

Health Policy NEWSLETTER

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FROM THE EDITOR

The Jefferson School of Health Policy and Population Health – Part One

On July 28, 2008, the Board of Trustees approved the establishment of the *Jefferson School of Health Policy and Population Health (JSHPH)* as a stand-alone entity within Thomas Jefferson University. This new School will enroll its first students by September 2009 and was the direct outgrowth of a multi-year strategic planning process that identified “health policy and population health” as immediate priorities crucial to Jefferson as a healthcare leader in the 21st century.

The Department of Health Policy, including its current faculty, staff, programs and research, will be organizationally relocated from Jefferson Medical College to form the nucleus of the new School. David B. Nash, MD, MBA, Chair of the Department of Health Policy, will serve as the founding Dean. An Advisory Committee, composed of key members of the Jefferson community and chaired by Richard C. Wender, MD, Alumni Professor and Chair of the Department of Family and Community Medicine of Jefferson Medical College, will serve as the primary consultative resource for the new School.

The mission of the Jefferson School of Health Policy and Population Health is to prepare leaders with global vision to develop, implement and evaluate health policies and systems that improve the health of populations and thereby enhance the quality of life. The School will fulfill its mission through provision of exemplary graduate academic programming, continuing education courses and conferences, and sustained research and consulting in the areas of health policy, population health, and healthcare quality and safety.

The Master’s in Public Health (MPH) degree and certificate programs, presently offered through Jefferson College of Graduate Studies, will move to the new School. Over the next few years, JSHPH will offer certificate and master’s degree programs in health policy, healthcare quality and safety, and chronic care management. It will also provide doctoral degree programs (PhD and DrHP) in population health and health policy. Because of their innovative and pioneering content, it is anticipated that the programs in chronic care management, healthcare quality and safety, and population health will help to define the future of education and research in these vital areas.

Why a School of Health Policy and Population Health? Why now?

The answer is simple: the nation’s healthcare system is in crisis.

- Chronic illness is epidemic and unmanaged, accounting for nearly 80% of all healthcare spending and affecting 133 million Americans (45% of the population).
- Health insurance premiums have risen almost 90% since 2000.
- 47 million Americans are currently uninsured and 16 million are underinsured.
- Poor and minority populations have limited or no access to healthcare of any kind.
- The aging of the U.S. population is increasing demands on all sectors of the healthcare system.
- The Institute of Medicine estimates that almost 100,000 patients die annually in US hospitals due to medical errors.
- The failure to incorporate the latest in evidence-based practice leads to misdiagnosis or inappropriate care.
- Threats of national disasters (Katrina) and global epidemics (Avian flu, MRSA) are ever-present and can easily overwhelm local or national healthcare resources.

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Unfortunately, increased expenditure on health care has not led to increased quality, safety, affordability or accessibility. While the United States spends more per capita annually for health care (a total of \$2 trillion) than any other industrialized country, it ranks at the bottom for even the most fundamental quality indicators such as infant mortality and life expectancy.

The need to address the healthcare crisis in the United States – its quality, safety, affordability and accessibility, is *incontrovertible*. It is no longer possible to prepare high-quality healthcare providers and educators without addressing these issues holistically from the perspective of population health and with the tools of health policy analysis.

As a discipline, population health is broadly defined as health *outcomes* (e.g., mortality, morbidity, quality of life) and their *distribution* within a population; the health *determinants* (e.g., medical care, socioeconomic status, genetics, public health) that influence this distribution; and the *policies and interventions*, both social and individual, that impact these determinants. By definition, population health is holistic. It views the world as a system and looks for patterns and connections within this system. It analyzes problems – such as healthcare quality and safety or chronic disease – in context and looks to the patterns and pervading variables to develop the best solutions.

Why a School of Health Policy and Population Health at Jefferson?

There are four compelling reasons:

First, it helps Jefferson to fulfill its mission of education, research, clinical excellence, and community service. The size and complexity of the healthcare system have created a need for continued research and a demand for the preparation of health services professionals and practitioners who are trained in these areas at the graduate level.

Second, it provides a means for Jefferson to achieve its vision, which is to maintain and enhance its position as a leading academic health center within the national arena and to expand its influence and contributions to the global community.

Third, the resources and capabilities necessary to build a premier center in health policy and population health are already present within the Jefferson community.

The Department of Health Policy has a national reputation for expertise in health policy, especially in areas of healthcare quality/safety and chronic care management. For the past decade, the Department has demonstrated sustained ability, via major grant funding, to conduct research and continuing education programming in these and other policy areas. The University has further demonstrated commitment to population

health through its establishment of an accredited master's degree program in public health (MPH). Additional expertise is found in the Department of Family and Community Medicine; the Kimmel Cancer Center, especially its Division of Population Science in the Department of Medical Oncology; the Center for Applied Research on Aging and Health (CARAH) of Jefferson College of Health Professions; and in key leadership areas of Jefferson Hospital and Jefferson University Physicians (JUP).

The establishment of the School of Health Policy and Population Health will recognize and build on existing Jefferson strengths and provide a venue for these strengths that is visible nationally and internationally. It will serve as a platform to expand opportunities for related research and grants within the School, collaboratively across the University, and through new national and international partnerships.

Finally, establishing a School of Health Policy and Population Health is in keeping with Jefferson's historic tradition of clinical excellence and service to the community. Over time, however, the definition of community has changed - from city to region - from region to nation - and now, the world. Assuring the health and wellness of all populations, in all places, and providing quality and compassionate healthcare to all who need it will remain a defining theme of the 21st century. It is no longer possible for Jefferson to achieve clinical excellence, to educate medical and health professionals, and to serve the community without making health policy and population health a central focus of these efforts.

In 2024, Jefferson will celebrate its bicentennial. To achieve such a milestone is rare for any institution. Jefferson is fortunate in that it can reach into a rich and illustrious past as it builds for the future. Two hundred years of wisdom and experience have produced continued success, valued reputation and strategic vision. The establishment of the School of Health Policy and Population Health will enable Jefferson to maintain and enhance its position as a leading academic health center and to expand its influence and contributions to the global community.

The Health Policy Newsletter will include periodic updates on JSHPH as we move toward its September 2009 opening. You may follow our progress online at the JSHPH website www.jefferson.edu/JSHPH and blog <http://departmentofhealthpolicy.blogspot.com/>

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PUBLICATIONS

<http://www.jefferson.edu/dhp/pubs.cfm#new>

Thomas Jefferson University
Philadelphia, Pennsylvania

is proud to announce the establishment of the
Jefferson School of Health Policy and Population Health
Enrolling students beginning in September, 2009

The Jefferson School of Health Policy and Population Health builds upon Thomas Jefferson University's long standing commitment to high-quality education of health professionals and community service. Under the leadership of David B. Nash, MD, MBA, current Chair of the Department of Health Policy of Jefferson Medical College, the School will offer programs in Quality and Safety, Public Health, Health Policy, and Chronic Care Management.

Faculty Positions Available

Program Director, Quality and Safety: This full-time faculty member will oversee establishment of the Quality and Safety program and lead expansion of a well-established research agenda in quality measurement and improvement. The ideal candidate will be doctorally-prepared, have academic publications in the quality and safety arena, and have experience applying quality measurement and improvement principles in a clinical setting.

Faculty Members, Doris N. Grandon Center for Health Economics and Outcomes Research: Full-time faculty positions are available for doctorally-prepared individuals with HEOR research experience in industry, consulting, and academic positions. Individuals will be expected to support the Department's HEOR consulting practice, to develop grant proposals to support their own HEOR interests, and teach courses. Areas of expertise that are of particular interest at this time include: development of pharmacoeconomic models, productivity measurement, and retrospective analysis of large claims and other research databases.

Other Research Faculty Members: Additional positions are available for doctorally-prepared individuals with significant research experience to join the Department's faculty. Faculty members are expected to develop research grant proposals as lead investigators, contribute to the development of collaborative grant proposals and consulting projects, disseminate research findings through publication and meeting presentations, and teach courses in the new school's masters and doctoral programs. Areas of expertise that are of particular interest are: epidemiology and biostatistics, addressing disparities in health care, addressing global population health needs, chronic illness and aging, and impact of climate change on health.

For more information on these positions, please contact Neil Goldfarb, Vice Chair for Research, Department of Health Policy, neil.goldfarb@jefferson.edu, or 215-955-0427.



Redefining Health Care Education

THOMAS JEFFERSON UNIVERSITY

Birth of a Center for Interprofessional Education

The Institute of Medicine (IOM) report entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*¹ recommended a realignment of the health care system to enhance quality, safety, patient-centeredness, efficiency, and equity. One of the recommendations was restructuring clinical education toward an interprofessional practice. A subsequent IOM report² stated that “clinical education simply has not kept pace with or been responsive enough to shifting patient demographics and desires, changing health system expectations, evolving practice requirements and staffing arrangements, new information, a focus on improving quality, or new technologies...”

Once in practice, health professionals are asked to work in interdisciplinary teams, often to support those with chronic conditions, yet they are not educated together or trained in team-based skills. Interprofessional education (IPE) “occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.”³ The most recent 2008 Cochrane Review⁴ on interprofessional education indicated that IPE produced positive outcomes in the following areas:

- Emergency department culture and patient satisfaction;
- Collaborative team behavior and reduction of clinical error rates for emergency department teams;
- Management of care delivered to domestic violence victims; and
- Mental health practitioner competencies related to the delivery of patient care.

IPE is more common in Canada and the United Kingdom, where inclusion is mandated in their educational systems. Across the US, the University of Washington and University of Minnesota are known for contributions to interprofessional education. This article discusses the initiatives of the newly developed Jefferson InterProfessional Education Center (JCIPE) at Thomas Jefferson University (TJU) in Philadelphia.

JCIPE was initiated and funded by the Deans of Jefferson Medical College and Jefferson College of Health Professions in early 2007, and is dedicated to improving patient care through implementing and evaluating patient-centered, interprofessional education throughout the TJU curriculum. This includes preclinical/didactic education, clinical simulation, and clinical education within highly effective team-care settings working with outpatient practices, Thomas Jefferson University Hospital (TJUH), affiliates, and community partners. JCIPE serves as a coordinating body to facilitate the development and expansion of interprofessional education, faculty development, and evaluation across TJU. With strong university administrative support, initial activities of the co-directors included establishment of a diverse, enthusiastic steering committee that meets monthly; establishment of the center’s website; dissemination of activities and information; and a faculty survey to assess interest and feedback.

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The importance of patient-centered care delivered in integrated health care teams is essential to improve patient outcomes and satisfaction in our complex health care system. JCIPE provides opportunities for learners to collaborate with other health professional students early in their educational curricula. Interprofessional faculty member teams are involved early in the planning, implementation, and evaluation of Center activities to ensure an interprofessional perspective and to model collaborative behavior.

On Thursday October 23, 2008, JCIPE will launch its 1st Annual Conference, *InterProfessional Care for the 21st*

Century: Redefining Education. This conference is an exciting opportunity for educators, health and social service professionals, policy makers, researchers, and interested stakeholders to cultivate collaborative approaches to interprofessional education programs. Participants will take a closer look at the impact of interprofessional practice on the provision high quality, patient-centered care. This free conference will take place from 7:30 am – 4:30 pm, with the morning session covering an array of topics such as: Advancing Interprofessional Education; Improving the Quality of Care; and Mentoring Programs. The afternoon session will consist of specific workshops covering innovative models of curriculum and skill development. A networking lunch and poster session will also be included.

To learn more about this conference and other JCIPE programs, please visit: <http://jeffline.jefferson.edu/JCIPE/>.

For conference registration questions, please contact Cassie Mills at Catherine.Mills@jefferson.edu.

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The Jefferson Doctor of Nursing Practice Degree

In 2004, the American Association of Colleges of Nursing (AACN) decided to move the level of preparation for advanced practice nurse (APN) roles from the master's to the doctoral level.¹ AACN also called for educating APNs and other nurses seeking top leadership and clinical roles in Doctor of Nursing Practice (DNP) Programs. AACN envisions the DNP degree as the terminal degree for advanced nursing practice by 2015.

AACN outlined the benefits of the Doctor of Nursing Practice as follows:

- Developing needed advanced competencies for increasingly complex practice, faculty and leadership roles;
- Enhancing knowledge to improve nursing practice and patient outcomes;
- Enhancing leadership skills to strengthen practice and health care delivery;
- Better matching of program requirements and credits and time with the credential earned;
- Providing an advanced educational credential for those who require advanced practice knowledge but do not need or want a strong research focus;
- Enhancing the ability to attract individuals to nursing from non-nursing backgrounds; and
- Increasing the supply of faculty for practice instruction.²

The Jefferson School of Nursing (JSN) is one of over 70 schools nationwide that offer a DNP degree. In September 2007, Jefferson welcomed its first cohort of 18 DNP students, representing a wide variety of practice specialties, including acute care, primary care, healthcare administration, population health, education and industry. Twenty students comprise the second cohort entering in September 2008.

The DNP program at JSN is an inter-professional education experience that prepares professional nurses at the highest level for advanced practice in clinical practice, administration or policy. Through a variety of practica, courses, and on-line learning experiences, the program prepares leaders who can evaluate the evidence base for care and facilitate the translation and integration of research into quality care to improve patient outcomes, deliver the highest standard of care, influence health care policy, and work skillfully as members of inter-professional teams.³

Preparing advanced practice nurses is a key strategy to mitigating the predicted impending shortage of healthcare professionals, particularly in rural communities. In July 2007, JSN was awarded federal funding to expand its graduate

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education programs. A portion of this funding allowed for the extension of the new DNP program beyond the reach of its urban Philadelphia campus to the JSN campus at Geisinger Health System in Danville, PA. (Danville is in Montour County, the smallest county in the Commonwealth of Pennsylvania.) Previously, JSN's rural campus offered one undergraduate program. The grant allowed four of the initial cohort of DNP students to participate in classes via a combination of web-casting and live video over the Internet.

This change in professional education for nurses, while innovative, is not without controversy. Some concerns have been raised by the American Medical Association (AMA) surrounding the scope of practice for nurses with the DNP credential. In April 2008 the National Board of Medical Examiners announced it would develop a voluntary DNP certification exam based on the same test physicians take to qualify for a medical license.⁴ In June the AMA proposed two resolutions to protect the titles of "doctor," "resident," and "residency," and DNP supervision stipulations.⁴ Continuing dialogue will be needed to respond to some of these concerns.

Educational institutions and nurses themselves continue to discuss the impact of the DNP degree and what it will mean to advanced practice nursing, to the institutions that prepare nurses for practice, and to the profession as a whole.¹ Jefferson School of Nursing is meeting the challenge of educating the next generation of nurses to fully participate in evolving complex healthcare delivery systems.

Information on Jefferson's DNP program can be accessed at: <http://www.jefferson.edu/jchp/nursing/dnp.cfm>.

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Stretching the Boundaries of Medical Education

Nearly 100 years ago Abraham Flexner¹ proposed that undergraduate medical education in America follow a standard model: a preclinical curriculum covering basic sciences followed by a clinical curriculum covering the technical skills and clinical sciences. Years one and two have historically been devoted to didactic classroom instruction, while years three and four have been dedicated to “apprentice” experiential training. The common thread through all four years is an overwhelming focus on the sciences, with very little in the curriculum addressing the policy of healthcare delivery, the healthcare system, and fundamental “intangibles” of patient-centered care such as cultural competency, patient education, and evidence-based decision-making.^{2,3}

Why consider these intangibles? These are the topics that medical students don’t master during standard training. Typically, these are nominally included in the preclinical curriculum. Medical students from different schools have called this the “touchy feely” curriculum, the “toolbox,” the “hodge-podge,” and the “part that doesn’t matter because it isn’t on the boards.” Unfortunately, uncoordinated presentation of the material and disregard by faculty for these issues (as noted in the literature on the hidden curriculum⁴) may turn off medical students from the most important topics in patient care. In the clinical years, there are lectures available on such topics, but rarely do these “extracurricular” opportunities have sustainable support or cohesion to bring the miscellaneous lectures into a logical framework.

The imperative for broadening medical training is clear. Challenges in quality, safety, affordability, and access of health care reveal the need to train healthcare professionals that are capable of coordinating and managing care in a complex system. However, reform in medical education is a slow process with built-in obstacles related to funding, examination standards, and sluggish adoption by the education community. Cooke et al⁵ suggest that “it can be hard to teach messy real-world issues, but practitioners need to understand how these issues affect patients and how to interact with, and ultimately improve, an exceedingly complex and fragmented system to provide good patient care.”

The call for solutions *within medicine* has led to the birth of the AMSA Academy, a new school within the American Medical Student Association (AMSA), training students to become physician-leaders and agents of change. AMSA Academy has been launched simultaneous to the approval of the Jefferson School of Health Policy and Population Health (JSHPPH). Bearing a shared vision with JSHPPH, Jefferson faculty and AMSA leadership are quickly coming together to build bridges and generate discussion about how to achieve common goals.

Founded in 1950, AMSA is the oldest and largest independent association of physicians-in-training in the United States. Built by and for students of medicine, AMSA is dedicated to the advancement of medical education and improvement of health care for all people. Throughout its 58-year history, the

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organization has served as the “other” school for medical students, training them to have an increased awareness and understanding of their profession, their patients, and the system.

As of July 2008, AMSA’s executive leadership approved the formal adoption of the organization’s long-standing educational opportunities into the AMSA Academy.⁶ Course offerings include topics such as health disparities, professionalism, environmental health, and healthcare access. These courses integrate skill-building in areas such as patient advocacy, political activism, grant writing, project planning, teamwork, and teaching.⁶ Certain courses are 3-5 day intensive institutes that bring students together in person to participate in a combination of lectures, workshops, and panels, with the support of a multidisciplinary team of faculty. The institute model has been tried and tested for nearly 10 years within AMSA and 2008-2009 offerings feature nearly 20 such programs. Other programs follow a year-long distance learning format where students learn through readings and conference calls with key experts in a particular discipline such as medical humanities and health equity.

These educational experiences, along with other modalities of AMSA Academy described elsewhere,⁷ are organized by and for students, allowing the curriculum to be specifically focused on their needs and interests. Many programs involve a considerable amount of peer education, a teaching model which has been previously validated in medicine, particularly cited as improving students’ intrinsic motivation and reducing faculty burden.⁸⁻¹⁰

AMSA Academy programs are aligned with a philosophy of action following education. Past participants have engaged in curricular reform projects at their medical schools, joined national advocacy and lobbying networks, planned community-oriented programs, and taken on national leadership roles. Through this model of learning and the vast selection of courses, medical students are able to access enrichment on fundamental issues and build skills that will empower them to become compelling advocates and leaders. These programs allow like-minded, passionate students to come together and empower them to enact change in the profession.

Continuing medical education programs serve in part to fill the knowledge gaps of practicing physicians. However, it is both necessary and expected that future physicians will tackle the challenges of medicine from their first day on the wards, and will have competence in the “intangibles and touchy-feely” aspects of residency and beyond. While medical education reform slowly treads to catch up to times, medical students now have a home for continuing their undergraduate medical education. The student population, fresh and unaccustomed to embedded traditions of medical education, can serve as powerful advocates and leaders in this cultural transformation.

Information on the AMSA Academy can be accessed at: <http://www.amsa.org/academy>.

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Navigating Toward a Quality Career

In the decade since the publication of *To Err is Human*¹, many organizations and educational programs have been established in an effort to develop health care leaders ready to confront the enormous task of

building a better health care system. We all know that our health care system is in crisis, but where can we find professionals that are qualified to meet the challenge? How do we plan for the future and create the skilled workforce that is so desperately needed?

In response to this national focus on quality and safety, we find that students in programs of health administration, medicine, and allied health professions are being introduced to these topics in their undergraduate training. Though this is a significant step, students at this juncture in their preparation will likely be exposed to basic information and lack real-world experience within a health care system. Students with an interest in ensuring the health of populations would be likely candidates to pursue advanced educational opportunities in quality and safety. Graduate studies provide advanced curricula, and develop competency and credentials in a specific area and arm a professional with proof of education.

Having quality at the forefront of the national agenda will inevitably create opportunities for employment. However, since there are as yet no standard qualifications and credentials, young professionals can face significant roadblocks on the path to a career in quality. Because this is not yet a well known or common career path, popular employment search engines (eg, Monster.com) do not provide adequate features and the criteria needed to identify positions in the field. Many professionals pursuing this line of work have been clinicians who have chosen to switch from or supplement their clinical work, thus limiting educational resources for non-clinical professionals. Finally, and perhaps most significantly, work experience is key to understanding and implementing the systems changes inherent in pursuing a career in quality. A degree in health administration is not sufficient to meet the job requirements of many positions, and it is not clear how candidates can gain the experience needed to establish an appropriate career trajectory.

How — and where — can someone interested in health care quality and patient safety get the required education and experience? Although opportunities for professional development are expanding, the majority are targeted at mid-career professionals. The Institute for Healthcare Improvement (IHI)

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will launch a program called IHI Open School for Health Professions in September 2008, creating an interdisciplinary educational community of health professionals interested in quality and safety.² Certifications

provide additional credentials which demonstrate competency, and fellowships are an educational opportunity to expand knowledge on a specific topic. The only current master's program in Quality and Safety (at Northwestern University)³ has a minimum requirement of five years of related work experience.

Alternatively, a master's program designed to admit students with a bachelor's degree as the minimum requirement would provide a foundation for those interested in this area. A clerkship, practicum, or some equivalent integrated into the curriculum may provide the experience that most of the positions require. Eliminating the minimum experience requirement would encourage early-careerists to pursue an advanced degree in health care quality and patient safety and may entice others who had not previously considered this field. Ultimately, this will help to open the doors, influence the workforce, and anchor future professionals in the field of quality and safety.

Quality and patient safety is important to all health care professionals and many more educational opportunities will soon be available to professionals interested in this important topic. In the meantime, continue to educate yourself about quality and safety because "The need for leadership in healthcare has never been greater..."⁴

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Alcohol Use in Pregnancy: A Public Health Problem

Alcohol consumption during pregnancy remains a significant public health problem. Prenatal exposure to alcohol can damage the developing fetus and is a leading preventable cause of birth defects and developmental disabilities.¹ Fetal alcohol spectrum disorders (FASDs) is an umbrella term used to describe the range of physical, mental, behavioral, and learning disabilities that can occur, many with lifelong implications.² Fetal alcohol syndrome (FAS), one of the most severe disorders along the spectrum, occurs in 0.5 to 2 cases per 1,000 births in the United States. However, it is estimated that for every child born with FAS, three additional children suffer from the milder forms of FASDs: fetal alcohol effects (FAE); alcohol-related neurodevelopmental disorder (ARND) and alcohol-related birth defects (ARBD). These children may manifest lifelong neurocognitive and behavioral problems arising from early alcohol exposure.³

Pregnancy offers an important opportunity to intervene and to reduce a woman's alcohol use. For many women, pregnancy appears to be a time of increased motivation to reduce or eliminate unhealthy behaviors that include alcohol consumption.⁴ Unfortunately, women who abuse alcohol often begin prenatal care after the first trimester.⁵ This late entry to prenatal care means that alcohol may have already caused fetal damage.

In 1981, the Office of the Surgeon General published its first public health advisory regarding the dangers of drinking during pregnancy. In 2005, the US Surgeon General issued an updated *Advisory on Alcohol Use in Pregnancy*, advising women not to drink alcohol if they are pregnant, planning pregnancy, or at risk of becoming pregnant. No safe level of alcohol consumption has been identified, and no period during pregnancy appears to be safe for alcohol consumption.³

Despite public health advisories and efforts to disseminate this information, recent data indicate that significant numbers of women continue to drink during pregnancy. While the overall rate of any alcohol use (at least one drink) among pregnant women has declined since 1995, frequent (7 or more drinks per week) and binge (5 or more drinks on any one occasion) drinking continues to occur. One in seven women of childbearing age (18 to 44 years of age) engages in "risk drinking" (7 or more drinks per week, or 5 or more drinks on any one occasion). In Pennsylvania, 2005 data indicated that 56% of women of childbearing age had at least one drink in the past 30 days, and 15% had engaged in binge drinking. This is a concern because if a woman is pregnant and does not yet know it, she risks causing fetal damage during the first trimester, a critical period of early organogenesis.⁶

Because women may not be aware they are pregnant initially, it is important to screen all women of childbearing age to prevent a potential alcohol-exposed pregnancy. Screening may take place in a variety of settings: a primary care visit; family planning or gynecologic visits; community health centers; nutrition programs; and the first prenatal visit. Using a validated screening tool, such as T-ACE⁷ (74% sensitive, 71% specific for "risk drinking"), Chang concluded

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that the T-ACE outperformed standard queries by health care providers in detecting use of alcohol.⁷ It takes about one minute to ask the T-ACE questions. A score of two or more points indicates that intervention is needed.

T-ACE ALCOHOL USE SCREENING TOOL

- T Tolerance:** How many drinks does it take to make you feel high? (*>2 drinks = 2 points*)
- A Annoyed:** Have people annoyed you by criticizing your drinking? (*yes = 1 point*)
- C Cut down:** Have you ever felt you ought to cut down on your *drinking*? (*yes = 1 point*)
- E Eye-opener:** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (*yes = 1 point*)

There is strong evidence that brief behavioral counseling interventions for risky drinking by both pregnant and reproductive age women reduce the risk of alcohol-exposed pregnancy.^{8,9} The FRAMES model¹⁰ has successfully helped clinicians deliver brief interventions

FRAMES: BRIEF INTERVENTION MODEL FOR RISKY DRINKING

- F Feedback:** Compare the patient's level of drinking with drinking patterns that are not risky. She may not be aware that what she considers normal is actually risky.
- R Responsibility:** Stress that it is her responsibility to make a change.
- A Advice:** Give direct advice (not insistence) to change her drinking behavior.
- M Menu:** Identify risky drinking situations and offer options for coping.
- E Empathy:** Use a style of interaction that is understanding and involved.
- S Self-efficacy:** Elicit and reinforce self-motivating statements such as, "I am confident that I can stop drinking." Encourage the patient to develop strategies, implement them, and commit to change.

A recent study by O'Connor⁹ randomized 250 pregnant women drinkers to either a Brief Intervention (BI) or Assessment Only (AO) group. The setting was a WIC center and the intervention was 10-15 minutes/month by a nutritionist. The BI group was five times more likely to be abstinent in the third trimester. Also, infants born to the BI group had higher birth weights and lengths, and had three times lower adverse fetal outcome (1 vs. 4). This study further illustrated that the intervention does not have to be carried out by a clinician to be effective.

The Department of Pediatrics at Thomas Jefferson University operates an addiction program, *Maternal Addiction Treatment Education and Research* (M.A.T.E.R.), which aims to assist pregnant women who are struggling with substance abuse, including alcohol dependence. Programs include an outpatient treatment program (Family Center), as well as a residential treatment program (My Sister's Place). Some of the services provided at both locations include medical and obstetrical services; 12-step meetings; individual, group, and family psychotherapy; specialized groups on women's issues; and a parenting support group.

M.A.T.E.R. is located at 1201 Chestnut Street (11th floor) and can be reached by calling 215-955-8577.

For more resources or information, please contact the author at: Joshua.Barash@jefferson.edu.

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The 16th Annual Paul Brucker Lecture: Patient-Centered Primary Care

The Paul Brucker MD Lecture in Health Care, established in 1990, was endowed by current and former Jefferson faculty, affiliate faculty, preceptors, family medicine resident graduates, and fellowship graduates in order to honor his many important contributions to Thomas Jefferson University and to American medicine. The Lecture was created at the time Dr. Brucker moved from his role as Alumni Professor and Founding Chairman of Family Medicine to President of Thomas Jefferson University. In so doing, he became the first family physician in the country to lead an academic medical center. Each year, the Brucker Lecture addresses current issues related to health care.

This year's speaker was Paul Grundy, MD, MPH, who spent much of his early career working overseas for the US State Department, advising US Ambassadors on healthcare programs for diplomatic posts, and working extensively in the international AIDS pandemic. Currently, he serves as Director of Healthcare, Technology and Strategic Initiatives at IBM's Global Wellbeing Services and Health Benefits. Dr. Grundy also serves as Chairman of the Patient-Centered Primary Care Collaborative (PCPCC), a coalition he led IBM in creating in 2006. The PCPCC is dedicated to advancing a new primary care model called the Patient-Centered Medical Home¹ in an effort to fundamentally reform healthcare delivery, which is essential to maintaining US international competitiveness.

Dr. Grundy's talk, "Patient-Centered Primary Care: Why Large Employers are Rediscovering the Value of Family Medicine and Primary Care," focused on the employer perspective regarding health care. He discussed how employers, a major payer, are increasingly dissatisfied with the cost and quality of health care they purchase for their employees. US employers pay substantially more for employee health benefits than their international competitors, making it increasingly difficult for them to compete globally. And, despite paying higher costs, they are currently unable to purchase quality comprehensive health care. Dr. Grundy discussed a major failure of the current US health care system — the lack of a primary care system that is structured and reimbursed in a way

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that adds value to health care. He emphasized the current consensus that it is critical to transform our system to make it more patient-centered. He presented well-accepted US and international data showing that good primary care results in decreased mortality, morbidity, and cost, as well as increased patient satisfaction and higher quality.

The current system focuses on and financially rewards episodic care provided primarily by subspecialists who are not involved in the management of a patient's overall health. This situation often results in significant waste and decreased quality. Dr. Grundy discussed the increasingly popular concept of the patient-centered medical home¹ and the need to adequately reimburse this model of care. The medical home model is currently being supported by the Centers for Medicare and Medicaid Services (CMS), Congress, Pennsylvania's new program (for which Jefferson's Family Medicine practice is a major participant), and by the National Center for Quality Assurance (NCQA), which has recently developed accreditation criteria for the medical home.

Dr. Grundy noted that large employers are using their leverage to push for blended payment to reimburse care provided by primary care physicians. They are adding a significant "care management fee" for providing comprehensive, coordinated care, in addition to the current fee-for-service reimbursement and a pay-for-performance incentive payment. Appropriate reimbursement for primary care would serve as an incentive to provide comprehensive care, and may serve to attract increased numbers of physicians to enter primary care practice. The entire lecture can be viewed at: <http://jeffline.jefferson.edu/videos/jdc/bruckerRef.mov>.

The author can be reached at howard.rabinowitz@jefferson.edu.

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AUDIOCONFERENCE OVERVIEW

Population health broadens the focus to include the impact of environmental, social, cultural, and economic factors on overall health care and quality of life. It provides a context for developing, implementing, and evaluating the system and policy changes that affect health care quality, access and outcomes at the population level.

Learn more about this emerging field by joining us for a discussion with some of the experts, moderated by:

David B. Nash, MD, MBA, FACP,
*Dr. Raymond C. and Doris N. Grandon
Professor of Health Policy, and Chair of the
Department, Jefferson Medical College,
Thomas Jefferson University*

Annual Fellows Day: The Changing Landscape of Ambulatory Care Outcomes Research – June 30, 2008

The Department of Health Policy has mentored Outcomes Research Fellows for more than 10 years. It has become a tradition for the Department to host an annual reunion of the group each spring. Fellows Day offers current first year Fellows the opportunity to showcase their work, and graduating Fellows a chance to celebrate their completion of the program. This half-day event welcomes both current and alumni Fellows, Senior Scholars, and invited guests from the pharmaceutical companies that sponsor our Fellowship programs. At this year's event, first year Fellow Paresh Chaudhari, PharmD, MPH and Bettina Berman, RN presented their projects that examine the impact of changes in the ambulatory care environment on outcomes research.

Paresh K. Chaudhari, PharmD, MPH

Ortho-McNeil Janssen Outcomes Research Fellow (2007-2009)

Paresh Chaudhari's research project examined the access to acute care at convenient care clinics (CCC), which are small clinics located in retail stores that treat episodic ailments, and provide routine vaccinations and preventative screening tests. This retrospective study examined data from electronic medical records of Take Care Health Systems, one of the nation's largest CCC providers. Patient encounters for four of the most common conditions (ie, acute pharyngitis, sinusitis, bronchitis, and upper respiratory infections (common cold) seen at the clinics were examined to answer: to what extent does care-seeking through convenient care clinics help patients overcome a barrier to access to the traditional primary care system? Descriptive analysis of the demographics for the four conditions showed that approximately two-thirds of the visits were from female patients; approximately 25% of the patients were without insurance; and most of the patients ranged in age from 25-45 years.

This study supports current evidence¹ that the CCC model provides care to those that may otherwise not seek care or delay care.

Bettina Berman, RN

Bettina Berman shared her experience with a patient safety performance improvement project currently being implemented across the Jefferson University Physicians (JUP) Faculty Practice Plan. To ensure the highest level of patient safety in an increasingly complex ambulatory care setting, the JUP Clinical Care Subcommittee selected the Physician Practice Patient Safety Assessment (PPPSA) tool to aid in a JUP-wide safety assessment of the clinical practices.

The PPPSA tool, developed by Health Research Education Trust (HRET), Institute for Safe Medication Practices (ISMP), and the Medical Group Management Association (MGMA), evaluates the practice's level of implementation of best practices across the six domains of medication management, hand-offs and transitions, surgery and anesthesia, practice management, and communication. The self-assessment questionnaire heightens provider knowledge of characteristics that enhance practice safety and helps identify opportunities for improvement.

Following a data analysis and comparison to national benchmarks, the performance improvement team helps individual practices develop action plans as needed. During the implementation process, the team has provided monthly updates to the Clinical Care and the Risk Management Subcommittees. The next step in the process will be to present the survey findings, including recommendations for performance improvement implementations.

Following the presentations, a panel of five experts in ambulatory care outcomes research was invited to share their insights in this evolving model of patient care. The interactive panel discussion afforded the audience an opportunity to ask questions in addition to those posed by the moderator, Dr. David Nash.

Panelists included:

- **Peter Miller**, *President and CEO – Take Care Health Systems*
- **Michael P. Rosenthal, MD**, *Vice Chair, Academic Programs, Department of Family and Community Medicine – Jefferson Medical College*
- **Somesh Nigam, PhD**, *Director of Convergence Technologies, Research & Development Information Management – Johnson & Johnson*
- **Edward Kim, MD, MBA**, *Associate Director, Outcomes Research USA – Bristol-Myers Squibb*
- **Ross Maclean, MB, ChB, MSc, MD, MBA**, *Executive Director, Outcomes Research USA – Bristol-Myers Squibb*

The Department presented recognition certificates to alumni who completed the Fellowship training more than 10 years ago.

Fellowship Director **Vittorio Maio, PharmD, MSPH, MS**, presented graduation certificates to graduating Fellow Seina Lee, PharmD, MS, in recognition of her completion of two years of rigorous training.

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The Greater Philadelphia Schweitzer Fellowship Program: Fellow-Site Mentor Evaluation and Site Expansion

Though Albert Schweitzer Fellows Program (ASF) has been evaluating itself for almost a decade, this year's (2007-2008) graduating evaluation was even more rigorous, thanks to a recent grant from the an Merck Company Foundation (MCF).

Several years ago, the ASF sought support to expand and upgrade its strategic evaluation process. As the MCF is mandated to "assess value of the [non-profit, community-based] programs, fellows, and the communities and agencies they serve, and to develop efficient systems for ongoing program evaluation and improvement,"¹ the Foundation was a natural choice of funding partner for ASF. Among other goals, ASF sought to employ systematic quality improvement efforts, including measurable quality benchmarks and a "sharing best practices" approach.¹ The new evaluation was piloted in 2006, and the surveys were officially distributed in 2007-2008.

The results of this year's evaluation confirmed the value of the U.S. Schweitzer Fellows Program to the communities and agencies served, to the site mentors, and to the Fellows themselves. Due to the timing of the MCF grant funding stream, the evaluation for (2007-08) site mentors and Fellows was a post-survey. Pre-surveys were administered to only the new (2008-09) Fellows to determine their perceptions of community service prior to the Schweitzer Fellowship Program. The national ASF office compiled and evaluated the survey results with the assistance of Abt SRBI Inc., a full-service global strategy and research organization.

Among the highlights of the Fellows surveyed: 82% were "absolutely certain" that they would continue to pursue community service after the fellowship year; 93% felt that their project benefited both themselves and the clients; 84% felt their projects benefited their community site. In terms of personal values, 98% valued "helping others"; and 91% valued honesty, personal growth, and hard work.

Seven of the eight Greater Philadelphia site mentors

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responded to the survey (88% response rate), representing 11 Fellows mentored. Among the site mentor post-survey results: If the Fellow's project was new, 50% of site mentors said the idea for the project evolved through collaboration between the Fellow and mentor. One hundred percent of mentors felt that the Fellows added creative elements to existing projects. Nearly half (47%) of mentors indicated the Fellow made significant contributions to their organization or the clients served. Fifty-seven percent of mentors believed their agency would continue to support and sustain the project created or worked on by the fellow, and 86% said they would recommend participating in the Schweitzer Fellows Program to another community-based agency.

The MCF grant also enabled ASF to help create new programs in other underserved regions. Since receiving the MCF grant, five new sites have been added: Philadelphia, PA; San Francisco Bay Area, CA; New Orleans, LA; Los Angeles, CA; and Houston, TX. The first U.S. Schweitzer Fellows Program was launched in Boston in 1992, with 12 Fellows. This program has been replicated in 11 locales spanning nine states, with plans in progress for the creation of additional programs.

For more information about either the survey results or Greater Philadelphia ASF, please contact Nicole M. Cobb at Nicole.cobb@jefferson.edu.

The Fellow-Site Mentor Evaluation and Site Expansion program was made possible by Merck Company Foundation.

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HEALTH POLICY FORUMS: FALL 2008

The Forum meets on the second Wednesday of each month (September-June) from 8:30 a.m. to 9:30 a.m. in Conference Room 218, Curtis Building, 1015 Walnut Street, Philadelphia, PA. A light breakfast will be served.

September 10, 2008

What Language Are You Speaking? Why Communication is a Patient Safety Issue
Mario Moussa, PhD, MBA
Principal
Center For Applied Research, Inc.
ACPE No:
079-000-08-009-L05-P

October 8, 2008

Assessing Physician Performance: Challenges and Opportunities
Louis Diamond, MD, ChB, FACP
Vice President & Medical Director
Thomson Reuters
ACPE No:
079-000-08-010-L04-P

November 5, 2008

The Women's Wellness Guide
Leslie Stiles
Executive Director
Commonwealth of Pennsylvania
Commission for Women
ACPE No:
079-000-08-011-L04-P

December 10, 2008

Jefferson Center for InterProfessional Education
Molly A. Rose, RN, PhD
Christine Arenson, MD
Co-Directors – Center for InterProfessional Education
Thomas Jefferson University
Hospital
ACPE No:
079-000-08-012-L04-P

Department of Health Policy Forums

Value-Based Purchasing and the CMS 2008 Physician Quality Reporting Initiative (PQRI)

Barbara J. Connors, DO, MPH

Chief Medical Officer, Centers for Medicare and Medicaid Services, DHHS Region III

June 11, 2008

Pay for performance, lexicon of the federal Physician Quality Reporting Initiative (PQRI), is on the minds of virtually everyone in healthcare since the program's 2007 authorization. The initiative is perhaps the most dramatic and far-reaching change in the US healthcare system since the inception of Medicare and Medicaid in the 1960s. Under the auspices of the federal Centers for Medicare and Medicaid Services (CMS), a financial incentive is provided to physicians, therapists, and practitioners for voluntarily reporting claims (Medicare billing) data for certain quality measures.

Dr. Barbara Connors, Chief Medical Officer of the CMS Region III office, spoke in depth about PQRI. Dr. Connors began with a program overview, then reviewed and clarified virtually all aspects of the PQRI program. Among the new additions for 2008 are two reporting approaches: registry- and electronic health record (EHR)-based reporting (CMS is pilot testing both), and new quality measures (a total of 119 measures in seven categories). Financial incentives earned for the 2008 reporting period will be paid in mid-2009. Dr. Connors concluded her talk with a summary of lessons learned as PQRI unfolds.

For more information on PQRI and CMS' value-based purchasing efforts, please see <http://www.cms.hhs.gov/pqri> or contact Dr. Connors at: Barbara.Connors@cms.hhs.gov.

To listen the podcast for this forum, refer to <http://jdc.jefferson.edu/hpforum>.

Department of Health Policy Publications

Clarke JL. ACMQ Annual Meeting: Summary report and key messages. *Am J of Medical Quality.* 2008; 23(4): 311-317.

Harrop J, Youssef JA, Maltenfort M, Vorwarld P, Jabbour P, Bono CM, **Goldfarb N**, Vaccaro AR, Hilibrand AS. Lumbar adjacent segment degeneration and disease after arthrodesis and total disc arthroplasty. *Spine.* 2008; 33(15):1701-1707.

Haydar Z, Gunderson J, Ballard D, **Skoufalos A, Berman B, Nash DB.** Accelerating best care in Pennsylvania: Adapting a large academic system's quality improvement process to rural hospitals. *Am J of Medical Quality.* 2008; 23 (4): 252-258.

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Safarty M, Myers R. The effect of HEDIS measurement of colorectal cancer screening on insurance plans in Pennsylvania. *Am. J of Managed Care.* 2008;14(5):277-82.

Department of Health Policy Presentations

Reifsnnyder J. *Implementing the New Medicare Hospice Conditions of Participation.* Pennsylvania Hospice Network, Horsham, PA, August 14, 2008.

Safarty M. *Improving Office Practice in Colorectal Cancer Screening.* Webinar. American Cancer Society. April 17, 2008.

Safarty M. *Colorectal Cancer Screening in Primary Care Practice.* Presented at: Annual Scientific Update, California Academy of Physicians, San Francisco, CA, April 27, 2008.

Safarty M. *Breaking the Cycle: Improving Outcomes in the Primary Care Setting - An Evidence Based Approach Using the Colorectal Cancer Screening Model.* Presented at: Promedica Health System, Flower Hospital, Sylvania, OH and Promedica Health System, Navy Bistro, Toledo, OH, May 15, 2008.

Safarty M. *Improving Office Screening Rates for Colorectal Cancer Screening.* National Train the Trainer Program, American Cancer Society, Atlanta, Georgia, June 23, 2008.

Simmons R. *Public Health Policy and Advocacy: What it is, Why it's Important, and What we can do as a Chapter, as Health Professionals, and as Private Citizens.* Presented at: The Greater New York SOPHE Chapter General Membership Meeting, New York, NY, June 19, 2008.

July 10, 2008 DHP Summer Seminar The Jefferson School of Health Policy and Population Health

Every year the Department of Health Policy hosts its Summer Seminar, a “capstone” event and informational forum devoted to a topic of particular interest to the department’s Senior Scholars, supporters and constituents, and the Jefferson community at-large.

This topic of this year’s Seminar, held in the Foerderer Auditorium, was the Proposed *Jefferson School of Health Policy and Population Health* (note: on July 28, 2008, the School was formally approved by the Thomas Jefferson University Board of Trustees). The keynote address, “Bridging the Gap: Master’s Level Education in Healthcare Quality and Safety,” was delivered by Donna Woods, EdM, PhD, Co-Director of the Master’s Program in Healthcare Quality and Patient Safety at Northwestern University’s Feinberg School of Medicine (<http://www.medschool.northwestern.edu/ihs/education/master/index.html>).

Dr. Woods shared her experience and insights as an architect of Northwestern’s Master’s program—the only one of its kind nationally—“so that we may learn from Northwestern’s experience...a blueprint for our future efforts,” said David B. Nash, MD, MBA, referring to the imminent launch of the Jefferson School of Health Policy and Population Health (JSHPPH). Set to open its doors in September 2009, JSHPPH will be the second program in the nation to offer a graduate degree in Healthcare Quality and Safety.

Questions addressed at the Seminar include:

- What should be the program’s patient safety and quality educational competencies?
- What course content should be included in the core curriculum?

- In what format(s) (eg, online vs. in-classroom) should courses be taught?

Dr. Woods advised Jefferson to be sure to fully integrate the program into the university system, cultivate leaders, and do everything possible to “hit the ground running.” Program evaluation may prove particularly challenging, Woods added, because this program represents a new genre and is breaking new ground.

The agenda also included the following breakout sessions, moderated by DHP and Jefferson faculty:

- Population Health: What’s it all about?
- Establishing a Research Agenda
- Executive and Continuing Professional Education
- Building Community and Strategic Partnerships
- Academic Programming: Certificate and Degree Programs
- Opportunities for Local, Regional, and National Impact

After the breakouts, group moderators reconvened in a panel and presented their take-home messages to the audience, which Dr. Nash summarized in his concluding remarks. The program concluded with lunch in the Hamilton Building Lobby. A podcast of the panel discussion is available online at <http://departmentofhealthpolicy.blogspot.com>.

For more information about the Jefferson School of Health Policy and Population Health, visit the website at <http://www.jefferson.edu/JSHPPH>.

Pennsylvania Hospice Network Participates in 2-Day Intensive Workshop on New Hospice Conditions of Participation

In early June, representatives from Pennsylvania Hospice Network Board of Directors participated in a two-day intensive workshop on the new Medicare Hospice Conditions of Participation (Hospice CoPs), which were officially published in the *Federal Register* on June 5.

This is the first time that the guidelines have been significantly revised since they were created in 1983 and, at the same time, reflects a significant shift in focus for the Centers for Medicare and Medicaid Services (CMS), the federal agency tasked with developing and enforcing them.

The two-day intensive workshop, which was organized by the National Hospice and Palliative Care Organization (NHPCO), brought together more than 300 hospice leaders, representing 46 states. “The purpose of the meeting was to give hospice leaders a more in-depth understanding of CMS’s intent behind the revisions so they, in turn, can help educate providers in their states about what is now expected—and why,” said Judi Lund Person, NHPCO’s vice president of regulatory and state leadership.

The new Hospice CoPs focus on providing quality patient-centered care and putting the needs of the patient and family first. Moreover, they give providers flexibility with meeting many of the new requirements in recognition of the varying challenges hospice programs face. On the other hand, providers

are also being required to perform more thorough and ongoing assessments of the patient’s and family’s needs—and document their actions (and inactions) in accordance with the plan of care.

The new Hospice CoPs also place significant emphasis on quality assessment and performance improvement—known to many as QAPI. “What CMS is looking for,” notes JoAnne Reifsnnyder, PhD, APRN, Vice President of Pennsylvania Hospital Network’s Board of Directors and Research Assistant Professor, Thomas Jefferson University, is “tangible proof that programs have evaluated all aspects of their organizations and are making concerted efforts to make measureable improvements. They’re not expecting that all programs will succeed every time, but want to see that changes are being made, tested and evaluated—with the ultimate goal of improvement *over time*.”

The Pennsylvania Hospice Network sponsored four statewide workshops to help hospice administrators understand and implement the new requirements. For more information and resources refer to the Quality Partners program and the Regulatory and Compliance Center on NHPCO’s Web site: www.nhpco.org/regulatory. For information regarding this program, contact JoAnne Reifsnnyder at JoAnne.Reifsnnyder@jefferson.edu.

JoAnne Reifsnnyder was recently elected to the Board of Directors of the Hospice and Palliative Nurses’ Association.

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THE CALL TO LEADERSHIP

David B. Nash • William J. Oetgen • Valerie P. Pracilio

Physicians, nurses, pharmacists and other health care providers are increasingly accepting positions at the board's table. While these professionals are well-versed in the clinical aspects of medicine, they are often unfamiliar with the business side of health care. Understanding the principles of governance and the board's role in decision-making are crucial to the success of the organization. Those who accept a dual role as a health care provider and board member must learn about their role as decision-makers and stewards.

They must answer the call to leadership.

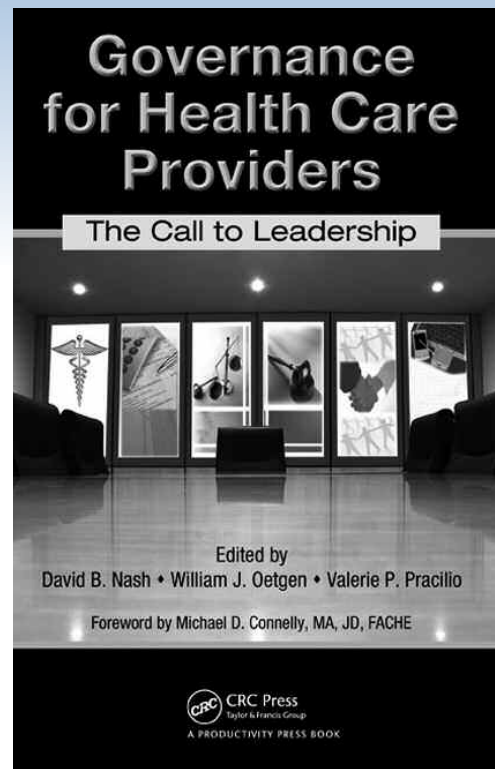
"Governance today requires a new level of preparation and education – in short, a commitment to continuous learning. This text represents a superb opportunity to prepare for those new accountabilities. This commitment to preparation is also an essential step to balancing the equilibrium of power between the board and the CEO. **Governance for Health Care Providers: The Call to Leadership** will guide trustees down the road to more fully accept the responsibility for the mission of the corporations they lead."

- from the foreword by

Michael D. Connelly, MA, JD, FACHE
President and Chief Executive Officer
Catholic Healthcare Partners

This book:

- Provides essential information to health care professionals serving on non-profit boards as trustees
- Covers the most important issues confronting modern non-profit boards in the health care sector
- Fills a major gap in the education of health care professionals
- Offers unique insight into a critical but rarely considered position
- Examines the future role of health care boards



Published by Productivity Press

List Price: \$79.95

ISBN: 9781420078534

ISBN 10: 1420078534

Publication Date: Fall 2008

300 pages, 6"x9" Hardcover

To order visit:

<http://www.productivitypress.com>

Cat. #: PP7853

Health Policy NEWSLETTER

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Health Policy Newsletter is a
quarterly publication of TJU,
JMC and the Department of
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