Jefferson School of Population Health

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GUEST EDITORIAL

Medical-Legal Partnerships as a Value-Add to Patient-Centered Medical Homes

Two innovative models of healthcare delivery focused on increasing access to care and improving quality have been independently gaining traction: the patient-centered medical home (PCMH) and the medical-legal partnership (MLP). Both models aim to improve health outcomes for patients and families, but approach it from differing and complementary perspectives. PCMHs establish networks of care and support around a primary point of care. MLPs provide free legal advice, advocacy and services to low-income and underserved populations to address social determinants that have a negative impact on health.[1] In these challenging economic times, it is imperative to identify innovative models of care which can potentially help to improve outcomes and reduce costs. Integrating MLPs into PCMHs may allow us derive value by leveraging the synergies to effectively meet these goals.

PCMHs and MLPs operate on similar principles: incorporating a 'whole-person' approach; improving the well-being and quality of life for individuals, families and communities; employing preventive measures and proactively addressing needs; and establishing collaborative networks to provide coordinated services and expand safety nets for those in need.

The federal government and healthcare experts have identified the PCMH as a model to engage and empower patients, coordinate, track and integrate care, efficiently manage chronic illnesses, reduce unnecessary and duplicative care and, in turn, reduce costs while improving outcomes.[2,3] The federal government has invested in PCMHs through the Patient Protection and Affordable Care Act[2] and by funding demonstration projects which integrate the PCMH model in federally qualified health centers (FQHCs) and advanced primary care practice settings.[4]

Medical-Legal Partnerships (MLP) were initially created in 1993 by Dr. Barry Zuckerman, a pediatrician at Boston Medical Center.[1]

Although healthcare providers have traditionally referred patients to local legal service agencies, these organizations lack sufficient financial and personnel resources to meet the needs of those eligible for services. According to a recent report by the Legal Services Corporation, for every individual who receives services, someone is turned away.[5] With the current economic crisis and high unemployment, the need for these services seems likely to increase.

What distinguishes MLPs from traditional legal service organizations are the relationships established between legal and healthcare staff involved in providing services, training, advocacy and evaluation. The MLP concept has been endorsed by the American Medical Association and the American Bar Association.[6] While there is no uniform MLP model, there are several common attributes:

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- Formal collaborations between healthcare institutions and legal organizations;
- A preventive approach, focused on identifying and responding to legal needs that have an impact on health;
- Interdisciplinary training of healthcare providers, social workers, attorneys and students;
- Interdisciplinary collaboration to support services and expand advocacy efforts on behalf of patients and families;
- Collaboration among attorneys and Health Care Providers (HCP) to:
  - Provide template forms with appropriate language to support applications for benefits and services;
  - Participate in meetings and hearings to support social, educational and environmental changes that improve communities;
  - Advocate for social, legislative and policy changes to improve the lives and health of their communities.[1,6,7]

The eligible populations, spectrum of legal services and models of delivery vary based upon community need, legal staffing and experience, contractual agreements with the respective health systems and funding. MLPs provide legal services to underserved populations in both urban and rural areas, generally in FQHCs, community clinics and hospital settings. MLPs work with a variety of patient populations, underserved populations (citizens who are homeless, have physical or mental disabilities, veterans and refugees) and health care practices. MLP attorneys primarily address issues around access to public benefits and services, including Social Security, environmental and housing, landlord-tenant, family, domestic violence, education, employment, disability and other consumer and civil rights matters. Legal matters not supported by the MLP are referred to local legal clinics or attorneys.

In 2010, the US Department of Health and Human Services' Health Resources and Services Administration (HRSA) awarded three demonstration grants to incorporate MLPs in Healthy Start programs. Based upon the value of MLPs in healthcare settings, HRSA recognized the benefits of extending the model for attorneys partnering with social and outreach workers to reduce infant mortality and to improve perinatal outcomes in underserved populations.[8]

In 2010, more than 30,000 individuals and families received legal assistance from 85 MLPs affiliated with over 200 health centers, community and federally-qualified health clinics and hospitals in 38 states.[6,8]

The positive impact of MLPs on healthcare is recognized by patients, HCPs, health systems and government officials. Patients have reported satisfaction with attorney-client communications and expressed gratitude for access and support of legal staff to resolve their problems. Successful legal outcomes include the securing of public benefits (eg, medical assistance, social security disability benefits and services, educational evaluations and placements); remediation of environmental household hazards; resolution of landlord-tenant and public housing disputes; protection of victims of domestic violence; and resolution of custody and guardianship issues.[1]

MLPs are reporting the financial benefits of legal services provided to their clients and their healthcare partners. In 2010, MLPs collectively recovered $5.3 million for patient-clients and $692,000 for healthcare partners.[9] MLPs are demonstrating their value by evaluating return on investment.[10,11] In Illinois, a full-time partnership reported a 150% ROI of MLP services by tracking Medicaid reimbursement.[11]

The time has come to invest in incorporating MLPs into PCMH practices. The potential benefits to improve access and health outcomes, and reduce costs for patients and healthcare systems are great. The strategy is feasible, with minimal logistical challenges, and healthcare systems that have institutionalized MLPs are reporting returns on their investments. In the current economic environment, considering the actual and anticipated rates of uninsured/under-insured, and the prevalence of chronic illness and stress, integrating MLPs into PCMHs and primary care practices is a meaningful, cost-effective investment. Federal legislators and healthcare systems should be encouraged to invest in this enhanced model of care. ■

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Important Message From The Dean

Dear Colleagues,

For over 20 years, our *Health Policy Newsletter* has been a cornerstone publication, featuring quick, easily accessible content regarding important issues in health care. With over 29,000 readers throughout the US, we understand the responsibility of producing a high quality newsletter that satisfies the interests of a diverse group of people.

The *Health Policy Newsletter* is going digital in 2012! That is a fact. In order to ensure that you continue to receive our publication in its online format, we really need your help. Please provide us with your current email address and use this opportunity to provide us with any other updates to your contact information. Please refer to the instructions below and throughout this issue.

Jefferson employees will receive notifications of the digital newsletter via PULSE.

All readers will continue to receive the *Prescriptions for Excellence* newsletter (sponsored by Lilly) in a print format.

I hope you share in my excitement as we embark on a new and improved format for the *Health Policy Newsletter.*

Sincerely,

David B. Nash, MD, MBA
Dean, Jefferson School of Population Health
Editor, *Health Policy Newsletter*

We really don't want to lose you!

As of 2012 the printed version of the Health Policy Newsletter will no longer be available.

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President Robert L. Barchi, MD, PhD

Thomas Jefferson University 2011 Commencement Speech

June 2, 2011

Kimmel Center for the Performing Arts

This year marks the 187th Jefferson commencement, continuing a long tradition that recognizes our outstanding graduates in the health sciences. It is a tradition built on great clinicians, transformational scientists, and influential policymakers, on compassionate care and discovery.

And to the graduates of the Jefferson Medical College, the Jefferson College of Graduate Studies, and the Jefferson School of Population Health, Class of 2011 – my warmest congratulations! For almost two centuries it has been Jefferson's mission to lead the nation in the art and science of healing – to define the future of clinical care. The degree that you will receive today signifies a reaffirmation and renewal of that mission.

You can take tremendous pride that today you become alumni of one of the oldest and most distinguished health science universities in the nation. Today's commencement marks the starting point of your professional journey, a journey that will lead you into a life of service, learning and discovery, a life intimately bound up in the public trust , a life that will be both fulfilling and rewarding in every sense of the word.

Traditionally at this point I should be laying on the platitudes and laudatory phrases, sending you off with words that might have applied equally well to thousands of graduates who have preceded you across this stage. But this year is different. This year you will enter a professional world in which the practice of medicine in our country is in the midst of fundamental change.

Recently, the most important piece of health legislation since Medicare was passed into law. You all know that a central and well-publicized element of this bill insures routine healthcare coverage for more than 34 million previously uninsured Americans who were lost in the midst of our nation's prosperity. The new law also takes significant steps toward health insurance reform. To be sure, these are landmark changes in policy.

But are these changes enough? Can we claim victory in dealing with our nation's healthcare crisis? Unfortunately the answer is "no." Make no mistake; fixing health care is not just about insuring the uninsured. While this is a critical first step, doing this alone will not change the fact that the cost of this nation's healthcare system is simply unsustainable, while the quality of health outcomes for our population lags significantly behind that of other developed nations.

Insuring the uninsured certainly creates great sound bites. But the real glimmer of hope in the new legislation lies in its mandate for experimental programs that explore new ways of delivering clinical care, and new approaches to how that care is paid for. The buzz words in the news these days include such terms as bundled payments, medical homes, and accountable care organizations. Although just pilots, these programs set out a new way of thinking about the manner in which we deliver and finance health care. These trials are the leading edge of the groundswell that will change your profession.

So, instead of platitudes, let me lay down a simple challenge to each of you. Be the leaders of that change. Use your Jefferson education to show others the way forward.

As tomorrow's physicians, you cannot afford the luxury of practicing in isolation. You must work collaboratively with other professionals, and rely far more on colleagues beyond the MD ranks, including advanced practice nurses, pharmacists, and allied health professionals as integral members of the new health care delivery team. Autonomy and independence must give way to interaction and coordination in the interest of quality clinical care. Sharing responsibility for clinical care will be a difficult social change in our profession. But as Jefferson graduates, you have already been trained in team-based medicine, and it is a transition that you can lead.

In order to meaningfully impact healthcare costs, you must assume more responsibility for outcomes and for objective measures of quality. Your focus as practitioners must broaden from the acute episode of illness to include the burden of chronic disease; from the treatment of sickness alone to include the maintenance of wellness. Many diseases that were fatal early in my career have been converted to costly chronic conditions by advances in medical science. Other critical risk factors such as obesity have skyrocketed in clinical impact, yet reflect societal attitudes that are not amenable to the approaches of traditional American medicine. Add to your list of personal challenges the need to engage actively in managing chronic disease and in modifying risky behavior in your patients. With the interpersonal skills that you learned first in the Hamilton Building, help your patients take ownership of their care.

In your professional world, medical piecework, with individual providers billing for each consult, each office visit, each surgery, will rapidly disappear. Your professional compensation will be tied to measured quality involving multiple providers along the entire continuum of care from hospital to home. Emphasis will shift to improving outcomes while reducing overall cost, and savings will be shared among all members of the healthcare team.

Well, that's simple to say, but hard to do….As tomorrow's policy-makers, you must not only design these new plans, but also help your colleagues accept them, even as the basic foundation of medical economics shifts.

Tomorrow's medicine will be built on today's research, and all of us who receive federal funding for research are beneficiaries of the same public trust that encompasses the rest of the health care professions. Those among you who embark on careers in research will find increasing demands for relevance and accountability in your use of shrinking federal research dollars. You will be challenged to put more emphasis on moving your discoveries from your laboratory to application in real healthcare settings. And throughout this all, the ethics of your research must be as central a concern as the outcomes. But you have been deeply grounded in research ethics at Jefferson; here, again, lead the way.

These transitions in research and practice will not come easily. Many will threaten the status quo of your professions. Some will be resisted by those trained before you. But as Jefferson graduates you should be

among the leaders of change. Make your own voice an independent one that speaks out clearly, one that sounds loudly enough to be heard by your colleagues, by your neighbors, by the establishment in medicine, and by your legislators. These issues are just too important for you to remain silent; the risks of failure, the consequences of the status quo, are too great.

Well, that's the challenge. But while all this may sound daunting, the good news is we are finally at a tipping point in national attitudes toward healthcare policy. There is at last recognition of the magnitude of the problem, and perhaps even a strengthening will to undertake fundamental change. These events will overtake you as you start your professional journey. They will engulf you. But you must not simply let them happen TO you.

- You must be activists in driving change within your professions.
- You must alter your own approach to patient care from isolated practitioners to care team members.
- You must accept responsibility for the full continuum of care while improving quality and outcomes.
- You must create an academic research system that weighs ethical risks and benefits, and that values transparency and accountability.
- In short, you must become the architects of a healthier future.

And here's the real excitement. Never in our history has a class of healthcare graduates had such an opportunity to change a profession, to shape policy, to make a difference. We on this stage now look to you, the next generation of healthcare providers, to accomplish what we could not.

You will recast American healthcare into a model that provides the highest quality care, with the best outcomes, to all of our population at a cost that our nation can sustain. And we are fully confident that you can indeed accomplish this.

On this note of optimism for your future and ours, we start you on your professional journey with a bit of nostalgia, a feeling of joy and the absolute certainty that you are well-prepared for the tasks ahead.

- In getting to this day, each of you has had to do well. But I believe you have yet to do your best.
- You have worked hard, but I know that you have yet to work your hardest.
- You have chosen a difficult path, but you have yet to meet your most difficult challenge.

You will change people's lives.

You will fix this broken system.

You will do this institution proud.

I wish you good luck, congratulations, and Godspeed. ■

A Teacher's Perspective on Online Graduate Education

In 2010, Jefferson School of Population Health (JSPH) started offering graduate courses online. Clearly, online education is a convenience for students, especially those who have other time consuming commitments with work and/or family. Reaching a vast, global audience is vital to sustaining programs and making an impact. Online education however, poses questions and controversy among faculty and students. *Will the lack of in-person, face-to-face communication diminish the learning / teaching experience? What do we lose when we move away from the traditional classroom experience?*

Evidence suggests that online learning can actually be more effective than traditional classroom learning – at the K-12 level, undergraduate, and in professional continuing education.[1] Research also shows that multi-component training (combining reading, writing, interaction, and other delivery methods) is more effective than a text-only online course.[2]

The JSPH online curriculum is tightly structured, to help students approach each topic from diverse perspectives, through multiple activities. Each week contains a standard set of components:

1) **Introduction**
   A guide to the week's materials

2) **Readings**
   A textbook chapter or published papers

3) **Assignments**
   Usually a short written assignment, with emphasis on analysis and evaluation

4) **Lecture**
   Online lectures are pre-recorded, and typically quite short (20 minutes) to maintain interest of the students. In addition to teacher lectures, it is possible to post video-conversations with experts on the topic, as "electronic guest speakers."

5) **Discussion Board**
   Typically two questions, encouraging students to explore a topic from multiple perspectives. These are conversations among the students, with the teacher as a guiding but mostly silent observer. Students add references and examples with their replies. These discussion strings can get lengthy and involved, and are the online equivalent of classroom conversation.

6) **Assessments and Evaluations**
   Teachers can post exams or tests

This weekly structure allows students to work through the week's materials and assignments in a logical sequence. Though there is a systematic way to work through the components, they do not necessarily need to do it in the same order. This structure allows the teacher to create a variety of materials, assignments and projects through reading, listening, watching, writing, online discussion. This mix of methods helps keep the students' interest and energy high while playing to the different strengths of each student.

Writing is an essential skill for all students, but even more so for online students. Everything, all communication, is written: assignments, discussion responses, and papers. Strong and comfortable writers have a distinct advantage as online students and those who may not yet be strong writers quickly improve writing skills. The variety of writing styles on a discussion board helps students develop their own style,

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and optimize their writing for focused and thoughtful communication.

As an online teacher I observe several benefits to the students including: stronger immersion in the subject matter; stronger analytical thinking and writing; and greater exposure to research and exploration.

Interactive writing results in a stronger immersion in the subject matter through its written, explicit, and "viewable by all" communication, therefore requiring a more thoughtful, in-depth response to questions and to other students' positions. Online students use references and sources to back up their viewpoints and opinions, more than those in the classroom setting.

With the large amount of writing, students need to write efficiently and effectively. I encourage analytical writing, focusing on pros and cons, strengths and weaknesses, successes and challenges – with emphasis on opinion and points of view and minimal preamble. The written arguments and examples go deeper than in-person classroom conversation.

The online venue also functions as an online research lab. Students link to online references (including papers available through Jefferson's JeffLINE online library), and links to web sites and blogs. For example, Dr. John Halamka's well-known health informatics blog[3] is a favorite source for materials.

One of the challenges created by online education is time needed by the teacher to sort through the discussion boards, papers, and assignments. In an effort to anticipate the various needs of students, JSPH created a position intended to assist the teacher in reading the discussion boards, and coach students toward more effective participation, and grading. Known as the Online Programs Administrative Liaison or OPAL, this person also helps students and teachers troubleshoot technical concerns.

A perceived downside of online education is the lack of personal, face-to-face interaction among students, and between students and teachers. To my own surprise, this has not been a detriment to the learning process. Online students quickly develop and show their personalities: methodical and balanced, fiercely argumentative, list-makers, casual conversationalists, rigorously referenced writers, diagram-drawers, or tentative but developing a stronger voice. Within 3 weeks, each person finds their style, their strength of communicating, and it's a pleasure to see these styles mingle in an online conversation.

Two or three real-time video conference sessions can help develop the rapport among students, and between students and teacher.

A multi-modal, online course is a powerful platform for students to learn and for teachers to teach.[2] It requires more dedication and more work from both parties. But this extra investment in time and effort pays of in greater immersion, with broader research and exploration, than one would achieve in the in-person classroom setting. ■

Harm J. Scherpbier, MD
Harm Scherpbier teaches health informatics, both as in-person and online classes, and shares his experience with online teaching from a faculty perspective. The author can be reached at: harm.scherpbier@jefferson.edu

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JSPH Summer Seminar - The Next Phase

July 21, 2011

The JSPH Summer Seminar provides the region with a perfect opportunity to gather together to discuss future trends in health care, share news on the work and progress of the School, and to network with colleagues and stakeholders on a hot summer day.

David B. Nash, MD, MBA, Dean of JSPH, opened the program by examining the issues that drive the need for the School of Population Health. The field of population health in and of itself is a primary reason for empowering JSPH to offer academic programming that addresses everything from health policy to health care quality and safety, and public health. Dr. Nash reiterated the mission of JSPH, which is to prepare leaders with global vision to develop, implement, and evaluate health policies and systems that improve the health of populations and thereby enhance the quality of life.

Caroline Golab, PhD, Associate Dean of Academic and Student Affairs, described in detail how the academic programs support the mission of the School. JSPH offers graduate degree programs in population health sciences, public health, health policy, healthcare quality and safety, health care quality and safety management, and applied economics and outcomes research, primarily available in an online format. Additionally, certificate programs are available in public health, health policy, healthcare quality and safety, and chronic care management.

Alexis Skoufalos, EdD, Associate Dean for Continuing Professional Education (CPE), explained the value of continuing professional education as it relates to fostering a learning culture within the healthcare system. She emphasized the need for leaders to remain actively engaged in the educational process so they may successfully manage and integrate new information into operations. The CPE division offers a number of different methods and educational activities for targeted workforce development and learning.

Dr. Nash closed the program with the announcement of the establishment of the Center

for Value in Healthcare. This new organizational component to JSPH will serve as the principal home for contract research and will focus on performance measurement and improvement to increase the capacity of the US health care system to deliver higher-quality, safer, more cost-effective care and, ultimately, better patient outcomes. Dr. Nash introduced the new Director of the Center, Mark Legnini, DrPH. Dr. Legnini brings a wealth of experience to JSPH, which includes the management of HMOs and academic medical centers; the organization and management of health policy research; and the design and implementation of performance measurement programs for both the public and private sectors.

Summer Seminar attendees were encouraged to share their comments, suggestions, and questions to help JSPH determine how to further improve programming and foster partnerships. To date we have received numerous inquiries, and the degree of interest and excitement is overwhelming. JSPH encourages all readers, colleagues, and stakeholders to engage in the dialogue by contacting members of our leadership team. ■

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JSPH Faculty Profile - Spotlight on Diane J. Abatemarco, PhD, MSW

Diane J. Abatemarco, PhD, MSW is an Associate Professor and Director of the Doctoral Programs at JSPH. Dr. Abatemaro joined JSPH in 2009 from the University of Pittsburgh, School of Public Health, where she was primary faculty and Associate Director for the Center for Evaluation Research and Community Health. Dr. Abatemarco has worked in doctoral education for many years and helped to create PhD and Dr.PH programs for major universities.

Dr. Abatemarco has extensive expertise in maternal and child health; perinatal HIV; and global health. She is particularly affected and influenced by the international programs she has worked on, including a program that helped medical students working with Haitian refugees in the Dominican Republic. She also had the privilege of working on a number of projects in Croatia, including an adolescent alcohol prevention initiative and a public health and prevention infrastructure project. She has formed deep professional and personal connections through these programs. When asked what impressed her the most about her global health experiences, she stated, "It is shocking to see economically disadvantaged countries have more sense of community and volunteerism than in the US; there is a sense of civic responsibility, a feeling of being able to do more."

Dr. Abatemarco lights up when she discusses the JSPH doctoral program in Population Health Sciences and shares her passion for the program's mission. She explains the importance of a program that "provides state-of-the-art education, and is designed to build upon the master's program…it prepares academic leaders, researchers, and clinicians to work in the field of population health and serves to integrate public health, clinical and health services research." The evolving healthcare landscape and the challenges ahead provide great impetus for students who want to actively participate in analyzing the complex questions and strategize for the solutions. Abatemaro states, "This program is the wave of the future. With its emphasis on transdisciplinary research, it is truly cutting-edge."

The demand for the program has been overwhelming. Students who are currently enrolled in the program represent a diverse range of professionals including: public health professionals; industry executives; and senior to mid-level leaders from non-profit organizations. The program offers a hybrid online and live classroom format to accommodate working students. It is one of the first Population Health Science doctoral programs in the country and the only such program in the region. Abatemarco takes great pride in providing a personal touch and an individualized approach for students who inquire about the program.

Dr. Abatemaro sees the value in creating multi-disciplinary professional relationships both within and outside of the Jefferson community. She is affiliated with the Department of Pediatrics where she mentors junior faculty and collaborates on research with Nemours/Alfred I. duPont Hospital for Children. She is on the Population Science research committee in the Department of Medicine; the research committee at Wills Eye Institute; and the research committee of the Maternity Care Coalition.

Diane Abatemarco, PhD, MSW, JSPH Doctoral Program Director

Abatemarco sees the future of Jefferson as having more emphasis on health services research and the population health sciences program fits in perfectly with this. "I hope that the program is pivotal in developing relationships with other faculty across the university." She also sees many avenues of potential program expansion including the possibility of a MD/PhD program.

Dr. Abatemaro is the mother of 5 and has 10 grandchildren. She loves her family life and is an avid runner. ■

For more information on doctoral programs at JSPH, contact Dr. Abatemarco at diane.abatemarco@jefferson.edu

Improving Health Literacy in the Cardiovascular Population: A Regional Approach in Southeastern Pennsylvania

A patient's understanding of a clinician's directions – whether it is basic health information, instructions about medications, or follow-up guidance, is vital to the quality of care, and patient safety and health outcomes. Health literacy is no longer just an interesting topic, it is a significant factor in the dialogue around improving care and impacting the health of populations.

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[1] Health literacy encompasses a range of skills that go beyond the visual and oral, but may also include numeric and computer literacy. It is incumbent upon health care systems and providers to delve deeper into their current practices and understand their role in ensuring and implementing care and guidance that is understandable to patients.

Research suggests that specific patient populations are especially vulnerable to limited health literacy, namely: those who are elderly,

of lower socioeconomic status, immigrant and minority populations, and people with chronic physical and mental health conditions. Moreover, limited health literacy can be found within all segments of populations receiving care within our healthcare delivery system.

The National Action Plan to Improve Health Literacy was published in May 2010. The Plan is based on two underlying tenets: (1) everyone is entitled to health information that allows them to make informed decisions about their health care and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life.[2] The Plan's mission is to engage organizations, professionals, policymakers, communities, individuals, and families in a collaborative manner to improve health literacy, and Southeastern Pennsylvania has been challenged to participate.

Recently, the Health Care Improvement Foundation (HCIF),[3] a non-profit quality and patient safety organization in Philadelphia, PA, was awarded a federal Preventive Health and Health Services Block Grant from the Pennsylvania Department of Health to improve cardiovascular health literacy and heart health in Southeastern Pennsylvania. Over the next two years, HCIF, in partnership with Thomas Jefferson University and Jefferson University Hospitals, will lead a regional multi-stakeholder coalition aimed at enhancing health care providers' capacity to address literacy needs and foster improved understanding of cardiovascular health information by adults aged 50 and older.

The ultimate goal of the initiative, named "Southeastern Pennsylvania (SEPA) Regional Enhancements Addressing Disconnects (READS) in Cardiovascular Health Communication," is to educate and encourage health care systems and their health care professionals to address health literacy needs in the cardiovascular patient population. The SEPA-READS project leadership will utilize a multi-pronged approach to achieve its goal:

1. Assess the quality and content of communication across multiple points of care in order to identify areas for focus at each participating hospital;

2. Support pilot projects in health literacy innovations, modification of materials, addressing e-health needs, and community partner programs;

3. Enhance professional development in regional hospitals and health systems by training healthcare providers and other staff; and

4. Activate healthcare consumers through peer-to-peer training sessions and interactions.

Teams of healthcare providers will participate in at least two formal training sessions in each year of the initiative. The training sessions will utilize the American Medical Association Foundation's Health Literacy program,[4] which focuses on an overview of health literacy and its relationship to health outcomes, creating a shame-free environment, and enhancing patient interaction and communication, both verbal and written. Through a train-the-trainer approach, these concepts will be dispersed to other providers within the organizations in order to integrate them as part of the standard practice of care.

Efforts will be undertaken to engage healthcare consumers within the communities served by these hospitals. Informal, educational sessions led by peer activators will be hosted by various community centers serving older adults. The focus of the sessions will be to increase the confidence of individuals to ask questions of their providers about their care plans by utilizing Ask Me 3™, which is a patient education program designed to promote communication between health care providers and patients in order to improve health outcomes.[5] The program encourages patients to understand the answers to three questions:

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

Through the efforts of the participating organizations, a Cardiovascular Health Literacy Toolkit, containing a compendium of best practices and health literacy materials, will be developed for dissemination to regional hospitals and community organizations. Additionally, a website related to cardiovascular health literacy and containing the toolkit and other references will be developed as an important product of the initiative.

Patricia Yurchick, RN, MBA, CPHQ
Senior Director, Quality Partnerships & Initiatives
Health Care Improvement Foundation

To obtain more information about the SEPA-READS project, please contact the author at pyurchick@hcifonline.org or 215-575-3742. ■

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2. National Action Plan to Improve Health Literacy, US Department of Health and Human Services, May 2010.

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4. American Medical Association. Health Literacy. http://nnlm.gov/outreach/consumer/hlthlit.html. Accessed August 11, 2011.

5. National Patient Safety Foundation. Ask Me 3™. http://www.npsf.org/askme3/. Accessed August 11, 2011.

Joseph S. Gonnella, MD Scholarship Awarded to Jonathan Musyt

The Jefferson School of Population (JSPH) has awarded the Joseph S. Gonnella, MD Scholarship to Jonathan Musyt, a Jefferson Medical College (JMC) student who recently completed his third year of medical school. Musyt entered the Master of Public Health (MPH) program at JSPH in September 2011.

The Joseph S. Gonnella Scholarship is named in honor of Dr. Gonnella, Distinguished Professor of Medicine, former Dean of Jefferson Medical College, and founder and director of JMC's Center for Research in Medical Education and Healthcare. This merit-based award is intended specifically for highly qualified students of JMC who wish to pursue an MPH in addition to their medical degree.

Musyt graduated from the University of Scranton in 2007 with a degree in Biochemistry and Philosophy. After college, he spent a year working with the Boston Health Care for the Homeless Program as part of the AmeriCorps Community HealthCorps program.

Since entering medical school, he participated in the Bridging the Gaps Community Health Internship Program, by working with a fellow medical student and a social worker at My Brother's House, a transitional housing facility for chronically homeless men with a dual diagnosis of mental illness and substance abuse. He was also a student volunteer in the JeffHOPE program and the Jefferson Medical Education Initiative.

Musyt plans to pursue a Family Medicine residency after completing medical school. Regarding the scholarship, Musyt states, "I believe that acquiring a formal education in public health will enable me to become a well-informed, more effective advocate for both individual patients and improved health care implementation and delivery in my future career as a physician." ■

Jonathan Musyt

Health Policy Forums

Personalized Medicine: Transforming the Future of Healthcare

Wayne Rosenkrans, Jr., PhD
Chairman of the Board
Personalized Medicine Coalition

June 9, 2011

The spring forum season ended with an enlightening presentation by Wayne Rosenkrans of the Personalized Medicine Coalition (PMC). Dr. Rosenkrans is a Distinguished Fellow at the Center for Biomedical Innovation at MIT, where he works on health care strategy and policy issues related to science and medicine. He is also a member of the Ethics and Systems Medicine Program at Georgetown University.

PMC is an organization designed to educate the public and policy makers, while promoting new ways of thinking about health care. PMC represents a broad spectrum of more than 200 academic, industry, patient, provider and payer communities, in an effort to advance the understanding and adoption of personalized medicine concepts and products for the benefit of patients.

Dr. Rosenkrans addressed the impending intersection of declining healthcare quality vs. increasing healthcare costs and the tools needed to find the solutions. He bluntly stated that the current situation in healthcare is not sustainable and that no single part of the healthcare system or any single sector of industry can do it alone.

Dr. Rosenkrans provided an overview of the federal agencies that play a significant role overseeing funding and research related to improving value in health care. Rosenkrans also described the role the Patient-Centered Outcomes Research Institute (PCORI), which was set up to as independent entity to complement health care reform and conduct research to offer information to patients and providers based on the best available evidence.

Rosenkrans emphasized that value in health care is often expressed as the increment in clinical benefit achieved (health and/or quality of life improvement), for those receiving a particular service or set of services in conjunction with the investment required.

He went on to define personalized healthcare as a model for generating meaningful segmentations of patient populations through appropriate technology, in order to increase the benefit of therapy. It is a proactive rather than reactive approach. He describes the "P" for the future or the characteristics of personalized health care as: prescriptive; precision; preventive; participatory; and performance.

Rosenkrans envisions a new paradigm in healthcare centered on Health Information Technology with linkages between comparative effectiveness, personalized health care, and real world effectiveness. ■

For more information on PMC visit:
www.personalizedmedicinecoalition.org

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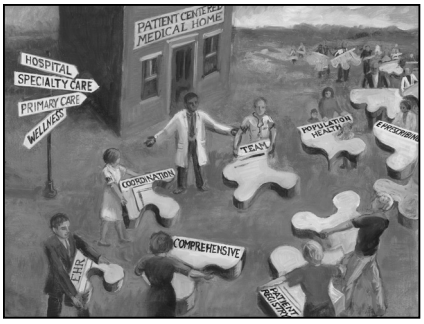

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JSPH Announces the Center for Value in Healthcare

This summer, the Jefferson School of Population Health (JSPH) unveiled a new organized research enterprise – the Center for Value in Healthcare. Mark W. Legnini, DrPH, who 10 years ago founded The Healthcare Decisions Group, a consultancy in Washington, DC, was named Director of the Center.

The Center for Value in Healthcare focuses on performance measurement and improvement to increase the capacity of the US healthcare system to deliver higher-quality, safer, more cost-effective care and, ultimately, better patient outcomes. The Center's work aligns closely with JSPH's academic programs and integrates the resources of Jefferson's other schools, the University's hospitals and its faculty medical practice. "We hope to provide patients, practitioners, purchasers and payers with information that will move us closer to the healthcare system we all want" said Legnini. Formation of the Center seizes upon a modern American social movement – the healthcare quality and value revolution – and the critical role it will continue to play in transforming the US healthcare system.

"Value is where the world is moving," said David B. Nash, MD, MBA, Dean of the School of Population Health. "This is a tremendous opportunity to provide better outcomes for patients."

At the Center's core are the "Six Aims for Improvement" established in the Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, paraphrased briefly here:

- Safety: Patients ought to be safe in health care facilities as they are in their own homes.
- Effectiveness: The health care system should match care to science, avoiding both overuse of ineffective care and underuse of effective care.
- Patient-centeredness: Health care should honor the individual patient, respecting the patient's choices, culture, social context, and specific needs
- Timeliness: Care should continually reduce waiting times and delays for both patients and those who give care.
- Efficiency: The reduction of waste and, thereby, the reduction of the total coast of care should be never-ending, including, for example, waste of supplies, equipment, space, capital, ideas, and human spirit.
- Equity: The system should seek to close racial and ethnic gaps in health status.

Mark W. Legnini, DrPH, Director, Center for Value in Healthcare

Dr. Legnini's background includes experience in the management of HMOs and academic medical centers, the organization and management of health policy research, and the design and implementation of performance measurement programs for both the public and private sectors. Most recently, Dr. Legnini was Research Director in the Engelberg Center for Health Care Reform at the Brookings Institution. ■

Food Matters: Clinical Education and Advocacy Training

June 11, 2011

The relationship between health and nutrition has an obvious link to human development and survival. As we observe the increasing rise in chronic health problems exacerbated by obesity and malnutrition, we know that nutrition is more complex than what is contained in the familiar food pyramid. Access to healthy, sustainable food is critically important throughout the life cycle. Knowledge, awareness, and behavior change among individuals, communities, and health care providers is an important first step in improving health and influencing systemic change.

On June 11, 2011 the Jefferson School of Population Health and the Center for Urban Health hosted *Food Matters: Clinical Education and Advocacy Training,* a ground-breaking program presented by Women's Health and Environmental Network (WHEN). This national training program was designed by Health Care Without Harm in partnership with the University of California San Francisco (UCSF) Program on Reproductive Health & the Environment, and San Francisco Physicians for Social Responsibility. It is being piloted in four cities, including Philadelphia. The overall goal of the program is to encourage hospitals and healthcare professionals to become leaders and advocates for a food system that promotes public and environmental health.

The Philadelphia program featured several prominent clinical leaders in the food advocacy and environmental health arena. Jill Stein, MD, Founder of the Massachusetts Coalition for Healthy Communities, opened the day with an extremely informative framework and rationale for the importance of healthy food. She emphasized the multi-layered contributors to disease and environmental degradation.

Joel Forman, MD, Associate Professor of Pediatrics and Community and Preventive Medicine at The Mount Sinai School of Medicine, provided a compelling argument regarding a potential relationship between exposure to

toxic chemicals in food systems (including perinatal exposures) and neurodevelopmental issues in childhood. He also shared evidence-based research on the problems associated with antibiotic resistance and food-borne illness.

Colette Acker, IBCLC, Director of the Breastfeeding Resource Center in Abington, PA, described the research to support the promotion of breastfeeding as an essential practice to reduce risks of illness. She emphasized the global picture of how breastfeeding benefits society in reducing costs and preventable disease.

Kendra Klein, PhD candidate, of the Department of Environmental Science, Policy and Management of the University of California, Berkley provided an overview of policy issues and advocacy initiatives that are designed to affect changes in systems. For example, she discussed the Healthy Food In Health Care Pledge created by Health Care Without Harm to enlist the commitment of hospitals to use fresh, local and sustainable food and food practices.

The training program included a lively panel discussion moderated by Dianne Moore, MS, MSW, Manager of WHEN, and breakout sessions designed to elicit ideas and action steps for advocating for a healthier food system. Attendees were treated to a delicious, sustainable lunch of locally sourced meats and produce provided by the department of Nutrition and Dietetics at Jefferson University Hospital. ■

For more information about the Food Matters training program visit: http://www.noharm.org/us_canada/events/foodmatters/

To learn more about WHEN visit: www.when.org

Upcoming Health Policy Forums - Fall 2011

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
American College of Physicians

Reconsidering Law and Policy Debates: A Public Health Perspective

December 14, 2011

John Culhane, JD
Professor of Law
Widener University, School of Law

Location:

Curtis Building, Room 218
1015 Walnut Street
Philadelphia, PA 19107

Time: 8:30 am – 9:30 am

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JSPH Presentations

Berman B. Value-based purchasing: Trends in ambulatory care. Presented at: The Tenth National Quality Colloquium, Cambridge, MA, August 17, 2011.

Borsky A, Harris D, Sarfaty M, Myers R, Sifri R, Stello B, Johnson M, Cocroft J, Gratz N, Kasper-Keintz M, **Pracilio V**. Understanding the contextual factors affecting a public health intervention to increase colorectal cancer screening using the practical, robust, implementation and sustainability model (PRISM) – A report from the CNA Health ACTION Partnership. Poster presented at: AcademyHealth Annual Research Meeting, Seattle, WA, June 12-14, 2011.

Cobb Moore, NM. Make your life your argument: An inntroduction to The Albert Schweitzer Fellowship (ASF). Presented at: University of Medicine and Dentistry of New Jersey, School of Nursing Multicultural Day, Strafford, NJ, August 3, 2011.

Goldfarb NI, **Pracilio VP**, Ng-Mak DS, **Couto J**, Sennett C, Hopkins M, Bumbaugh J, Silberstein S. Utilization of CT Scans and MRIs in an insured population with migraine. Poster presented at: The 53rd Annual Scientific Meeting of the American Headache Society, Washington, DC, June 2-5, 2011.

Harris D, Borsky A, Sarfaty M, Myers, R, Sifri R, Stello B, Johnson M, Cocroft J, Gratz N, Kasper-Keintz M, **Pracilio V**. Increasing colorectal cancer screening with the population-based SATIS-PHI/CRC Intervention – A report from the CNA Health ACTION Partnership. Poster presented at: AcademyHealth Annual Research Meeting, Seattle, WA, June 12-14, 2011.

Klaiman T. Epidemiology and 2009 H1N1. Presentation at: Global Health Academy @ Jefferson, Philadelphia, PA, July 14, 2011.

Klaiman T. 2009 H1N1: What happened and what can we learn from it? Presentation at: 2011 Lankenau Institute for Medical Research Summer Internship Program, Lankenau Hospital, Wynnewood, PA, July 7, 2011.

Klaiman T, Stoto M, Nelson C. Utilizing quality improvement methodologies for defining positive deviants during the 2009 H1N1 vaccination campaign. Poster presented at: 2011 AcademyHealth Annual Research Meeting, Seattle, WA, June 14, 2011.

Lieberthal RD. International evidence on medical spending risk. Presented at: 2011 American Risk and Insurance Association Annual Meeting, San Diego, CA, August 9, 2011.

Lieberthal RD, Comer DM, O'Connell KA. Validating the PRIDIT method for determining hospital quality with outcomes data. Presented at: 46th Actuarial Research Conference, Storrs, CT, August 12, 2011.

Lieberthal RD. International evidence on medical spending. Poster presented at: 46th Actuarial Research Conference, Storrs, CT, August 10-13, 2011.

Ng-Mak DS, **Pracilio VP**, Silberstein S, **Couto J**, Sennett C, Hopkins M, Bumbaugh J, Goldfarb NI. Association between triptan use and cardiac contraindications in an insured migraine population. Poster presented at: : The 15th Congress of the International Headache Society, Berlin, Germany, June 23-26, 2011.

Ng-Mak DS, **Pracilio VP**, Silberstein S, **Couto J**, Sennett C, Hopkins M, Bumbaugh J, Goldfarb NI. Association between triptan use and cardiac contraindications in an insured migraine population. Poster presented at: The 53rd Annual Scientific Meeting of the American Headache Society, Washington, DC, June 2-5, 2011.

Pelegano J. Value based purchasing in Orthopedics. Webinar presented at: Rothman Institute, Philadelphia, PA, June 6, 2011.

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JSPH Publications

Clarke JL. Seeking patient-centered solutions to a national epidemic. Symposium. *Pop Health Manag.* 2011;14(suppl 2):S-2.

Lieberthal RD. International evidence on medical spending. Casualty Actuarial Society E-Forum. Spring 2011; 1-22. http://www.casact.org/pubs/forum/11spforum/Lieberthal.pdf.

Maio V, Jutkowitz E, Herrera K, Abouzaid S, Negri G, Del Canale S. Appropriate medication prescribing in elderly patients: how knowledgeable are primary care physicians? A survey study in Parma, Italy. *J Clinl Pharm Ther.* 2011;36:468–480.

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Meiris DC. Insights from the 11th Population Health and Care Coordination Colloquium. *Popul Health Manag.* 2011;14:107-110.

Nash DB, Murphy SP, Mullaney AD. Governance: Current trends in board education, competencies, and qualifications. *Am J Med Qual.* 2011;26(4)278-283.

Nash DB, Toscani M, Vogenberg FR. The Biologic Finance and Access Council. 2nd Annual biologic healthcare survey: Views from key healthcare stakeholders. *Biotechnol Healthcare.* 2011;8(2):19-21.

Nash DB. Round 2 in the heavyweight match with diabetes. *Popul Health Manag.* 2011;14(suppl 2):S-2.

Nash DB. P4P versus P40. *Medpage Today.* June 2, 2011. http://www.medpagetoday.com/Columns/26820

Nash DB. A patient-centered approach to patient safety. *Medpage Today.* July 15, 2011. http://www.medpagetoday.com/Columns/27550

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Romney MC, Thomson E, **Kash K.** Population-based worksite obesity management interventions: A qualitative case study. *Popul Health Manag.* 2011; 4(3):127-132.

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