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GUEST EDITORIAL

One Book, One School

The Jefferson School of Population Health opened its doors on September 9, 2009 to students enrolled in graduate programs focused on public health, health policy and health care quality and safety. On the first day of school, every staff member was given a copy of a new book, *Health Care Will Not Reform Itself*.[1] We thought that having all of our faculty and staff reading one book on a topic of such critical importance would serve to focus our thinking together. Written by George C. Halvorson, CEO of Kaiser Permanente, this book provided an interesting perspective as to why health care reform is so difficult.

Halvorson takes a ground-up approach to tackling the multitude of complex issues in the reform debate. Kaiser Permanente, this country's largest and most progressive integrated managed health care system, represents the "gold standard" in health care. Overall, this book provides an insightful view, from within the health care industry, of what needs to be reformed, why reform needs to occur and the reasons why reform is so complex and difficult to accomplish. Let's look at some of the broad issues as to why health care cannot reform itself.

The book begins by setting the stage as to why health care is so difficult to reform and which aspects most need to be changed. The introduction outlines the steps that need to take place for reform to occur. Developing clear goals, having strategies to achieve each goal, and the tools to implement each strategy will lead to success in health care. The main tools are "connectors." Connectivity is critical for patients who are older, have several co-morbid conditions, or one of the many chronic conditions that drive up the cost of health care. These patients are frequently seeing several physicians for treatment, and their physicians are not connecting with each other. Physicians are not paid to communicate with patients' caregivers or other physicians; thus, most health care professionals do not invest the time in connecting with others.

By the numbers, this book is an eye-opener in terms of what this country spends on health care and why reform is necessary. Over 16% of the total US economy goes toward health care expenses and 75% of health care dollars are spent on chronic conditions. The United States is ranked number one for health care spending, yet we are ranked 72nd (out of 191 countries) in terms of actually having healthy people. If health care generates $2.5 trillion in revenues, why is it that there are over 40 million uninsured Americans? How can we reduce premium costs for an American family by $2500 in order to make sure every American is covered under a health insurance plan? In businesses as prices go down, sales go up; if the price of health insurance decreases then we will be able to provide health insurance for every American. Those who are leading the charge in health care reform should either be economists or think like an economist and be recipients of a health insurance plan in order to focus on what will work best for all Americans.

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Why aren't Americans the healthiest people in the world? Part of this answer, according to Mr. Halvorson, is that we do not get the "right" care half of the time. Bad care is actually profitable. The longer a patient stays in the hospital, the more revenue the hospital receives. There is no economic incentive or reward for getting it right the first time or improving the quality of health care. Databases (e.g., electronic medical records or EMRs) are essential for continuity of care, yet some health care systems are not equipped with them. Payment is based on a fee for service model that focuses on treatment for disease; there is no orientation towards wellness or prevention. Health care needs to be patient-focused instead of focused on provider cash flow.

Overall, health insurance and medical treatment should be equal for all Americans at all institutions. The book provides several concrete examples of how to save money by applying economics to the prevention and treatment for the top chronic conditions (e.g., diabetes, asthma, depression, cardiovascular disease, and cancer). One of the best examples of the effectiveness of prevention is diabetes. If we reduce obesity in this country, we can decrease the number of people with diabetes. If we lower the number of people with diabetes, then we lower the risk of circulation problems related to heart attack and stoke. In addition, lowering the risk for diabetes allows for fewer long-term complications of diabetes, including retinopathy, kidney disease and peripheral neuropathy. If the right treatment is given 100% of the time, the cost of chronic conditions is substantially decreased. The opposite side of the coin is that the lack of continuity for people with chronic conditions and co-morbidities contributes greatly to the rising costs of health care.

Although the book may seem redundant in several parts, Mr. Halvorson drives home the point that the health care system needs to and can be fixed. The four most important points for health care reform are:

1. The key to good health begins with wellness and prevention;

2. Connections and communication facilitate good chronic care management;

3. Quality and safety (getting care right) are critical components of health care; and

4. Access to health care for all individuals is a must.

One book, one school. We focused our attention on the crucial issues underlying reform and debated these issues through a school book review. We learned together as a school. We hope our elected leaders have a similar, rich discussion. Our country deserves nothing less. ■

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The Future Health Care Workforce for Older Americans

The American healthcare workforce "will be woefully inadequate in its capacity to meet the large demand for health services for older adults if current patterns of care and of the training of providers continue," according to the Institute of Medicine's report, *Retooling for an Aging America; Building the Health Care Workforce*.[1] The report goes on to say that as the population of seniors grows, the US health care workforce will be too small and critically unprepared to meet their health needs. The committee concluded that if our aging family members and friends continue to live robustly and in the best possible health, we need bold initiatives designed to:

- Explore ways to broaden the duties and responsibilities of workers at various levels of training;

- Better prepare informal caregivers to tend to the needs of aging family members and friends; and

- Develop new and more effective models of health care delivery and payment.

The starting point for all of these efforts is a foundation of leaders with geriatric expertise to take charge in improving systems of care for our older adults.

Jefferson's Geriatric Efforts

Thomas Jefferson University has been addressing the need for geriatric-trained physicians in several ways. Jefferson exposes medical students, as well as all residents, to geriatric principles. Core principles of geriatric care are woven throughout the medical school curriculum. Perhaps even more importantly, Jefferson's Health Mentor Program[2] has incorporated longitudinal, interprofessional team-based training which provides an opportunity for Jefferson students from the Medical College, School of Nursing, School of Pharmacy, School of Health Professions (occupational therapy, physical therapy, and couples and family therapy), the College of Graduate Studies, and School of Population Health (public health) to learn firsthand from a patient about things that really matter to those living with chronic conditions. Community-based outpatients serve as volunteer Health Mentors and help teach students how the roles of various health professionals complement one another in relation to patient-centered care.

The program embodies the principles embraced by the Institute of Medicine and summarized in their statement that "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."[3] By understanding the roles of their professional team-mates and the needs of their patients, students should be better prepared to facilitate each member of the team performing the full scope of their practice, as emphasized in the *Retooling for an Aging America* report.[1]

Health Care Reform Efforts

Several health care reform proposals have recognized the need for more geriatrics healthcare professionals and primary care providers to meet the unique care needs of older adults, and better prepare direct-care workers and family caregivers to do the same.[4] In addition to improving reimbursement for providers, growth in the geriatrics workforce can be accomplished through the following specific actions:

- Provide grants to Geriatric Education Centers (GECs) to offer courses in geriatric care, chronic care management and long-term care, and provide family caregiver training.
- Increase the number of Graduate Medical Education (GME) training positions in primary care, establish federal traineeships for nurses pursuing advanced training in geriatrics, and funding Geriatric Career Incentive Awards to foster greater interest in eldercare among health professionals.
- Establish either a Workforce Advisory Committee to develop a national plan addressing the need for eldercare providers, or a national center charged with ensuring an adequate healthcare workforce.
- Establish loan forgiveness programs for physicians, physician assistants, pharmacists, advanced practice nurses, psychologists, and social workers who complete training in geriatrics or gerontology, and make geriatricians eligible for a proposed primary care incentive payment of 5-10% by adding "specialization in geriatrics" to a list of qualifications for designation as a primary care practitioner.

There are also initiatives afoot aimed at expanding the adoption of promising new models of care coordination and delivery. These opportunities intend to be promoted through the following actions:

- Establish a Medicare "Innovation Center" to test new provider payment models–including models providing care coordination for older adults at risk of functional decline–to identify models that improve quality and reduce costs.
- Fill a gap in traditional Medicare by covering comprehensive geriatric assessment and care coordination services for high-risk and high-cost beneficiaries with multiple chronic health conditions.
- Create a new plan option under which beneficiaries with chronic conditions could designate a healthcare provider as their "medical home." This model is set to provide targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment.
- Track and reduce hospital readmission rates for high-cost conditions associated with a high incidence of avoidable readmissions.
- Fund eligible hospital and community-based healthcare organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at highest risk of rehospitalization.
- Establish a voluntary pilot program to both encourage hospitals, doctors, and post-acute care providers to achieve savings through increased collaboration and improved care coordination, and allow these providers to share in any resulting savings.
- Create a chronic care coordination pilot project to provide at-home primary care services to the highest-cost Medicare beneficiaries with multiple chronic conditions. Interdisciplinary teams of healthcare professionals caring for these patients would be eligible for a share of savings if they meet quality and patient satisfaction standards.

All of these initiatives are being tracked and encouraged by geriatricians through organizations like the American Geriatric Society through a focus on increasing awareness of geriatrics and growing the geriatrics workforce.

Short-Term Solutions

Even with these initiatives to expand our geriatric workforce, short-term solutions are needed now. Given the severe shortage of primary healthcare providers, the US House of Representatives recently passed a bill to extend the visa waiver program for international medical school graduates. Much of the US workforce caring for older Americans comes from outside the US, which places additional hardships on those countries seeing their best and brightest exit their healthcare systems.

Fortunately, efforts such as those underway at Jefferson to increase the geriatric expertise available to older Americans should provide some needed assistance to this problem while we wait for policymakers to complete the needed work in the efforts to reform health care for our older adults. ■

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For more information on the Jefferson Health Mentor program visit: http://jeffline.jefferson.edu/jcipe/hmp/.

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Wii-HAB: Using the Wii Video Game System as an Occupational Therapy Intervention with Patients in the Hospital Setting

The Nintendo Wii video game console has become the most widely used game system in rehabilitation facilities across the US.[1] In the past few years the Wii has been used with diverse populations, including children and adults with cerebral palsy, Parkinson's disease, stroke, and gross and fine motor deficits. Literature has shown the Wii being used in hospital, rehabilitation and school settings, all with the similar goals of improving patients' standing balance, strength, coordination and activity tolerance.[2,3] The unique features of the Wii allow Occupational (OT) and Physical Therapists (PT) to capitalize on their patient's functional abilities in a fun and novel manner. The Wii is currently being utilized by Occupational, Physical, and Recreational Therapists on the Comprehensive Acute Rehabilitation Unit at Thomas Jefferson University Hospital (TJUH) as well as in the acute care setting. On the Blood and Marrow Transplant Unit (BMTU) at TJUH, OTs are using the Wii to benefit patients physically as well as emotionally. This article highlights how the Wii video game system has been utilized to meet the specialized needs of the patient population on the Blood and Marrow Transplant Unit (BMTU) at Thomas Jefferson University Hospital (TJUH) and the initial observations of its benefits.

The Nintendo Wii gaming system consists of controllers with sensors that track acceleration and movement, allowing users to translate their own motion onto the game's characters. For example, when bowling, a player holds a controller in one hand, then swings his or her arm back and releases the ball at the time and speed they want their character to release the ball. This increases the amount of movement required by video game players and provides a physical challenge. Most recently, OTs on the BMTU have began using the Nintendo Wii video game system to gather patients together for leisure groups. The goals of the group include: increasing strength, endurance, range of motion, and building social relationships and support networks among members that can last beyond their hospital stay. Patients who meet through the group setting are encouraged to carry on their relationship after group by sharing information such as hospital room number and telephone extension. Sharing this information allows patients to use each other as a source of support.

The group was based upon the Rehabilitation Model and Ecology of Human Performance Model, and a group protocol was formed by Lindsay Rule, OTR/L, one of the staff Occupational Therapists in Thomas Jefferson University Hospital's Department of Rehabilitation Medicine.[4] The Rehabilitation Model focuses on a person's ability to return to the fullest physical, mental, social, vocational, and economic functioning. The Ecology of Human Performance Model expresses that the quality of a person's occupational performance is a direct result of the dynamic interaction of the person, environment and task.[4] Both models encourage therapists to be client-centered and to take into account the client's physical and emotional status as well as the environment and goals in order to make interventions successful. The protocol includes group goals, patient admission criteria, and discharge criteria. As stated above, goals include increasing strength, endurance, range of motion, and building social relationships and support networks among members.

Due to toxic doses of chemotherapy and radiation, long hospital stays, isolation from family and friends, and life-threatening diagnoses, patients on the BMTU are at high risk for becoming depressed and deconditioned. OTs and PTs work with patients throughout their stay to help them maintain their independence and prepare them for discharge from the hospital. In particular, OTs face the challenging task of addressing the patient's psychosocial status and helping them to remain motivated and positive throughout the transplant process.

Since the initial group began in September 2009, 15 to 20 patients have been asked to fill out a five-question survey to assess whether or not they felt they benefitted from the group and if they planned to return the following week. They were also encouraged to share suggestions and ideas for improving the satisfaction of the members. Overall, preliminary findings reveal that the majority of patients have enjoyed attending the group and feel that it is beneficial to meet and talk with other patients. After group sessions have concluded, many patients expressed the importance of being able to maintain human contact and share "battle stories" with others who are fighting the same issues. Often times, this opportunity to look outside of oneself and to help others adds to motivation and feelings of self-worth.

OTs leading the group often initiate conversations that help patients identify their own valued leisure activities. They also help patients discuss the difficulties they have faced in dealing with their diagnoses and their feelings around loss of certain roles and activities due to cancer-related fatigue. Another benefit of the Wii group is that patients can play sports such as bowling, tennis, golf, baseball and boxing without over-exerting themselves or using a day's worth of energy that they need to save for basic living activities such as bathing, dressing and eating.

In the future, OTs on the BMTU will continue to use the Wii as a method for psychosocial and physical rehabilitation with patients. Data will continue to be collected from the patient's experience and changes will be made based on feedback and new technological advancements. This small group of two to three patients gathering once a week for an emotional and physical workout has the potential to lead to a much larger support group inside and outside of TJUH's walls. Using the Rehabilitation and Ecology of Human Performance Models as guidelines, further research could investigate the relationship between participating in Wii groups in the hospital and returning to occupational roles once patients return home. It is our belief that participating in these groups helps patients physically and emotionally prepare for life outside of the hospital. ■

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Moving Forward: JSPH to Launch Online Courses

Continuing on its course of redefining healthcare education in Philadelphia, Jefferson School of Population Health (JSPH) is offering three online programs beginning this September – Masters of Science in Chronic Care Management, Health Policy and Healthcare Quality and Safety. An online Graduate Certificate is also offered in each of these disciplines.

In addition to its online offerings, the school continues to offer a traditional Master of Public Health program.

The school's online degree and certificate programs offer convenience and the same high quality as its on-site programs. Online courses provide the flexibility to work around your busy schedule and at your own pace – participating from anywhere that offers access to the internet.

Online does not mean "on your own." In addition to the independence of online learning, students enjoy participating in JSPH's thriving learning communities. Students will be introduced to the academic community at JSPH through a comprehensive online orientation, designed to provide a smooth transition into each program's coursework, resources, and student colleagues.

The move to online classes is in step with results of a recent study conducted for the Department of Education. The study, conducted by SRI International, concluded that "On average, students in online learning conditions performed better than those receiving face-to-face instruction."

Still, online learning is not for everyone, notes Caroline Golab, PhD, Associate Dean for Student and Academic Affairs at JSPH. "Success with online courses requires good organizational and time management skills. It is ideal for self-motivated and self-directed learners – those who like to work at their own, steady pace, and on their own time."

Until fairly recently, online education amounted to little more than electronic versions of the old-line correspondence courses. That has really changed with arrival of Web-based video, instant messaging and collaboration tools.

The real promise of online education, experts say, is providing learning experiences that are more tailored to individual students than is possible in classrooms. That enables more "learning by doing," which many students find more engaging and useful.

"Contrary to what you may think, there is more opportunity for discussion and presentation of your work," says David B. Nash, MD, MBA, Dean of JSPH. "When you sit in a classroom and the instructor asks a question, one or two students generally respond. When the instructor asks a question online, *everyone* has to respond. Also, in an online course you are able to share your work with other students, not just the instructor."

If you have any unanswered questions about online learning at JSPH, we recommend you take the quiz, *Is Online Learning for Me?* and look through Frequently Asked Questions (FAQs), available at www.jefferson.edu/population_health/online_info.cfm ■

For further information about online learning at Jefferson School of Population Health, or to register for the next informational Open House, call 215-503-5305, or visit www.jefferson.edu/population_health/.

American Medical Association - Medical Student Section Region VI Conference

On the weekend of February 5-6, 2010, a major snowstorm hit the Philadelphia area, suspending bus and taxi services. Yet no amount of snow could stop a group of inquisitive and driven medical students from convening at Jefferson Medical College for their annual 2010 American Medical Association-Medical Student Section (AMA-MSS) Region VI Conference.

The American Medical Association (AMA) is the largest association of physicians and medical students in the United States. The AMA's stated mission is to "promote the art and science of medicine for the betterment of the public health, to advance the interests of physicians and their patients, to promote public health, to lobby for legislation favorable to physicians and patients, and to raise money for medical education." The student section of the AMA is broken up into seven geographic regions; Region VI consists of Pennsylvania, New Jersey, Maryland, Virginia, and Washington, DC.

The scheduled keynote speaker was Dr. James Goodyear, the current president of the Pennsylvania Medical Society, and a strong student advocate. He has participated in several surgical skills nights throughout the state (including Jefferson Medical College), where he has taught students how to suture and tie surgical knots. Dr. Goodyear's keynote address was geared at educating the students about the current state of health care reform, and included his personal perspective on where it was heading, and how it would affect his practice. The major topics discussed at the conference were health policy, health care reform, and the importance of organized medicine (and its intersection with daily practice). Students also participated in various workshops where they learned how to write a resolution and lobby their local Congressional representative. They also shared ideas on community service projects and membership drives. The meeting was an important networking opportunity for students to make new connections, and plan projects and events at their local chapters. Some of the student ideas included a region-wide bicycle relay race to raise awareness of the uninsured, health fairs, and healthcare reform debates. The success of the conference, despite the weather conditions, is a testament to the spirit and enthusiasm of the student section and their ability to overcome adversity. ■

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The Adventure of Helping Abroad: Experiences Providing Health Care in Ethiopia

Interview with Jeffrey Panzer, MD and Erin Mc Carville, MPH

Jeffrey Panzer (JP), is a former Thomas Jefferson University Family Medicine resident. His wife, **Erin McCarville (EM)**, is a public health specialist. They are currently working in rural Ethiopia and documenting their experiences on their blog: http://erin-jeffinethiopia.blogspot.com/.

What was your motivation for pursuing this type of work? Is this the first time you have been involved in providing health care overseas?

JP: After college, I taught English in rural Costa Rica for a few months, which sparked an interest in international work that hasn't died down since. During medical school and residency, I did short-term stints in Honduras, Ecuador, Jamaica, and Guatemala.

In Costa Rica, I was shocked at the disparity between the developing and developed world. I realized how much I had taken for granted all the opportunities afforded to me throughout my childhood and young adulthood. It felt like I had opened my eyes for the first time to many realities of the world. From that moment on, I wanted to help others witness this disparity. At the same time, I've been striving to determine a way to be more than just a learner and observer in the developing world and work towards helping close the gap between the two worlds.

EM: Jeff and I both attended Pomona College in California. I received my Masters in Public Health from Johns Hopkins University. I have worked in Washington, DC for the US Senate as well as for the National Academy of Sciences and the Institute of Medicine. Most recently, I worked as a grant writer and public health non-profit manager for a the Health Promotion Council under the Public Health Management Corporation (PHMC) in Philadelphia.

What kinds of expectations did you have before you arrived in Ethiopia? Did you have any training or preparation for what you would encounter as a provider of health care there?

JP: Ethiopia sits between Sudan, Somalia, and Eritrea – all areas of current conflict. I expected to feel more unsafe and more like I'm in some estranged foreign land, but I really feel at home here. Medically, I was worried about being the only technical "doctor" for a population of 130,000 people, and that my skills would not be up to par. The best preparation that I had was my month in Guatemala during residency where I cared for patients in a resource-poor setting.

Tell us about the clinic you work in. How is it funded?

JP: We work in a clinic called Chiri Health Center. It is in the southwest part of Ethiopia, about a ten-hour drive from the capital Addis Ababa and a four-hour drive from the closest city. The health center has a unique managerial structure – it's a government health center, but most components are managed by an NGO (non-governmental organization) called Lalmba that's based in Denver. Lalmba pays for the American volunteers to work here (between 4-5 people at any given time), pays for the majority of the 40-person Ethiopian staff (managers, guards, cleaners, pharmacists, etc), and pays for most medicines and supplies. The government pays for our nurses and lab technicians. Some medicines for TB, HIV, malaria, and malnutrition are provided for free through large aid organizations such as USAID, World Health Organization, and UNICEF.

Describe the actual physical environment of the clinic you work in.

JP: The health center has two main buildings. The first houses our labor and delivery room (with two laboring beds) and our inpatient rooms, which consist of a main room (with 7 beds), a malnutrition room (with 4 beds), and an isolation room (with 3 beds). In spite of our cleaners' best efforts, the cleanliness of these areas is far from US standards. There are no sinks to wash your hands between patients, so I'm often left with a choice—touch the patients and risk spreading diseases between them, or not to touch them and miss some physical exam findings while seeming like a cold, uncaring foreigner. The second building has 5 outpatient exam rooms, an injection room for vaccines and family planning, and a treatment room for dressing changes and emergencies.

What one change would enable you to function better or improve the lives of the patients/community?

JP: The one change that would most improve the lives of the community would be a better public health system. If there's one thing I have learned being here, it's that there's a difference between *do-good* work and *feel-good* work. I'm reminded of what the doctor who oriented me said: "There will be some scary medical problems where you don't know what to do and that's OK." We're not here as a band-aid; we're here to put systems in place to vastly improve the public health. This is about the solution as opposed to the band-aid method. When you watch a tuberculosis patient gain 5 kg over the first two months of their therapy, you feel good about yourself and the work you do. But when public health work is done well and tuberculosis cases are prevented, for example, no one knows. The challenge to doing good international work is ensuring that the work you are doing is truly helping the community and not just making you feel better about yourself.

What are the most common types of ailments, injuries, and diseases that you see in the clinic?

JP: We see a huge variety of adult, pediatric, and obstetric patients. The most common disease causing hospitalization in children is pneumonia. We also see a large number of malnourished patients, either with severe wasting from calorie deficiency (marasmus) or swollen from protein deficiency (kwashiorkor). They usually spend two weeks in the malnutrition ward. We see an overwhelming amount of tuberculosis, which frustrates me. It is a completely treatable disease yet continues to ravage the population of countries like Ethiopia. We also see many acute diarrheal illnesses, intestinal parasites, gastritis, arthritis, skin infections and abscesses, malaria, typhoid, and other tropical diseases. We have antenatal clinic twice per week, and do many deliveries and other obstetrical procedures.

Was there anything that surprised you?

JP: We do see a large number of machete wounds from fights, especially on market days when lots of home brew is consumed in town.

What motivated you to create a blog and document your experiences?

EM: We started a blog to inform friends and families about our experiences here. But we soon realized that the blog was reaching a wider audience as co-workers, extended family, and friends-of-friends began to follow along. As a result, we adjusted the blog topics to make them more interesting and thought-provoking to a wider audience—discussing bigger-picture topics related to living and working in a developing country. We hope that these posts offer opportunities for thought and dialogue among our friends, family, and readers.

Your blog poignantly illustrates some distressing experiences where you had to "let go" and accept the impending and inevitable death of a patient. You describe this as a learning experience because you are trained and conditioned to "save" and never give up. Describe how these experiences might change your perspective or change you as a clinician.

JP: I've definitely changed my perspective of death since being here. I've learned to say to myself that I've done everything reasonable for this patient, and I'm more ready to face death as a possibility than I ever was in the US. What's interesting is that I don't think a CT scan or MRI would help these people much. In the US, I can only imagine how many tests would be run on some of these patients. And yes, their outcomes would be better for the most part. But mostly, their mortality rates are high because they waited too long to come in to the clinic, which is part of what I mentioned above – if our public health system (including having well-trained community health workers) was more functional, many of these deaths could be prevented. The main disadvantage in not having any radiology here (we don't even have an x-ray) is that we are forced to over-treat. But in the end, most patients go home healthy.

I've also changed my perspective on health. In the US, there is an expectation that if someone gets ill or dies it is someone's fault (sometimes the doctor). There is always a potential lawsuit. Without any threat of medical malpractice here in our corner of Ethiopia, I'm sure there is a certain amount of carelessness that leads to errors and that's a huge negative. But there is also not an expectation of good health regardless of the scenario that may lead to the skyrocketing healthcare costs in the US. I do believe that these experiences have changed me, but I worry that how I practice medicine will quickly revert when back in the over-litigious environment of the US.

On your blog, you wrote a very provocative essay, *What is Good Aid*? What concerns you the most about the way aid is distributed to underdeveloped countries?

JP: I think development work is much harder than people think. Many of us in the US sit in our comfy couches and watch documentaries from the third world and ask ourselves how we can help. I think that's a good thing. There's obviously a disparity and a need to address it. However, the first question I would tell others to ask themselves is not how they can *help*, but how they might *hurt* the situation if they try to help. Development dollars are a huge part of the economy of many of these developing countries. They have the potential to do a great good, but also the potential for much harm.

In *What is Good Aid?*, I described the perverse incentives for health professionals to attend trainings. Through this *per diem* system (where they get paid at their job back home and also get paid to be at the training), Ethiopians expect payment for participating in their own continuing education. Instead of paying to go to a conference like physicians do in the US, the conference pays them to be there. Certain diseases, such as HIV, seem to have more funding than others, allowing incentives to be that much more obvious.

How does this directly impact the clinic where you work?

JP: In our health center, I work with 7 nurses. We see more than 100 outpatients in a day. In addition, we supply daily medication to our TB patients. We care for up to 10-14 inpatients, including severely malnourished children. We have antenatal clinic twice per week. We see HIV patients in a confidential room. We have emergency traumas and deliveries on a near daily basis. Without much warning, 3 of our nurses will be taken away for sometimes as long as a week for a training. So, our number of nurses shrinks by nearly 50% and with it, our capability to care for the population and work towards our public health initiatives. And this type of occurrence is common.

Erin, describe some of your responsibilities as the Public Health Director.

EM: Lalmba's public health programs are still in the early stages of development. As Public Health Director, my job is to establish long-term goals and objectives for Lalmba, and to implement programs and services that will meet these objects. In particular, we are currently establishing education programs to address malnutrition, sanitation, and TB. We are also instituting community meetings to engage villages in public health projects and we are training government community health workers. Additionally we are conducting outreach to remote communities to vaccinate and screen for infectious disease.

What has been your greatest challenge?

EM: The most challenging component of this work is to maintain preventive health services as a community priority in the face of countless other pressing needs. All too often, public health work is underfunded, or undervalued as a community service. It is therefore easy to argue that more funding and investment in public health programs is needed, but funding is just one important piece of the public health puzzle.

Are there particular needs that you feel need more attention and funding?

EM: I would argue that, specifically, smart investment is needed in developing and replicating community-based best-practice work. Country or region-wide public health projects often fail to understand the local needs and cultural nuances that impact the implementation of public health programs locally.

What have you enjoyed the most?

EM: It is necessary to know a culture and community thoroughly in order to deliver public health services most effectively and efficiently. It is for this reason that I appreciate my work with Lalmba – an organization dedicated to truly understanding and working with the communities which we serve. ■

For more information on Lalmba visit: http://www.lalmba.org/

Partnerships for Health in a Rwandan Genocide Survivors Village: The Rwanda Health and Healing Project and *Barefoot Artists*

In 2005, Staff from Jefferson was invited to travel Rwanda to work with Lily Yeh, the founder of the Village of Arts and Humanities in Lower North Philadelphia and a partner organization, *Barefoot Artists*. These organizations share the mission to "work with poor communities around the globe to help people heal and thrive through self expression and action." The organization has completed numerous community-based art and development projects across the globe.

The organization's initial project in Rwanda was the Rwanda Healing Project, a two-year, multi-dimensional art project that expands the boundaries of art as a vehicle for social change. The project consisted of two simultaneous and complementary programs, The Survivors Village Transformation and The Genocide Memorial Park. The Survivors Village Transformation Project honors the living by equipping surviving family members with economic resources and tools to heal, learn skills, and take actions to better their lives. Located in Rugerero (Northwest Rwanda), these projects aim to engage 50 houses of 100 families with 190 children. Of these households, 67 are headed by females and eight are male-headed. Government construction of the Village began in 1997 to provide housing for people rendered homeless during the 1994 genocide.

In October of 2005, Thomas Jefferson University (TJU) faculty and a team of Jefferson medical students, as a component of Jeff *Health (*Helping Africans Link to Health), began working with Barefoot Artists.

In June of 2006, with support from the Arnold P. Gold Foundation, two faculty, three medical students and one public health nursing student traveled to Rwanda begin a comprehensive community health assessment. The goals of this assessment were three-fold; 1) to document the needs of community members through key informant interviews and focus groups, 2) to evaluate and document the health resources currently available through site visits and semi-structured interviewing of established organizations, and 3) to better understand health needs in context of the unique social and political history of Rwanda.

Once in Rwanda, the Jefferson team developed a Health and Hygiene Train-the-Trainer program, which included an environmental walk and training on hand washing and disease transmission. They also organized a health fair with the Village and managed to collect heights and weights on 150+ children as part of an initial Nutrition Assessment.

A Jefferson group returned in early April 2007 to follow-up on the nutrition assessment/activities and to determine next steps for collaboration, including meeting with faculty and students from the Rwandan School of Medicine. In June 2007, seven Jefferson medical students completed a nutritional assessment in the entire Village, provided HIV/AIDS education and linked the Village to Rwandan medical students as a component of the Rwanda Village Concept Project, an international student-run project, with a mission to improve the living standards in a Rwandan community by using simple and low cost methods and to develop the capabilities of students in participatory development work.

Since the initial work, 35 TJU medical, nursing and public health students have traveled to Rugerero focusing on heath education and promotion (elder care, HIV/AIDS, prenatal care, family planning, and nutrition), through a train the trainer program with the Village Health Association. Jeff HEALTH has also partnered with the Mid-Atlantic Chapter of Engineers Without Borders, who have repaired a majority of the latrines and septic systems in the Village.

The Jefferson medical students also began a partnership/exchange with Rwandan medical students. The exchange allows these students to receive additional training in the United States while Jefferson students participate in clinical clerkships in the National University of Rwanda's Medical School in Butare, Rwanda. To date, nine Rwandan students have been on Jefferson's campus for two months. In 2009, Jeff HEALTH began duplicating its programs in an additional Village – Akarambe.

James Plumb, MD, MPH

Professor, Department of Family and Community Medicine
Center for Urban Health, Thomas Jefferson University and Hospital

For more information, please contact James Plumb at James.Plumb@jefferson.edu

National Public Health Week

Healthy Philadelphia and Delaware Valley: Innovative Public Health Initiatives from Five Communities

Symposium and Luncheon
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To register visit: www.nphw2010.eventbrite.com.

A Healthier America: One Community At A Time

April 5-11, 2010
http://www.nphw.org/nphw10/home1.htm

Creating Our Future Leaders

AMSA 2nd Annual Patient Safety and Quality Leadership Institute

January 8-10, 2010

The Jefferson School of Population Health (JSPH) hosted the American Medical Student Association (AMSA) Second Annual Patient Safety and Quality Leadership Institute (PSQLI) in Philadelphia the weekend of January 8-10, 2010. The PSQLI worked to create a focus on quality improvement, teamwork, and communication skills and to foster a sense of urgency toward improving safety and quality nationwide.

Students from the University of Illinois-Chicago College of Medicine, Drexel College of Medicine, Robert Wood Johnson Medical School, and Jefferson Medical College attended this year's Institute. According to Boris Rozenfeld, one of the program organizers, the goal of the conference was to "educate and expose our members to issues of quality and safety in its infancy, and to teach the necessary skills that would allow AMSA leaders to become more involved in this emerging field."

David B. Nash, MD, MBA, Dean of JSPH, opened the weekend by introducing Michael J. Vergare, MD, Senior Vice President of Academic Affairs at Thomas Jefferson University, who discussed the emerging issues with regard to safety and quality and the effect on healthcare professionals. Dr. Nash followed these remarks with a discussion about the importance of knowledge about safety and quality and how it will have a profound impact on healthcare in the coming years.

Other featured speakers included: Neil Goldfarb, Associate Dean for Research, JSPH; Ralph Halpern, MSW, Director, Content Development and Program Evaluation, Tufts Care Institute; Peter Katsufrakis, MD, MBA, Associate Vice President, National Board of Medical Examiners; Valerie Pracilio, Project Manager for Quality Improvement, JSPH; Susan DesHarnais, PhD, MPH, Program Director, Health Care Quality and Safety, JSPH; Lee Ann Riesenberg, PhD, RN, Director, Medical Education Research, Christiana Care Health System; and Peter Fleischut, MD and Adam Evans, MD, MBA, both from New York Presbyterian Hospital – Weill Cornell Medical College. Topics covered included: Measuring and Improving Quality in Outpatient Care; Faculty Development and Curricular Needs; Licensing and Maintenance of Skills; How to Get Engaged in Quality and Patient Safety; Studying Errors and Processes; and Methods of Analyzing Quality and Safety Problems.

Students learned about the basic organizational structure of the hospital and the key members of the hospital staff involved in safety and quality. For example, Dr. Fleischut and Dr. Evans, both anesthesia residents at Weill Cornell Medical Center, described several initiatives that they have implemented at Cornell that significantly improved patient safety during their residency. For example, Dr. Fleischut and Dr. Evans collaborated with administrative staff to create an electronic notification that prohibits order entry until a medical reconciliation form is created. Since the initiative was started, Dr. Fleischut and Dr. Evans reported that there was an incredible increase in compliance, from 40% to 99%.

Another issue described in depth, was the difficulty of defining exactly what safety and quality means. Dr. DesHarnais provided a detailed description on what it means to measure safety and quality and what exactly defines an 'outcome measure'. Dr. DesHarnais also provided an explanation of risk adjustment and why it is considered so crucial to include when measuring safety and quality, particularly in underserved populations.

Mr. Rozenfeld noted that the conference attendees also learned "that [we] need to move away from simply clinical research to more qualitative research; to do this, we are learning how to understand abstract details currently understood by few in the healthcare field." Mr. Rozenfeld then described how students are often unaware of ways in which different disciplines can work together to improve patient safety and quality, and how speakers like Dr. Riesenberg have broadened the attendees' knowledge about other specialties and their efforts to improve safety and quality.

Institute participants were also treated to a tour of the University Skills Center and Simulation Center by Drs. Dale and Kate Berg, and a panel discussion on work-life balance issues.

On January 19th, the students involved in the institute participated in a webinar hosted by Dan Henderson, another one of the student leaders in AMSA. Along with Mr. Rozenfeld, Mr. Henderson presented different techniques on how to approach and sell the idea. Mr. Henderson reminded students that one of the hardest parts about increasing safety and quality is creating awareness and a sense of urgency, and focused his discussion on ways for students to seek out appropriate faculty champions to help them advance the causes of safety and quality in each member's institution. ■

Justin Abraham
MD/MBA Candidate
Jefferson School of Population Health

AMSA 2nd Annual Safety and Quality Leadership Institute

TOP row (from left to right): Todd Rubin, Marcia V. Wilkof, Susan DesHarnais, Kate C. Blenner, Lee Ann Riesenberg, David B. Nash, Louisa Baxter, Marina V. Zeltser, Catalina Morales, Mary d'Alelio, Minda Aguhob, Ben Goold, Isabel Lazo, Aimee Williams, Zach Landau

BOTTOM row (from left to right): Nida Dygesis, Gregory Azzam, Justin Abraham, Pankaj Kaushal, Joshua Weinstock, Rohit Tonk, David Pierce, Boris Rozenfeld, David Rand

Health Policy Forums

Achieving Cultural Competency: Using a Case-Based Approach for Teaching and Learning

Lisa Hark, PhD, RD
Associate Professor
Jefferson Medical College and Wills Eye Institute

Horace M. De Lisser, MD
Associate Dean, Spirituality and Cultural Competency
Associate Professor of Medicine
University of Pennsylvania School of Medicine

December 9, 2009

Many health care encounters are challenged by cultural misunderstandings and lack of self-awareness. These breakdowns can profoundly affect the way in which care is delivered. Dr. Lisa Hark and Dr. Horace De Lisser, editors of the newly released book, *Achieving Cultural Competency: Using a Case-Based Approach for Teaching and Learning,* presented on these issues and offered strategies for improving the cross-cultural clinical encounter. Their work is focused on developing educational tools and integrating cultural competency into medical school curriculum.

Dr. De Lisser offered an overview and definition of cultural competency. He also described the process of cultural competency which includes self-awareness, communication and negotiation skills, knowledge of cultural norms, and knowledge of health-related disparities. He urged the audience to think about diversity and culture in the broadest dimensions such as religion/spirituality, age, gender, sexual orientation, ethnicity, and socioeconomic status.

Dr. Hark described the process for the development of research and case studies that were eventually used to teach students and residents. Using real-life scenarios, they established concrete examples, and included a number of vignettes and process questions that could be accessed online as a CME program. Dr. Hark and Dr. De Lisser presented some of these cases at the Health Policy Forum which led to a lively, thought-provoking audience discussion.

For an example of an online CME cultural competency course created by the presenters, visit: http://cme-online.med.upenn.edu/index.pl?id=452455.

Health Care Reform: Future Implications and the Role of the Physician Advocate

Valerie Arkoosh, MD, MPH
Professor of Clinical Anesthesiology, Obstetrics and Gynecology
University of Pennsylvania School of Medicine
President-elect, National Physicians Alliance

January 13, 2010

A new year of Health Policy Forums opened up with an eloquent and thoughtful presentation on health care reform by Valerie Arkoosh, MD, MPH. Dr. Arkoosh is the president-elect of the National Physicians Alliance, an organization focused on improving health and well being and to ensure equitable, affordable, high-quality health care for all people. Dr. Arkoosh is also Professor of Clinical Anesthesiology, Obstetrics, and Gynecology at the University of Pennsylvania School of Medicine.

Dr. Arkoosh introduced the issues at hand by sorting through the larger themes of the health care reform debate: the patient's view, society's view, the US system, costs, and policy solutions. Dr. Arkoosh then guided the audience through a step-by-step overview of the difference between the House and Senate in health reform. She discussed areas of agreement, and differences in proposals in categories such as: individual mandates, affordability, employer responsibility, and Medicaid.

Dr. Arkoosh also discussed more difficult challenges ahead which may take more time to resolve. For example, the public option may not appear in the final legislation. There are dramatic differences in House and Senate legislation on allocations for the public health workforce. Additionally, the physician payment system and malpractice reform is likely to be tabled for the future.

At the heart of this presentation was the profound argument that despite disagreements, there is a tremendous cost in doing nothing. As the valid practical and philosophical arguments continue, it will take a deliberate and tactful policy solution to improve the future of health care.

For more information on the National Physicians Alliance visit: www.npalliance.org

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

If you have topic ideas or speaker suggestion for future Health Policy Forums, please email: emily.frelick@jefferson.edu

Young Journalists Deliver Public Health Message

The reporters left the staff meeting intent to understand several pressing issues: Why hasn't hand sanitizer been installed in a far wing of the school? When would the walking trail be built? What prompted the cafeteria to change its meal tickets?

While these concerns might not be typical front-page fodder for *The New York Times,* they are intriguing for these fourth-grade reporters and the readers of their school health newspaper. By delving into subjects that matter in their school community, they are directly engaging their classmates, parents and teachers with health information that is relevant in their daily lives. In the process, their publications help advance the proposed Healthy People 2020 objective of increasing "knowledge and skills," as outlined in the National Health Education Standards — a set of goals that educators and organizations can use to develop curriculum for elementary, middle and high schools. [1]

The fourth-grade reporters are part of the Healthy Times Student Media program that began in Upper Darby, PA in 2003 and has expanded to a dozen schools in the Philadelphia region. The program teaches children basic journalism skills so they can produce relevant and engaging publications to heighten awareness about health, fitness, nutrition and safety. Writing becomes their means to foster positive changes in their schools and communities.

"I've heard and seen that kids are excited about eating healthier," wrote one student newspaper staff member in a survey. "I think we should keep encouraging the kids." The newspaper "acted like a role model to people because it helped my family eat healthier," wrote another young reporter.

Each school program sets up its own "mini city room" staffed with students who pledge to write fairly, accurately and clearly. They must attribute information to reliable websites and other sources, and promise they won't copy other people's work.

The journalists, who are typically in third through eighth grades, gather information primarily through interviews with classmates, nurses, physical education teachers and other school personnel. They also query outside health experts by telephone or in school-based press conferences.

At the invitation of the Centers for Disease Control and Prevention (CDC), five students covered the "Weight of the Nation Conference" in July 2009. Their interview subjects included the Acting Surgeon General and top CDC officials. More recently, a group of sixth graders attended the American Public Health Association Annual Meeting in Philadelphia and were briefed on topics such as the National Physical Activity Plan.

The student journalists write news and feature stories, review health-related books and websites, and participate in taste tests that expose them to smoothies, avocados and other healthy food. They also contribute illustrations and games, and oversee newspaper-sponsored activities such as a healthy poetry contest. Each paper is typically two or four pages and generally includes between three and 10 articles.

After an issue is printed (up to four times a year), the young reporters often help promote or distribute it throughout the school building. The reporters in one school handed out their free papers while singing a nutrition song penned by the music teacher and two students specifically for the school publication. Grants, donations and volunteers help support the program.

The response to these newspapers is very positive. In a 2009 evaluation conducted by The Food Trust, a Philadelphia nonprofit, the 26 teachers who responded to a survey said they would recommend that other schools have a Healthy Times newspaper. Eighty-one percent said the newspaper has a positive impact on the health beliefs or attitudes of their students.

Among 240 surveyed third and fourth grade students who read a Healthy Times newspaper, 80 percent would recommend a paper to other schools and 73 percent learned something about being healthy from the paper.

"This year I read about (a school teacher)… she runs every day. I think I should go outside more than I usually do," wrote one reader. Another student wrote, "After I used the tips that the (newspaper) gave me, I felt less stressed."

In one evaluation conducted by The Food Trust, a sample of 12 newspapers was reviewed to assess whether the content addressed the eight National Health Education Standards.[1] The standards, developed by a joint committee of national health organizations, are "written expectations for what students should know" about health by certain grades. For the purposes of this evaluation, a newspaper issue that satisfied at least one indicator for each standard was counted as having addressed that standard. Through this analysis, it was found that all 12 newspapers dealt with at least six of the eight standards, giving schools a hands-on resource for health education instruction. To date, newspapers have been developed independently of these standards, making this an intriguing finding for future program development.

The healthy newspapers deliver more than health facts; they provoke critical thinking about current, complex health issues inside and outside of the school environment. They also promote literacy and can be used as creative teaching tools. A major focus moving forward will be on increasing teacher engagement, and developing materials and messages that will promote the use of Healthy Times newspapers as a teaching tool.

Looking to the future, an ideal model would be the implementation of school policies for using the newspapers in ways that address literacy and health education requirements. In its next stage of development, the Healthy Times program plans to further develop its curriculum and to create an interactive website to support schools. As it grows, the program is interested in forming new partnerships to broaden its reach. Healthy Times recognizes the value of evidence-based methods, and for this reason, will conduct further in-depth evaluation to illustrate the program's impact and its evolution. ■

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The Food Trust

For more information, contact Marian Uhlman at uhlman23@aol.com.

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Good Publication Practice: Maintaining the Integrity of Scientific Communications

Good Publication Practice (GPP) is a set of guidelines within the health care communication industry that encourages the responsible and ethical publication of scientific data. GPP has its origins in the mid-1990s when it first came to public awareness that involvement of unacknowledged, industry-funded medical writers could compromise the integrity of scientific articles. While medical writers were initially regarded skeptically by medical journal editors, their valuable contribution to the accuracy and currency of scientific communications is now fully acknowledged and a more balanced view of the relationship between author, sponsor and medical writer is gradually emerging. In fact, a 2007 article in the *British Medical Journal* commented that: "medical writers are not a fifth column but are working in a fast-moving modern environment to help disseminate scientific information…. and their work needs to be embraced and acknowledged…".[1] Furthermore, the World Association of Medical Editors (WAME) urges editors to make it clear in their instructions to authors that medical writers can be legitimate contributors.[2]

However, a recent editorial in the *Financial Times* makes it clear that, "Using professional writers to improve the standard of manuscripts submitted to medical journals is acceptable, and even desirable. Ghost-writing, which conceals the underlying influence and authorship, is wrong."[3] Since it is in the interest of all parties involved in disseminating scientific data to eliminate such questionable practices, various national and international guidelines have been developed to ensure that manuscripts are not only of a high quality, but that the preparation process is beyond reproach.

The Good Publication Practice for the Pharmaceutical Companies[4] (GPPPC) guidelines were first published in 2003 and updated in 2009. These guidelines are aimed to increase transparency and to encourage the ethical dissemination of data. Numerous guidelines produced by associations representing medical writers, medical editors and the pharmaceutical industry have followed and continue to evolve.

Authorship is key to the integrity of any written communication, and the definition of an author given by the International Committee of Medical Journal Editors[5] (ICMJE) is widely accepted. According to this definition, an author must make a substantial contribution to the conception and design, acquisition of data or analysis and interpretation of data, as well as writing the first draft of the article (or revising it critically) and giving final approval. The ICMJE also stipulates that all authors must take public responsibility for their work. If authors do use the services of medical writers, they must always agree with the content and outline with the writer before the first draft is written and the two parties must maintain contact throughout development of the manuscript.[4]

Given the ICMJE criteria, it is clear that medical writers will not usually qualify to be authors, perhaps with the exception of review articles in which the writer performed the literature search, identified articles and evaluated the data. However, there is universal agreement that a medical writer's contribution should be clearly acknowledged in the article and any funding disclosed.[2,4,6] WAME goes further and considers all parties involved in concealing medical writer involvement to be responsible (including marketing, communications and medical education companies) and suggests the 'naming and shaming' of culprits.[7]

Of course, the scope of GPP guidelines goes beyond the single issue of medical writers and covers other areas crucial to the unbiased communication of biomedical literature. The ICMJE and the GPPPC discourage duplicate publications of data. Exceptions include symposium proceedings, alternative analyses, data grouping with other studies and publication for different audiences.[4,5] Furthermore, WAME requires that authors disclose details of related papers they have authored, even if they are in a different language, in press or submitted to another journal.[3] The ICMJE and the GPPPC consortium are also among the organizations seeking to persuade pharmaceutical companies to publish all trial results, negative as well as positive.[4,5] To this end, the ICMJE, the GPPPC and WAME strongly support the registration of clinical methodology,[4,5,7] while the 2007 FDA Amendment Act goes a step further and requires that researchers also register all trial results. This policy should go a long way to identifying unpublished–and therefore probably negative–data which will help to avoid a potentially misleading weighting of results.

Conflict of interest disclosure is another area taken very seriously by medical journal editors; the Journal of the American Medical Association investigates all allegations of undisclosed conflicts, emphasizing that reporting the best available biomedical science is of prime importance and should not be jeopardized by such misrepresentation.[8]

GPP guidelines are continuing to develop and are gaining wide acceptance by all parties involved in the communication and dissemination of biomedical information. The principles of clear, unbiased and ethical reporting of results, opinions and ideas can only be of benefit to the medical community in particular and society as a whole. ■

Jackie Mayne, MSc
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For more information on BioscriptUS visit: www.bioscriptus.com

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7th Annual Interclerkship Day:

Improving Patient Safety

January 4, 2010

The 7th Annual Interclerkship Day on Improving Patient Safety was a unique opportunity for Jefferson Medical College's (JMC) 3rd year students to explore their own attitudes and beliefs about medical error and patient safety, while benefiting from lessons learned from the aviation model of crew resource management and its application to medicine. Sponsored by Office of the Dean of JMC and the Jefferson School of Population Health (JSPH), the program was moderated by David B. Nash, MD, MBA, the Dean of JSPH. The day opened with a welcome from Michael J. Vergare, MD, Senior Vice President of Academic Affairs.

The keynote speaker was internationally known aviation safety expert, John J. Nance, JD. Nance is a founding board member of the National Patient Safety Foundation; a former airline pilot; and a broadcast analyst on aviation for ABC News. He presented compelling evidence illustrating how medicine can use crew resource management (CRM) principles from the airline industry to improve patient safety and increase professionalism. He emphasized the importance of communication and the creation of an environment and culture that allows a junior team member to actively participate and speak up if something is amiss. This type of environment fosters teamwork while ultimately improving patient safety.

The application of CRM in the medical environment via medical simulation was presented by David Lindquist, MD, FACEP, Assistant Professor of Emergency Medicine at the Warren Alpert Medical School of Brown University. Dr. Lindquist shared tools and techniques that can easily be used in most situations. He also showed simulation videos that are used to educate healthcare professionals about communication practices and improve leadership and team behaviors.

Following the morning presentations, students had the opportunity to listen to Gregory C. Kane, MD, Professor of Medicine, Residency Program Director and Vice Chairman in the Department of Medicine, during a luncheon presentation. Dr. Kane gave a very encouraging and supporting vote of confidence to the students by giving them permission to speak up and be an integral part of the quality and safety solution.

The afternoon program opened with a panel discussion, and question and answer session that focused on family and patient perspectives. The first panelist, Jay Scott, Executive Director of Alex's Lemonade Stand shared an emotional story about the initial time period when his daughter Alex first developed symptoms of her disease and the frustrations encountered by his family when trying to get a diagnosis, appropriate care, and effective treatment. It was a moving story which revealed the shortcomings of the medical system and highlighted opportunities for improvement. Mr. Scott's take-home message for the students was to ***listen.*** The second panelist, Linda Kinney, Executive Director and President of Medically Induced Trauma Support Services, Inc. (MITSS), in Massachusetts, shared a very personal story of how a medical error impacted her health and her family. Although she endured a very frightening event, she was able to use this experience to develop a platform that advocates for patients and families. She is also very interested in supporting providers by helping them to understand the cathartic nature of apology. An interesting twist developed in Ms. Kinney's story. She gained a great deal of support and interest from the physician responsible for the error in her case and he went on to become an advocate and active member of her organization.

It can be very difficult to communicate a bad outcome to patients and families. Jason Baxter, MD, MSCP, Assistant Professor in the Division of Maternal-Fetal Medicine, offered a very interactive presentation and dynamic exchange with the audience that helped to characterize the elements of a successful encounter with patients and families. Through the use of case scenarios and student involvement in role-plays, the audience observed important skills, actions, language, and non-verbal cues which enhance the provider-patient encounter and lead to patient satisfaction.

This particular clerkship program provides an important venue for integrating patient safety issues into educational programming for JMC students and it will continue to thrive in future years to come. ■

JSPH holds fundraiser for Alex's Lemonade Stand

David B. Nash, MD, MBA, presents Jay Scott, Executive Director of Alex's Lemonade Stand with a check.

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Upcoming Health Policy Forums - Spring 2010

Consumer Health Informatics and Healthcare Disparities

April 14, 2010

Michael Christopher Gibbons, MD, MPH
Associate Professor
Johns Hopkins Urban Health Institute

Changing Social Environments to Promote Health: Evidence, Opportunity, and Challenges*

May 12, 2010

Karen Glanz, PhD, MPH
Penn Integrates Knowledge (PIK) Professor of Medicine and Nursing
University of Pennsylvania
*** Please note, this Forum will take place in Bluemle 105/107**

Physician Leadership and Medical Group Performance: A National Study

June 9, 2010

Louisa Baxter, MD, Msc, MRCP (UK)
Commonwealth Fund Harkness Fellow In Health Care Policy and Practice
Jefferson School of Population Health

Location for Health Policy Forums:

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

Time: 8:30 am – 9:30 am

For more information call: (215) 955-6969

Health Policy NEWSLETTER

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