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GUEST EDITORIAL

The Impact of the Current Financial Situation on Public Health Prevention Efforts

Millions of Americans look to state and local health departments for disease screenings, immunizations and other disease prevention programs. The current economic situation in the United States has led to drastic cuts in funding for public health agencies. State and local health departments have been increasingly unable to provide programs and services upon which community members depend, as evidenced in numerous media reports.¹⁻³ Most alarming is a recent report published by the National Association of County and City Health Officials⁴ that noted that more than half of all local health departments reduced or eliminated at least one program in the last year.

Community Health Centers (CHCs) are especially feeling the pinch, as they serve predominantly low-income patients who are uninsured or who rely on public insurance. "The significance of CHCs as sources of care for the uninsured and underinsured has grown as a result of recent Federally Qualified Health Center (FQHC) expansions and a worsening economy."⁵ Health departments are also responsible for assessing community health, enforcing laws and regulations that protect health, and preparing for emergencies. Anyone who has seen the film *Contagion* can understand the need for a robust public health infrastructure.

Research has shown that consistent funding is one of the most important contributors to health

departments' ability to meet public needs.⁶ Increases in health department expenditures are significantly associated with decreases in infectious disease morbidity at the state level,⁷ and increased public health investments can produce measurable improvements in health.⁸

However, this evidence has not generally led to consistent, highly funded local health departments: in fact, public health funding is extremely variable^{9,10} and driven by the realities of public finance and political agenda setting. Health departments have tried to deal with funding cuts through various strategies including regionalization of services, and greater utilization of volunteers; however, budget cuts have led to drastic job losses and program cuts in many communities.⁴

We know that healthy communities and individuals are more productive, live longer, and cost society less money; however, the dependence on public funding for most population health activities may have to be reconsidered given the current financial crisis. Rather than forgo health promotion and disease prevention activities, I recommend consideration of two key areas to preserve and expand public health activities even during times of financial stress.

First, I recommend integrating population health into other government departments and activities.

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Researchers have suggested the integration of public health and urban planning by sharing conceptual frameworks and theories in order to marry the two disciplines.¹¹ Many conceptual theories in different disciplines are complementary and can be used together to create synergy between different goals. Ensuring green spaces, trails, bicycle access, and adequate lighting can encourage the use of urban areas for healthy activities. Similar strategies can be used to bring public health together with departments of education, recreation, and emergency preparedness.

Population health is impacted by every agency in a community; however, people who are trained in other disciplines often overlook public health. For example, in Pennsylvania, Marcellus Shale drilling has been virtually unregulated by the Department of Health or Environmental Protection Agency.

The long-term health impacts of drilling for natural gas and introducing chemicals into groundwater have not been considered because of the economic gains such drilling may bring to the state. Ensuring a population health perspective is represented at the table when developing energy policy can help to make communities healthier without a great deal of financial investment.

While it is the responsibility of the government to help fund and maintain public health agencies, my second recommendation is that population health practitioners partner with non-traditional funding agencies for specific initiatives. For example, partnering with a sneaker company to help fund an athletic program in a local school or recreation center or working with a local health food store to give healthy cooking lessons to parents can not only increase healthy behaviors, but bring in new

partners who may be interested in investing in local communities. Public-private partnerships have been successful in many global public health initiatives,¹² and such partnerships can expand the reach of population health into new sectors in the community, and can advance the population health agenda.

Financial challenges will continue to be of concern for population health as it is for all publicly funded agencies. As population health practitioners and researchers, we must begin to think of new and creative ways to maintain our relevance and sustainability. ■

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COMMENTARY

Educating Future Leaders in Public Health*

Once again, we are mired in the muck of health care “reform.” A variety of forces, chief among them increasing costs, has pushed providers and payers in the health sector to search for new approaches to managing the myriad transactions and multiple institutions and organizations that together constitute the sector, and managerial innovation has come to health care with a vengeance. Like it or not, and for better or worse, the logic of managerial efficiency has infiltrated the sector and now permeates discussions of strategy, budget, physician recruitment, technology investment,

clinical effectiveness, accountability and quality of services provided. With this development has come an army of what are affectionately known as “the suits,” the men and women trained in the techniques and tools of management but most of whom lack any formal clinical training. It is mainly these people, who have been tasked with introducing tools developed in other sectors of the economy to the management of hospitals, community health centers and other organizations in the health sector, and their arrival in the pinstripes of managers rather than the white coats

of clinicians has often been greeted with all the warmth of an igloo in winter.

This lack of enthusiasm on the part of clinicians is certainly understandable. The world of providing health services has long been divided into two camps, clinical and administrative, and the oft-noted tensions between the two are born of the different training, missions and values – the thought worlds, in short – of the two professional groups. In the past 25 years, however, there has been a shift in the second group from administrators whose primary

responsibility was to maintain order and support the clinicians to managers whose primary responsibility is to insure efficient deployment of organizational resources. This shift is hardly surprising given the problem of escalating costs, and “the suits” are playing an increasingly visible role in both strategic and operational decisions, decisions that often have a significant impact on clinical practice. The question this shift raises is at what point focus on the “bottom line” might dominate clinical judgments about what is best for the patient. And what is important in developing future leaders in public health is insuring that they have the background and tools to find the appropriate balance between these two seemingly contradictory pressures. Should they be clinicians, should they have MBAs, should they have MPHs, or some combination of these alternatives? What kind of training, in other words, will best meet future challenges, and where will this training be found? Will it be found in medical schools, in nursing schools, in business schools, in schools and programs in public health, or, perhaps, in some other enterprise altogether?

The answer is that it could be found in any of those settings *if* those responsible for educational design and curricular development understand the future contours of the landscape and are able to construct their offerings accordingly. This requires a new mindset, one that recognizes the cost-saving potential of effective health promotion and prevention, the need to balance infinite health needs and finite resources, and the cost-increasing consequences of the ever-growing incidence of chronic illness. This is the challenge that faces the organizations providing the education and training.

To what extent will they be able to design or redesign their offerings to meet what the evolving landscape of public health *needs* as opposed to simply re-branding what they already do and thus offering a version of what they *already know*?

Preparing leaders in public health for careers in a world that is changing rapidly certainly requires more than a formal academic degree. It requires continual updating of skills, continuous learning from experience, and active participation in defining the conditions under which the business of public health plays out. The truly effective leaders in public health in the future will be those who actively manage their careers based on the assumption that what they “know” today is not necessarily what they will need to know tomorrow, and effective educators will be those who understand the career trajectories of successful leaders, who appreciate the interplay of formal education and front-line experience in shaping those trajectories, and who are able to design offerings that are appropriate at different points along the career path of their “students.” This means that institutions involved in preparing these leaders will have to be willing to continuously reevaluate the relevance of both the “what” and the “how” of what they do, that is, the *content* of their curricula and the *modes of delivery*. It will mean reevaluating the very core of their own technologies, including, but not limited to, the role of the formal classroom in the educational process. It will mean being on top of new technologies that link students virtually and that create a different role for “place” in the educational process. It will mean reconceptualizing, for example, the meaning of an MPH degree and linking educational initiatives more to the development of personal portfolios of

“students” than to particular academic degrees. It will mean taking very seriously the incorporation of experience acquired outside of the academic institution into their portfolios systematically and rigorously and building on it. It will require rethinking the already packed sets of requirements for particular degrees in ways that give priority to what students need as opposed solely to what faculty offer. And, more specifically, it will mean exposing them directly to the consequences of underinvestment in public health around the globe and to the unparalleled opportunities to contribute in a meaningful way to improving health by equipping them with new perspectives and insights into the new tools and approaches that are available to help them succeed.

The challenge is both daunting and energizing. It means that schools and programs of public health in particular will have to take a leadership role. It means that they will have to be ready to change both the “what” and the “how” of what they do. This will be hard, very hard. But nothing could be more important than the mission of preparing leaders in public health for tomorrow. ■

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“Preparing Leaders in Public Health for Success in a
Flatter, More Distributed and Collaborative World.”*

JSPH and the America-Israel Chamber of Commerce Host Health IT Conference

Health care is big business in Philadelphia, and nowhere was that more apparent than at a conference hosted November 16, 2011 by the America-Israel Chamber of Commerce (AICC) and the Jefferson School of Population Health (JSPH).

A delegation of 11 Israeli health IT and healthcare technology companies visited the City that day, making a case for regional healthcare companies to adopt their software systems and applications and for investors to park their capital with them. Many of the companies presenting – including Mediviz Systems and Safend – have already established

partnerships with healthcare providers in the US. Other companies, such as CureMyWay, an early stage start-up seeking an investment of \$1 million to \$2 million for a digital health platform to help people make informed decisions about their care, are still hoping to get their foot in the door.

“There are very few cities that could sponsor and fill an auditorium with investors interested in health information technology companies, with potential application to the American healthcare system,” said David B. Nash, MD, MBA, dean of JSPH. “Health care is the biggest industry in

Philadelphia, so it was no surprise that this town was able to pull off a day like we just had.”

During a kickoff event for the conference, regional health leaders were honored by the AICC for achievements in health-related collaborations between Israel and the Philadelphia region. These honorees included: Dr. Alberto Equenazi, Director, Moss Rehabilitation; Harry Lukens, Chief Information Officer, Lehigh Valley Hospital and Health Network; Dr. Banu Onaral, Director, School of Biomedical Engineering, Drexel University; and Dr. David Nash, Dean, Jefferson School of Population Health. ■

Preparing the Healthcare Workforce for the 21st Century

This article summarizes topics addressed at *Creating the Healthcare Workforce for the 21st Century Conference*; a collaborative educational program organized by Thomas Jefferson University and University of Delaware, and held on the Jefferson campus in Philadelphia, Pennsylvania on October 21, 2011.

Thomas Jefferson University President Robert L. Barchi, MD, PhD, and University of Delaware President Patrick T. Harker, PhD, began the day-long program by sharing their vision for a partnership that enhances the health and science offerings in the region. The Delaware Health Sciences Alliance was formed to align resources to create a unique, broad-based collaboration among experts in medical practice, health economics and policy, population sciences, public health, and biomedical sciences and engineering and strengthen these offerings in the region.

A key component of developing the health sciences in the region is in educating and training a prepared workforce. Through the October 21 conference, over 200 professionals gathered to discuss ongoing change in the delivery of healthcare and how it relates to the workforce.

Susan Dentzer, Editor-in-Chief of *Health Affairs*, spoke on the benefits of cultivating collaborative and coordinated care and the great responsibility vested in academic medical centers, such as TJU,

to train tomorrow's medical professionals to work collaboratively as a team, and the importance of reducing waste and medical error to cut costs and improve medical outcomes.

Joanne Conroy, MD, Chief Health Care Officer of the Association of American Medical Colleges, addressed the need for transformational change in the education of health care professionals, calling for "the right mix of physicians and essential health care providers with the right skills and training, in the right places."

Former Pennsylvania Governor Edward G. Rendell gave the luncheon keynote and expressed his concern over America's loss of a competitive edge in science and technology; the need for the education of America's youth to once again take center stage, and a call to return to the "can do" attitude that once made America the world leader in innovation, discovery, and scientific breakthrough. He spoke of the importance of the healthcare industry to the Greater Philadelphia region, and how conferences such as this one underlie how Philadelphia can serve as the point for an era of drastically improved healthcare in terms of quality, safety, innovation, and job creation.

The afternoon included two diverse panel discussions. In one discussion, George W. Bo-Linn, MD, Chief Program Officer for the Gordon and Betty Moore Foundation's San Francisco

Bay Area Program, underlined the importance of teamwork in healthcare, and how critical it is for health care professionals to engage their patients – or "persons," as Dr. Bo-Linn prefers – in their own health care. "The current most widely unrecognized and largest workforce is patients and their families," Dr. Bo-Linn declared.

In the final session Mike Strazzella spoke from the vantage point of the hospital, reminding the group that hospitals offer the community both fiscal and physical well being. He also encouraged the audience to reach out to the local representatives and educate them on the many benefits hospitals provide to the community, including a large number of jobs and a positive economic impact.

The health care workforce for the 21st century will need to adapt to a health care system currently in reform, but the most basic tenet remains the same, surmised David B. Nash, MD, MBA, Dean of the Jefferson School of Population Health - "Patients, or persons, will remain at the center of all we do." ■

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To listen to the podcast and view slides for this program visit: <http://jdc.jefferson.edu/creatinghealthworkforce/2011/>

Change – Both a Journey and a Destination

Impressions from the Annual National Forum on Quality Improvement in Health Care

"Change almost always comes as a surprise."¹ This simple truth was shared by Maureen Bisognano, CEO of the Institute for Healthcare Improvement (IHI), during her opening remarks at the 23rd Annual National Forum on Quality Improvement in Health Care in Orlando, Florida, December 2011. The 5,700 healthcare professionals in attendance all seemed to be in agreement. Over the past year, our healthcare system has experienced significant changes as the various phases of health reform are implemented in the face of threats of significant funding cuts. Through all of the uncertainty about where we're headed, health care providers around the country

are bracing themselves for the ride and remain hopeful that change, while we may be slow to adopt it, will propel us forward.

As a Forum participant, I listened intently as Ms. Bisognano outlined a vision that could be achieved through the collective impact of improvement professionals working together. One thing that was clear is that healthcare professionals must partner with patients to achieve that goal. Delivering patient-centered care, addressing population needs, achieving value, and continuously strengthening our improvement capability relies on being open

to and giving consideration to feedback from our patients and colleagues. We must adopt a "nothing about me, without me" mentality. This point was affirmed throughout the Forum when a leader who builds the will for change (Maureen Bisognano) outlined it as a vision, a patient (Michael J. Fox) described illness as a matter of perspective or what you make of it, and a national leader and humanitarian (Don Berwick) gave us a call to action.

Including the patient is not a new concept. It has been part of safety improvement discussions for the last several years. What is new is the

realization that we can't achieve this vision using only the knowledge we currently have. We must build improvement capability to develop a healthcare workforce trained in the skills of quality improvement.

Healthcare professionals are not simply expected to participate in improvement, but to lead it – and that requires a specific skill set.² A session that I co-presented with David Nash, MD, MBA at this year's Forum focused on how to build the skills necessary to improve the system where we practice and receive care. One element that will move us toward that goal is transparency regarding medical errors. Open discussion when things go wrong provides an opportunity

to learn and prevent it from happening again. Transparency is an individual decision but it relies on cultural acceptance. If you choose to openly discuss a situation, it must be received and transmitted into action. The benefit is that we can begin working on transparency today. It's immediate. It doesn't require infrastructural changes or resources. Just one of many skills that will advance the system, transparency is essential to improvement.

Behind every movement is a journey and further ahead, a destination. The journey began when the Institute of Medicine realized the magnitude of deaths occurring from medical errors each year and it will continue its work until the

goals of delivering truly patient-centered care, addressing population needs, achieving value, and strengthening our improvement capabilities are achieved. Commitment to open discussion and gaining improvement skills, while keeping the vision in mind, will allow us to have collective impact. As Don Berwick stated in his closing remarks, "You [we] have a chance to make what is possible real." ■

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Summer Institute in Public Health at Lankenau Medical Center

Recognizing the increasing popularity in the study of Public Health at the undergraduate level, the Center for Public Health Research (CPHR) based at the Lankenau Medical Center inaugurated a collegiate internship program in summer 2011. Throughout June and July, CPHR was home to 17 highly talented and motivated students representing Haverford, Bryn Mawr, Villanova, MIT, Penn State, Rochester, and Emory. Located in the Lankenau Institute for Medical Research (LIMR), CPHR launched 8 major center projects with the help of this hardworking group. Evaluated as part of all projects were issues of healthcare disparity and identifying the social determinants of health that may be causative factors. These are areas of very significant interest to the present younger generation and, in many cases, is the driving force for their participation in summer programs and exploration of future careers in healthcare.

The projects reflect the diversity in Public Health. Divided into small groups, students were paired with physician, nursing, and administrative mentors throughout Lankenau. The projects, coordinated through CPHR, focused on disease management and prevention, and involved issues of tobacco usage and cessation, child safety, and pulmonary disease. Aspects of increasing

accessibility to screening mammography for the detection of early breast cancer were evaluated in conjunction with the LMC Cancer Center. Other students were teamed with LMC nurses and social workers as they helped to implement improved discharge planning and transitional care models designed to decrease hospital readmissions. And another small group evaluated a potential screening program to detect young athletes at potentially high risk for sudden cardiac death.

All 17 students were assigned one summer-long project in which aspects of undergraduate public health programs were discussed on a weekly basis. In particular, student input was sought pertaining to ways to build and strengthen relationships between the Main Line Health System and undergraduate institutions based upon a campus-community partnership model in public health. Such a model involves students in experiential learning projects throughout the year based at Main Line Health and co-mentored with collegiate faculty. This model was particularly attractive to students at Haverford, Bryn Mawr, and Villanova due to the location of their institutions on the Main Line.

Project work was the foundation of the summer experience. It was supplemented by field trips

related to public health and a comprehensive weekly lecture series sponsored and provided by the Jefferson School of Population Health at the direction of Dean David Nash. In June the group visited the College of Physicians of Philadelphia and met with its director, Dr. George Wolreich, followed by a guided tour of the world-famous Mutter Museum. July's visit to the Jefferson School of Population Health included a lunch meeting with Dr. Nash and discussion of current public health issues and advice on launching careers in healthcare

Throughout the entire program, summer interns benefited from a comprehensive lecture series devoted to public health that was largely provided by faculty of the Jefferson School of Population Health. Designed jointly by JSPH's Associate Dean Caroline Golab and CPHR's director, Stanton Miller, the lecture series served as an introductory core curriculum to the field. Topics ranged from ethical conduct of research, principles of population health, health informatics to issues of pediatric water safety and maternal/child health research. Faculty from JSPH gave of their own time by traveling to the Main Line to deliver the lectures onsite at LMC. This proved to be a very popular component of the program.

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The summer program concluded with oral presentations of group projects to the Main Line Health community in a half day program held at LMC, followed by a farewell luncheon. A capacity crowd at the Annenberg Center for Medical Education was treated to a series of high-quality presentations, all of which had significant practical relevance to the mission of the health system. Projects ranged from a study of local water supply in conjunction with the Pulmonary Medicine division to increasing compliance rates

for screening mammography and colonoscopy in an uninsured/underinsured population.

Overall this program was viewed as highly successful. It provided an opportunity to introduce careers in healthcare to a whole new generation of young people. The combination of projects, field trips, and lectures proved quite popular with the students. One student described his summer experience as “life-changing.” And, most importantly, projects launched in the summer are now growing and continuing

throughout the course of the year. Also notable was the successful collaboration of CPHR and JSPH. Plans are for this program to continue next summer. It is hoped that funding will be attained so as to provide stipends for students and assist in even greater program design and staff support. ■

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Institute Of Medicine Convenes Workshop On The Allied Health Workforce And Services

Allied health professionals make up the majority of the health care workforce in the United States. They are a diverse group of health care professionals, including clinical laboratory personnel, physical therapists, occupational therapists, dietetic services, medical record personnel, radiologic services, speech-language pathologist and audiologists, and respiratory therapists. Physicians, nurses, dentists and podiatrists are not included under the allied health umbrella.

The term allied health emerged in the mid-1960s as a means to identify the kinds of groups eligible to obtain federal grants and contracts to address certain kinds of workforce shortages. By Federal statute, in order to be considered an allied health professional, one must possess a certificate; an associate's, bachelor's, master's, doctoral degree; or post-baccalaureate training in a science related to health care.¹ However, even with the definition there is disagreement as to what professions should be designated as part of allied health. For example, the Federal Government lists over 200 occupations as allied health professions (many with on-the-job training), while the American Medical Association lists 52 verifiable disciplines. This lack of consensus as how to define allied health is a major reason why they are the least studied group of health professions and adds to the difficulties in understanding this workforce and their contributions to health care. It also has serious consequences, since policy makers are often unaware of the impact of their decisions on the services provided by allied health professionals.

Periodically, Congress will mandate the Health Resources and Services Administration (HRSA)

of the US Department of Health and Human Services to provide information regarding issues in the health care workforce. HRSA will then commission the Institute of Medicine (IOM) of the National Academies of Sciences to impanel a committee of experts to study this issue and make recommendations to Congress. The first and only IOM Committee report dealing with allied health personnel was published in 1989. *Allied Health Services: Avoiding Crises*² made recommendations regarding the issues identified related to the allied health care workforce. These included the need of a better definition of allied health professionals and their role in health care delivery, the importance of measuring the supply and demand of allied health professionals, the need to recruit students from less traditional pools, issues related to accreditation and the need to advance the scientific base of allied health. In the period since that report, little progress has been made at addressing those recommendations.

On May 9-10, 2011, the IOM, with support from HRSA, convened a workshop on the current allied health workforce. The purpose of the workshop was to consider how the allied health care workforce can contribute to solutions for improving access to health care, particularly for underserved, rural and other special populations. The intent was to collect information from those knowledgeable about each of the subject areas and to prepare a summary report to HRSA for future action. One possibility of this action would be to impanel another IOM Committee to make recommendations to Congress. The major topics of this workshop were: gauging supply and demand; critical roles of allied health professionals in various environments such as

hospitals, urban and rural areas; and accreditation issues and education, particularly the future of team-based care:

Based on the presentations at the workshop, some of the issues identified in the 1989 report remain unresolved.

- For example, with some exceptions, there is still little systematic data collected on the allied health workforce. While some states, such as North Carolina, have a sophisticated data collection system, the systems in many other states are fragmented at best. Although the Bureau of Labor Statistics (BLS) publishes supply and demand projections yearly, researchers at the workshop questioned the accuracy of data projected more than two or three years in the future because of unforeseen changes in the environment. For example, they claimed that projected demand for pharmacists in the next 5 years was significantly lower than BLS projections.
- HRSA, is renewing its efforts (started in the 1980s) to develop a Minimum Data Set to classify all of the allied health professions in an attempt to arrive at better understanding of the workforce.
- Accreditation continues to be a contentious issue for all allied health professions, with many at universities questioning its expenses and validity.
- The future role of allied health professionals in various settings was discussed, as was the definition of allied health. There was sharp

disagreement among the participants at the workshop about whether the definition should be an inclusive or exclusive one. Many were in favor of maintaining the current broad-based federal definition in hopes that this large group could have more influence over health policy. Others were in favor of a more exclusive definition based either on educational level or amount of patient interaction or influence. This debate appeared to be the most contentious of all, resulting in no recommendations from the participants.

The workshop was primarily a fact finding meeting, so no concrete answers emerged. The IOM will make recommendations based on the presentations, which may lead to convening another IOM Study Committee in the near future provided that Congress and HRSA deem the issues identified at this workshop sufficiently important to warrant more in-depth study.

One important feature of the workshop itself is that it provides improved visibility for allied health and is an indication of their increased

importance to HRSA. If HRSA decides that another IOM Study Committee is warranted, it could lead to funding to address some of these important issues. ■

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Jefferson Center for Interprofessional Education (JCIPE) Highlighted at Institute of Medicine Workshop

I was invited to participate in the Institute Of Medicine (IOM) workshop (May 9-10, 2011) on the allied health workforce. The program examined various aspects of the allied health care workforce, to consider how it can contribute to solutions for improving access to health care, particularly for underserved, rural and other populations. The major topics of this workshop were: gauging supply and demand; critical roles of allied health professionals in various environments such as hospitals, urban and rural areas; accreditation issues; and education, particularly the future of team-based care.

My role in this meeting was as part of the panel on team-based care. Because of the current momentum of interprofessional approaches to care, there is significant interest in whether this momentum will continue and, if so, how it will affect the workforce in the future. The focus of my presentation was on interprofessional education and training. I was asked to define interprofessional education (IPE), discuss why it was important, speculate as to whether it will have a long-term impact on education, and describe the extent of involvement of allied health in IPE.

Interprofessional approaches to care (IPC) go back to the turn of the last century. Emphasis on

these approaches have waxed and waned over the years. However, during the past few years there have been serious efforts calling for an increase in IPC. Two IOM reports, "Crossing the Quality Chasm" in 2001 and "Health Professions Education: A Bridge to Quality" in 2003 made strong cases for the effectiveness of the approach. With the publication of the 2010 World Health Organization report which recommended that we should move toward embedding interprofessional education and practice in all health services, the approach appears to have gone global. There is also significant collaboration across borders, particularly between the US and Canada through the American and Canadian Interprofessional Health Collaboratives. In addition, there are 11 major university health programs with extensive IPE programs.

I identified factors that are required for programs to be successful, using the Jefferson Health Mentors Program (run through the Jefferson Center for Interprofessional Education) as a case study. In this program, first and second year students in medicine, nursing, occupational therapy, physical therapy, pharmacy and public health work in interprofessional teams over a two-year period. The students work with a volunteer from the community who has one or more chronic conditions. The teams work

collaboratively and with the Health Mentor around issues related to their chronic conditions. These include preparing a comprehensive life and health history, preparing a wellness plan, assessing patient safety and evidenced-based practice. The teams often visit the Health Mentor in their home and then return to campus to debrief regarding their experiences. The collaboration with students in other disciplines provides an understanding of the contributions of other disciplines to the provision of health care. Working closely with the patient also provides these students with an understanding of the chronic condition from the patient's perspective.

I was able to show how the JCIPE program met the criteria for successful programs and highlighted the responsiveness of the program to the extensive analyses that we do, and the positive student attitudes toward their participation and IPE. ■

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Physician Profiling in Primary Care in Emilia-Romagna Region, Italy: A Tool for Quality Improvement

According to the American Academy of Family Physicians (AAFP), physician profiling is an analytic tool that, via epidemiological approaches, supplies physician groups with information on physician practice patterns across various quality of care dimensions.¹ The desired benefit of profiling is that analyzing and comparing patterns of care will raise provider awareness of quality and will help stimulate improvement by reducing the variation in performance among physicians through audit and feedback.²

Primary care lies at the core of the Italian National Health Service (NHS), which maintains universal coverage to all citizens either free or at minimal charge at the point of service.³ In each of the 21 regions of Italy, Local Health Authorities (LHAs) are responsible for the delivery of primary care provided by general practitioners (GPs) to a geographically designated population. Traditionally, GPs have worked in solo practices. However, in the last ten years, in an effort to increase coordination of care the Italian NHS has introduced substantial reforms seeking to encourage collaborative arrangements among GPs. Since 2006, in order to build on earlier national reform, the Emilia-Romagna region--a large region located in northern Italy with a population of about 4.6 million inhabitants--has required GPs in the 11 LHAs of the region to join a Primary Care Team (PCT). A PCT includes, on average, 15 GPs; the GPs, many of whom remain in solo practice, act in full autonomy, but are part of clinical networks designed to provide patients with integrated delivery of healthcare. As such, in the team GPs are mandated to collaborate and share information and, by means of clinical governance, to engage in improving the quality of healthcare services provided to patients. GPs elect a member as the team coordinator, who is in charge of organizing meetings on a regular basis to discuss care activities within the LHA healthcare initiatives.

To facilitate the role of the team coordinator and promote collaboration and the sharing of information among GPs, the Emilia-Romagna region established a tool to supply each PCT with data on the quality of care offered to their

population. To this end, using the regional healthcare administrative database (an anonymous comprehensive and longitudinal database linkable at the patient and provider level)⁴ in 2007 the Emilia-Romagna region and Thomas Jefferson University began collaborating to provide PCTs with patient quality data via “profiles.”

The profiles were initially developed and tested for the 21 PCTs of the LHA of Parma and subsequently for the 23 PCTs of the LHA of Reggio Emilia before being launched in 2009 in all 216 PCTs of the Emilia-Romagna region, reaching a total of 3,215 GPs. The profiles, distributed to the PCTs on an annual basis, describe the demographic information and morbidity data of the PCT population, furnish data on healthcare resources used by PCT patients, including hospital care, outpatient pharmacy data, and specialty care, and provide information on a number of quality indicators related to the activities in several clinical areas provided by the GPs. A scientific advisory committee including clinicians and representatives of all LHAs, coordinated by the Emilia-Romagna region and Thomas Jefferson University representatives, annually reviews and updates the content of the profiles and monitors the project.

How are the profiles being used? Every year the profiles are presented to the team coordinators in educational sessions; in turn, they are mandated to introduce the profile data to their peers in the team. The team coordinators are assisted by a group of professionals selected in each LHA called “facilitators,” trained to help the physicians review and interpret the data. Then, the GPs in each team are asked to identify at least one critical area of the profile data and initiate quality improvement activities in their practice accordingly, and when appropriate, review guidelines with specialists and hospital clinicians.

Through an agreement with the LHA, GPs may receive financial incentives to participate in the activity of the PCT profile. It is important to note that the profiles are not meant to be “punitive;” rather, the profiles are intended to promote teamwork and coordination, ingrain a culture of

quality and encourage clinical discussion in the PCT in order to improve the organization and delivery of the services to the population.⁵ It is too early to say whether the PCT profile has achieved its objectives; however, preliminary results in the two LHAs of Parma and of Reggio Emilia, early adopters of the profiles, are promising. Performance for the quality indicators has overall improved. For instance, the proportion of AMI patients receiving beta-blockers and statins in the ambulatory setting after hospital discharge has increased to about 90% in 2010 from approximately 70% in 2007 before the intervention. In addition, GPs seem to have a positive view of the profiles. A focus group recently conducted in both LHAs showed a substantial agreement among GPs on the usefulness of the profiles to reflect on their daily activities and foster a culture of quality; to increase the colloquium within the PCT; and to encourage reviews of current practice and reach uniform clinical behavior.

As the profiles are currently implemented in all 216 PCTs in the region, the hope of the Emilia-Romagna region is that these results will be replicated in all Local Health Authorities. The use of physician profiling in primary care in Emilia-Romagna associated with a no-punitive strategy appears to be an effective way to help clinicians as they strive to improve the quality of care they provide to their patients. ■

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For information on quality indicators, their specifications, and related literature visit the Emilia-Romagna regions website at: <http://www.regione.emilia-romagna.it/prim>
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The Aging Population and Health Care: A Japanese Perspective

This past summer, with my colleague Takao Saito, MD, PhD, I had an opportunity to meet with faculty members of the Jefferson School of Population Health and executives of Thomas Jefferson University Hospital. We are very appreciative of the invaluable information they provided. I learned that health care experts in the US are very concerned about the increasing elderly population and the magnitude of their healthcare issues. The population aged 65 years or older was 12.9% of the US population in 2009, but that's expected to grow to be 19% of the population by 2030.¹ It is quite reasonable for Americans to be anxious about future care problems for the elderly. I would like to introduce the public, mandatory long-term care insurance (LTCI) system used in Japan.

Japan is a country whose aging population is growing the fastest among developed countries. People aged 65 years or older represented about 12% of the population in 1990, but that figure had increased to 23% by 2010, owing to the aging baby boom generation (8 million who were born from 1947 to 1949) and the recent decrease in the birth rate.^{2,3} It is projected that the proportion of the elderly will continue to increase to 40% of the population by 2050.³ The care for the elderly in Japan has been a family responsibility and traditionally it has been provided by women. However, the custom is no longer sustainable because of a changing family structure and increasing number of working women.

The Japanese Government implemented public, mandatory long-term care insurance (LTCI) in 2000, although half of it is financed by taxes. People aged 40 years and older have to pay premiums because they are eligible for benefits. The eligibility is evaluated by items based on activities of daily living and categorized into one of seven levels according to their needs. The ceiling for the amount of benefits per month is decided by the level of care and clients have to pay 10% copayments.

The insurance covers home services; non-institutionalized outside services including day care, day care with rehabilitation, short-stay or respite care; and institutional services including nursing homes and healthcare service facilities. However, it does not provide cash benefits. Interestingly, day care has become the most popular service, and is now used by 1.9 million or 6.5% of people aged 65 years and older.⁴ It might be because 40% of the elderly live with their families.⁵ It has been reported that LTCI has decreased physical, mental and financial burdens on their families. In addition, women living with the elderly have more chances to work outside with the help of LTCI.

There are two main problems in LTCI. First, expensive institutionalized care has been favorably used. However, we cannot increase institutions for elderly care because of governmental finance limitations. Secondly, workers are underpaid with the consideration of working conditions under LTCI. Therefore, there is a shortage of human resources. We will have to increase premiums of LTCI and taxes to protect the dignified lives of the elderly. In addition, we need to create reasonable senior citizen caring facilities such as small-scale, multifunctional group homes.

In the US, huge public resources are spent on medical care for the elderly through Medicaid; while respectively little public funds are spent on non-medical care. Most residents in assisted living facilities pay for care out of their own funds. Although some elderly care facilities including continuing care retirement communities (CCRCs) provide assistance with daily activities as well as healthcare to contribute to their qualified lives, there are many senior citizens who are not able to access this standard of care in the US. *New York Times* reporter, Jane Gross suggests Medicare pays for useless and harmful acute care while not paying for long-term care in a supervised,



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Dr. Babazono has contributed to health care policies of Fukuoka Prefecture, including the Committee of Health Care System for the Elderly, the Committee of Health Care Cost Control in Fukuoka Prefecture, and the Committee of Disease Prevention.

Dr. Babazono teaches health policy, health care marketing, and health care organizing. He is interested in health service research to make healthcare systems better and sustainable. He has studied the Japanese healthcare system, technology assessment, and health promotion.

Dr. Babazono earned his MD from Kyushu University and his MS in clinical epidemiology from the University of Pennsylvania.

safe place for frail or demented elderly people, or for home aides to help with stopping, transportation, bathing and using toilet⁶ I agree that there is a mismatch between what is covered and what is actually useful in Medicare today.

I believe that non-medical spending is an important factor for health outcomes as well as quality of life. If available resources are limited, spending too much on medical care for the elderly is not effective in improving health outcomes. Balancing medical care spending with non-medical care spending is important. *Continued on page 10*

It is a common problem for us to cope with aging populations among developed countries. We would therefore like to exchange experiences and knowledge with each other. ■

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Health Policy Forums

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

Michael Stoto, PhD

Professor

Health Systems Administration and Population Health

Georgetown University

September 14, 2011

During the week of the 10th anniversary of the 9/11 terrorist attack, Michael Stoto, Professor of Health Systems Administration and Population Health at Georgetown University opened the Fall Forum season with a timely presentation on emergency preparedness. A statistician, epidemiologist, and health policy analyst, Dr. Stoto's research includes methodological topics in epidemiology, statistics, and demography, research synthesis/meta-analysis, and performance measurement as well as substantive topics in public health practices, especially with regard to preparedness.

Dr. Stoto started out by defining public health emergency preparedness (PHEP) as "the capacity of the public health and health care systems, communities, and individuals, to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities."¹ The goal of PHEP is to mitigate the mortality, morbidity,

psychological, and social consequences of public health emergencies.

Stoto made specific distinctions between PHEP capabilities and capacities. For example, capabilities refer to assessment, policy, assurance, communications, leadership and management. Capacities refer to what needs to be in place to enable an effective response (i.e. infrastructure).

Stoto described assessment challenges that often become barriers to implementing effective programs and responses. Public health systems are often fragmented with major differences between city, county, regional, state, federal and global institutions. An effective response emergency is complex and multi-factorial. Additional public health emergencies are rare, making it difficult to measure outcomes directly.

Dr. Stoto emphasized the importance of learning from past critical incidents involving bioterrorism,

emerging and re-emerging pathogens, food borne disease outbreaks, and natural disasters. For example, the H1N1 outbreak provided a wealth of information to examine and assess. Public health officials were able to identify three critical events of H1N1 (California, Mexico, New York) and were able to respond fairly quickly due to advances in technology and global surveillance.

In general, the United States is better prepared for public health emergencies since 9/11 and this can be attributed to a population health approach which looks at a broader array of determinants of health than in traditional public health. Particularly important is the building of social capital in the PHEP system. Despite the benefits of technology, the establishment of trusting relationships across disciplines and all levels of institutions factors into the success of PHEP.

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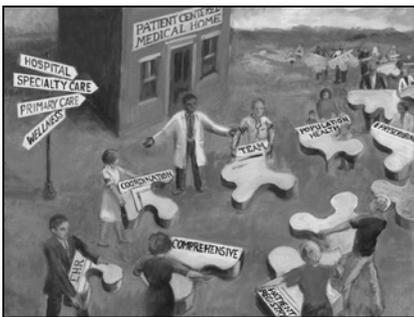


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Health in All Policies (HiAP): How Can We Make It Work?

Shiriki Kumanyika, PhD, MPH

Professor

Biostatistics and Epidemiology

University of Pennsylvania Perelman School of Medicine

October 12, 2011

Dr. Shiriki Kumanyika is Professor of Epidemiology in the Department of Biostatistics and Epidemiology and in the Nutrition Section (Gastroenterology) of the Department of Pediatrics at the University of Pennsylvania's Perelman School of Medicine; she is also Associate Dean for Health Promotion and Disease Prevention in the School of Medicine. She has engaged in global public health advisory roles through the World Health Organization, World Cancer Research Fund, and the International Association for the Study of Obesity's International Obesity Task Force, which she co-chairs.

Dr. Kumanyika had the privilege of participating as Vice Chair of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 and shared her invaluable insights at the October 2011 Health Policy Forum. She described the conceptual framework for these objectives, which include: emphasis on prevention; an ecological approach that fosters deepened understanding of causal factors and determinants of health; and reduction of health inequalities. The overarching goals of *Healthy People 2020* include:

attainment of high-quality, longer lives free of preventable disease, disability, injury, and premature death; achievement of health equality, elimination of health disparities, and improvement of health of all groups; creation of social and physical environments that promote good health for all; promotion of quality life, healthy development and behaviors across all life stages. She stressed the influence of social and physical determinants.

Dr. Kumanyika discussed in detail the "Health in All Policies" approach which is "an innovative strategy that introduces improved population health outcomes and closing the gap as goals to be shared across all parts of government. HiAP seeks to address complex health challenges through an integrated policy response across all sectors."¹ This movement has developed from International Meeting on Health in All Policies that took place in Adelaide, Australia in 2010.²

One of the interesting highlights from the Adelaide meeting focused on the notion of "Joined-Up Government." This emphasizes the interdependence

of public policy. It involves the coordination of policy making by developing strategic plans that set out common goals and requires a partnership with civil society and the private sector. It is important for the health sector to engage systematically across government and with other sectors to address the health and well-being dimensions of their activities. Some of the challenges of HiAP is that it tests the current health establishment and depends on actions in non-health sectors. Opportunities of HiAP include the underlying causes of disease; the focus of optimal health; attention to inequities and diversity within risk populations; and integration of domains of knowledge and discourse.

Dr. Kumanyika summarized her presentation by pointing out that health goals are being restated in more fundamental and holistic terms and that HiAP will integrate several themes. Some of the implications include the possibility of creating a HiAP friendly and HiAP capable workforce affecting health professions training and professional workforce and the public health sector.

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

Michael S. Barr, MD, MBA, FACP

Senior Vice President

Division of Medical Practice, Professionalism, and Quality

American College of Physicians

November 2, 2011

Dr. Michael Barr, Senior Vice President of the Division of Medical Practice, Professionalism, and Quality at the American College of Physicians (ACOP) presented on the impetus behind the Patient-Centered Medical Home (PCMH), the future of coordinated care, and training health care professionals.

Dr. Barr first discussed the history of the PCMH, which dates back to 1967 as a concept developed by the American Academy of Pediatrics (AAP). Over the years it has evolved and been recognized and adapted by many medical societies. Though never quite executed, the Tax Relief and Health Care Act in 2006 included a Medicare Medical

Home Demonstration project. By February 2007 joint principles of the PCMH were outlined and included some of the following components: personal physician, physician- directed medical practice, whole person orientation, coordinated/integrated care, quality and safety, enhanced access to care, and payment to support the PCMH.¹

During this time, the Patient-Centered Primary Care Collaborative (PCPCC) was formed; it included six collaborative centers and over 500 stakeholders. It was started to facilitate improvements in physician-patient relations and create a more effective model of healthcare delivery.² Today, the primary focus of the collaborative is to develop and advance the PCMH.

Dr. Barr explained two key historical markers and their impact on the PCMH. The Affordable Care Act encourages the development of new patient models and emphasizes the establishment of community support teams to support PCMH. The Comprehensive Primary Care Initiative, a program of the Center for Medicare and Medicaid Innovation, was designed to foster collaboration and strengthen primary care in the US. According to Dr. Barr, it is a “game changer.”

Dr. Barr went on to describe the Patient-Centered Medical Home Neighbor (PCMH-N) which takes into account the fact that care is often needed outside of a PCMH. The model emphasizes integration and coordination of services by specialty providers with the PCMH.

Barr also provided an overview of traditional and competency-based education models and explained the characteristics of Entrustable Professional Activities (EPAs) which focus on the demonstration of the necessary knowledge, skill, and attitudes to be “trusted” to perform the activity independently. Some of the top EPAs identified at a recent summit include: assess and create customized care for patients with language/and or cultural barriers; provide care in non-traditional ways; understand and engage the patient’s care team; and continuity over other sites of care.

The context for teaching to prepare health care professionals should include: whole person orientation; care coordination; quality and safety; and knowledge of enhanced access and payment models.

It is important to note that Jefferson Family Medicine Associates (JFMA) achieved NCQA recognition as a Level 3 PCMH a few years ago, and continues to actively adopt and implement many components of the PCMH.

To listen to Health Policy Forum podcasts visit: <http://jdc.jefferson.edu/hpforum/>

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Ronald E. Myers, PhD, DSW
Professor
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Brian Duke, MBE
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Chief, Division of Cardiothoracic Surgery
Lehigh Valley Health Network

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JSPH Presentations

Berman B. Meeting the challenge of value-based purchasing in the outpatient setting. Presented at: University HealthSystem Consortium Annual Conference 2011, Chicago, IL, September 21, 2011.

Borsky A, Harris D, Sarfaty M, Myers R, Sifri R, Stello B, Johnson M, Cocroft J, Gratz N, Kasper-Keintz M, **Pracilio V.** Assessing factors that affect the implementation of an evidence-based colorectal cancer screening intervention: A report from the CNA Health ACTION Partnership. Poster presented at: the American Public Health Association (APHA) 139th Annual Meeting and Exposition, Washington, DC, October 29-November 2, 2011

Lieberthal RD. International evidence on medical spending. Podium presentation at: 9th International Conference on Health Policy Statistics, Cleveland, OH, October 6, 2011.

Lieberthal RD. High frequency evidence on variation in spending growth. Poster presented at: 9th International Conference on Health Policy Statistics, October 6, 2011.

Lieberthal RD. Strategies for financing healthcare costs over the long term. Poster presented at: 9th International Conference on Health Policy Statistics, October 6, 2011.

Nash DB, Pracilio VP. A Career Path Toward Quality. Presented at: Institute for Healthcare Improvement 23rd Annual National Forum on Quality Improvement in Health Care, Orlando, FL, December 4-7, 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: 136th Annual Meeting of the American Neurological Association, San Diego, CA, September 25-27, 2011.

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Pracilio VP, Nash DB. JSPH Chapter of the IHI Open School. Poster presented at: Institute for Healthcare Improvement 23rd Annual National Forum on Quality Improvement in Health Care, Orlando, FL, December 4-7, 2011.

Pracilio VP, Hilliard R. IHI Open School: A Snapshot of Northeast Regional Chapter Activities. Poster presented at: Institute for Healthcare Improvement 23rd Annual National Forum on Quality Improvement in Health Care, Orlando, FL, December 4-7, 2011.

Simmons R. The role of government and public health. Presented at: Have We Become a Nanny State? Risk, Regulation and Free Agency, seminar, Drexel University, Philadelphia, PA, September 29, 2011.

Simmons R. Training future physician public health leaders: Incorporating population health and health promotion into medical education. Presented at: Society for Public Health Education (SOPHE) Annual Meeting, Washington, DC, October 28, 2011.

Simmons R. SOPHE & AAHE: Collaborating to strengthen the health education profession. Poster presented at: Society for Public Health Education (SOPHE) Annual Meeting, Washington, DC, October 28-29, 2011.

Simmons R. The expanding role of public health in our society: Challenges and opportunities for leadership. Presented at: University of Delaware Health Science Honors Program, Newark, DE, November 30, 2011.

JSPH Publications

Des Harnais SI, **Nash DB.** Reforming the way medical students and physicians are taught about quality and safety. *Mount Sinai J Med.* 2011; 78: 834-841.

Klaiman T. Learning from top performers using a positive deviance approach. *AJMQ.* 2011; 26(6):422. <http://ajm.sagepub.com/content/26/6/422.full.pdf+html?rss=1>

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