health services research and develop a "Learning Healthcare System" in which policy decisions are validated by data. Through this system, AcademyHealth hopes to achieve relevance, reliability, and responsiveness – engaging stakeholders, introducing methodological rigor, and assuring timeliness and openness.

As the American Recovery and Reinvestment Act (ARA) is fully implemented more funding will become available to advance health services research. The increased focus is good news for the industry, but necessitates development of an infrastructure that supports learning across networks. Dr. Holve described a health data ecosystem in which all communities – patients, providers, community leaders, policymakers, researchers, and corporations – work together to find synergies. This idea originated from Todd Park, Chief Technology Officer at the Department of Health and Human Services, and is validated by a recently launched website www.HealthData.gov, an effort to share community health data quickly.

Beyond development of a learning community, Dr. Holve shared news of several emerging data resources available to researchers. She discussed expanded claims data, electronic health records and registries, as well as "mashups" which occur when data is merged from various sources. Patient-contributed data is also a new area and includes patient-reported information, biomonitoring, and crowd-sourced data. There is currently an opportunity to determine what personal use of data will look like, and how researchers can compile, compare and utilize this emerging area of research. These new sources of data will require stringent privacy and security precautions.

In addition to developing a research community, AcademyHealth is focused on educating the general community on the value of health services research. A more informed public understands the value of their personal health information and the importance of their participation. Dr. Holve admits that the research community could improve its efforts in this area, and urges researchers to represent their field by engaging the public so that they understand how this work is beneficial to patients and providers.

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A Decade after 9/11, Are We Any Better Prepared for Public Health Emergencies? A Population Health Perspective

September 14, 2011

Michael A. Stoto, PhD
Professor, Health Systems Administration and Population Health
Georgetown University

Health in All Policies: (How) Can We Make it Work?

October 12, 2011

Shiriki Kumanyika, PhD, MPH
Professor of Biostatistics and Epidemiology
University of Pennsylvania School of Medicine

Implications of the Patient-Centered Medical Home Concept for Health Professional Training Programs

November 2, 2011

Michael S. Barr, MD, MBA, FACP
Senior Vice President
Division of Medical Practice, Professionalism & Quality
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Reconsidering Law and Policy Debates: A Public Health Perspective

December 14, 2011

John Culhane, JD
Professor of Law
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Time: 8:30 am – 9:30 am

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Editorial Board Bids Farewell to Jim Diamond

Jim Diamond, PhD, has been an active and invaluable editorial board member to the Health Policy Newsletter since its inception. The editorial board and JSPH is extremely grateful to his many years of service and we wish him well in his retirement.

L to R: Rob Simmons, Lisa Chosed, Alexis Skoufalos, Emily Frelick, Kevin Lyons, Etienne Phipps, David Woods, Joel Port. Center: Jim Diamond

The 20th Annual Dr. Raymond C. Grandon Lecture

Michael B. McCallister, MBA
Chairman of the Board and CEO
Humana, Inc.

May 12, 2011

Mike McCallister didn't mince any words as he addressed the capacity crowd gathered on May 12 in Connelly Auditorium for the 20th Annual Dr. Raymond C. Grandon Lecture.

"We have an absolute disaster on our hands if we don't address population health," the Humana, Inc. chairman of the board and CEO noted. "If we don't get ahead of this, we're toast."

McCallister's talk, "A Roadmap to Creating a Real Health Care System," touched on the unintended consequences of health reform; how real problems persist and are getting worse in the wake of reform, and how behavior change – one person at a time – can help fix our broken system.

We're simply not taking care of ourselves and are therefore becoming an obese nation, McCallister said, leading to diabetes and other chronic illnesses.

This came as no surprise to the health care professionals gathered for the lecture. What was surprising, perhaps, were a series of pilot programs put into place by Humana to address the issue within its own ranks. The goal is "to help people achieve lifelong well-being."

The "Well-Being Pilots" introduced to Humana associates include:

Personal Health Score
Purpose: Provide objective clinical data coupled with actionable information to drive health improvement
Results: More than half (55%) of associates improved their individual score

Personal Well-Being
Purpose: Improve participants' sense of their own overall well-being
Results: After five months, associates' "thriving" self-assessment increased from 26% to 41% and "suffering" decreased from 10% to 6%

The BiggestLoserClub.com
Purpose: Deliver a social, mobile and virtual weight loss pilot for associate participants who have a BMI ≥ 28 and a desire to adopt healthy behaviors
Results: Total pounds lost for all members = 3,474.40 lbs.

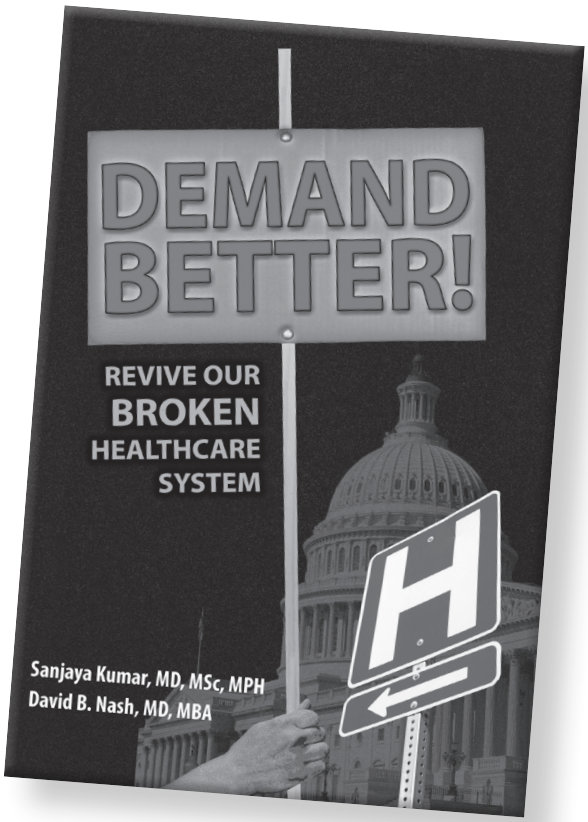
Win, Place, Show Me The Money
Purpose: To understand the efficacy of financial incentives in facilitating behavior change and healthy weight maintenance relative to weight loss over time
Results: Total net weight loss across all participants = 8,657.81 lbs.

McCallister's presentation, and the pilots he outlined, received rave reviews from Thomas Jefferson University Panel Reactors Janice Burke, Rebecca Finley and Mary Schaal. They liked the idea of such programs, designed to "make healthy things fun and fun things healthy." Such ideas need to take root across the country in order for real change to occur, noted Mary Schaal – a real health care revolution, if you will. ■

L to R: Rebecca Finley, PharmD, MS, Dean, Jefferson School of Pharmacy; Janice Burke, PhD, OTR/L, FAOTA, Dean, Jefferson School of Health Professions; David B. Nash, MD, MBA, Dean, Jefferson School of Population Health; Michael B. McCallister, MBA, Chairman of the Board and CEO, Humana, Inc., Michael J. Vergare, MD, Senior Vice President of Academic Affairs, and Mary Schaal, EdD, RN, Dean and Professor, Jefferson School of Nursing.

DEMAND BETTER!

REVIVE OUR BROKEN HEALTHCARE SYSTEM



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.

There is no easy fix to these problems, of course. But there is a best place to look: focus on quality. This is a book about debunking healthcare myths through the lens of quality.

DEMAND BETTER! synthesizes for the healthcare executive the many trends, initiatives, reports, organizations and policies that look beyond our healthcare myths and stand on the front lines of the quality and safety revolution.

This is not a utopian critique. It is based on a quality revolution that is already underway and is gradually transforming the way medical care is delivered in the U.S.

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.

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

ISPOR 16th Annual International Meeting

May 21-25 2011, Baltimore, MD

Podium Presentation

Dudash K, Negri G, Baccarini S, Rabinowitz C, **Maio V**
Prevalence and predictors of potentially significant drug-drug interactions in the elderly.

Poster Presentations

Dudash K, Templin M, Keith SW, Del Canale S, **Maio V**
The impact of a quality improvement initiative on inappropriate medication use in the outpatient elderly.

Foley K**, Lim S**, Schulman KL
Methodological considerations in modeling the economic value of diagnostic accuracy.

Jutkowitz E, Gitlin L, Pizzi LT, **Lee EH**, Dennis M.
Cost-Effectiveness of ABLE, a functional program to decrease mortality in community-dwelling older adults.

Maiese BA, Lee EH, **Toscani M.**
Biosimilars literature review: The current landscape and implications of recent healthcare legislation for the United States market.

Pizzi LT, **Jutkowitz E,** Gitlin L, Suh DC, Dennis M.
Baseline results from Beat the Blues.

Toscani M, Vogenberg R, **Nash DB**, Peskin S
Issues associated with biologic agents: Healthcare stakeholder survey.

Kellie Dudash, PharmD, left, was the recipient of the "Best New Investigator Podium Presentation" at the 16th Annual International Society for Pharmacoeconomics and Outcomes Research International Meeting. Kellie is an Outcomes Research Fellow at the Jefferson School of Population Health, under the Ortho-McNeil Janssen Scientific Affairs, LLC/JSPH fellowship program. Pictured with Kellie is Joseph Couto, PharmD, MBA, Assistant Professor and Outcomes Research Fellowship Director, Jefferson School of Population Health.

JSPH Publications

Abraham J, Wade DM, **O'Connell KA**, **DesHarnais S**, **Jacoby R**. The use of simulation training in teaching health care quality and safety. An annotated bibliography. *AJMQ.* Published online April 13, 2011. http://ajm.sagepub.com/content/early/2011/04/13/1062860610384716.full.pdf

Dudash K. Alzheimer's disease: New therapies and the role of biomarkers. *Biotechnol Healthcare.* 2011;8(1):26.

Nash DB. Timeout! *P&T.* 2011;36(4):174.

Nash DB. HHS programs bring end to 'business as usual.' *Medpage Today.* May 3, 2011. http://www.medpagetoday.com/Columns/26253

Nash DB. Staying healthy – it's complicated. *Medpage Today.* March 31, 2011. http://www.medpagetoday.com/Columns/25642

Nash DB. Easier said than done? *Medpage Today.* March 2, 2011. http://www.medpagetoday.com/Columns/25141

Pracilio V. A new kind of reform: Population health. *H&HN Daily.* April 12, 2011. http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=3790007520

JSPH Presentations

Berman B. Quality management in the physician office. Presentation at: Zurich Health Care Symposium, Schaumburg, IL, April 5-6, 2011.

Del Canale S, Fabi M, Brianti E, **Maio V**. Improving the appropriateness of prescribing in elderly patients. Is it feasible? A comprehensive approach in the Local Health Unit of Parma, Italy. Presented at: 7th European Congress Healthy And Active Aging For All Europeans II. Bologna, Italy, April, 17, 2011.

Goldfarb NI. Value-based purchasing of health benefits: strategies and outcomes. Presented at: PEBA (Pennjerdel Employee Benefits Association) 29th Annual Forum, Philadelphia, PA, April 21, 2011.

Goldfarb NI. What will it take to improve health care quality in the United States? Presented at: Healthcare21 14th Annual Health and Productivity Forum, Board Dinner, Knoxville, TN, May 2, 2011.

Klaiman T, Kraemer, J, Stoto M. School closures in response to A/H1N1: Issues for decision-makers. Presented at: 2010 National Emergency Management Summit. Washington, DC, March 3, 2010.

Klaiman T, Stoto M, Nelson C. Utilizing quality improvement methodologies for defining positive deviants during the 2009 H1N1 vaccination campaign. Presented at: 2011 Keeneland Conference for Public Health Systems and Services Research. Lexington, KY, April 12, 2011.

Klaiman T. Utilizing a positive deviance framework for understanding best practices in local health department 2009 H1N1 vaccination campaigns. Presented online at: Pfizer Foundation Medical and Academic Partnership Advisory Board, March 24, 2011.

Simmons R. Public health policy and advocacy 101. Presented at: The Advocacy for Public Health Conference, New Jersey Public Health Association, New Jersey Society for Public Health Education (SOPHE), Monmouth University, West Long Branch, NJ, March 25, 2011.

Simmons R. Society for Public Health Education (SOPHE)/American Association for Health Education (AAHE): Collaboration to strengthen the health education profession. Poster presentation at: The National Association of Chronic Disease Directors/Society for Public Health Education (SOPHE) Midyear Scientific Meeting, Albuquerque, NM, May 2-4, 2011.

Simmons R. Healthcare and community approaches to improving health literacy with vulnerable senior populations. Presented at: The National Association of Chronic Disease Directors/Society for Public Health Education (SOPHE) Midyear Scientific Meeting, Albuquerque, NM, May 4, 2011.

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