

# Health Policy NEWSLETTER

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FROM THE EDITOR

## Safety by Design

Regular readers of this column will remember that the 16th Annual Grandon Lecture, held on the Jefferson campus, was delivered by Dr. John Reiling.<sup>1</sup> Reiling, whose innovative work has been featured in the *Wall Street Journal*, is helping to design the safest hospital in America on the grounds of the current Boca Raton Community Hospital in Boca Raton, Florida.<sup>2</sup> We featured aspects of Dr. Reiling's 2007 presentation in the *Health Policy Newsletter* and in *Prescriptions for Excellence in Healthcare*,<sup>3</sup> a supplement devoted to quality. This topic was also featured at a recent leadership conference in a presentation by Blair Sadler.<sup>4</sup> In my view, Reiling and Sadler represent an important trend in the design and construction of healthcare facilities for the 21st century. Healthcare leaders, physicians, nurses, pharmacists, and architects recognize that the evolving discipline devoted to designing safety practices into the bricks and mortar of an institution may go a long way toward helping us reduce the epidemic of medical errors.

As a member of the National Advisory Committee for Boca Raton Community Hospital, I recently had an opportunity to "kick the tires," so to speak, by touring a full scale mockup of key components of the proposed Charles E. Schmidt Medical Center in Boca Raton, Florida. The experience left a deep impression on me and I wanted to share aspects of my real-life tour to give you a more tangible sense of *safety by design*.

In a nondescript strip mall, blocks from the current Boca Raton Community Hospital, interdisciplinary teams are hard at work designing the safest hospital in America. I think our readers recognize that standardization in design and construction enables activities to become subconscious so that caregivers can focus their attention on providing the best possible patient care. What exactly do we mean by a standardized design and what specific features in both patient rooms and procedure rooms can force functions to a safer level? Well, how about a red light that won't go off until a caregiver washes his hands in front of the patient! This red stop light appears not only in front of the sink but at the foot of the patient's bed, enabling the patient to comfortably ask the provider, "Gee, I don't see a green light, did you wash your hands?" Some may scoff at this so-called "forced function" for hand washing, but with a national hand washing rate still hovering at approximately 50%, I was mesmerized by the demonstration of this kind of technology.

I was also excited to see the rubber flooring products, the planned air filtration systems, the integral window blinds sandwiched between panes of glass that reduce the risk of infection by reducing dust, and the obvious excitement and passion displayed by the current hospital staff leading this effort. Other aspects of *safety by design* were equally impressive to me. I was quite taken by the individual room-based neonatal intensive care unit (NICU). As most readers probably recognize, current NICUs are usually designed with a large room and multiple bassinets lined up in rows. It is a noisy, scary, brightly lit area of controlled chaos and cacophony. Boca Raton is planning an individual room for each neonate that is large enough to house all of the critical equipment and includes a special chair designed for a tired parent to spend the night. All of these rooms are arrayed around a central nurses' station with direct lines of visibility for each neonate. The rooms are completely standardized and individually stocked with the necessary supplies. Staff members from Boca Raton Community Hospital have traveled across the country to benchmark best practices within the *safe by design* arena. Apparently, individual neonatal intensive care rooms are high on the list of key processes known to reduce medical error and improve clinical outcomes. Seeing this face-to-face was truly inspiring.

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Members of the National Advisory Committee also toured the ambulatory surgery suite and a mockup of the planned operating rooms. Everything is designed with the patient in mind: private areas to speak with harried surgeons, forced-function hand washing, ceiling-mounted patient lift equipment in all of the rooms, and caregiver work stations that are especially designed to allow for increased face-to-face communication. I tried to visualize what it would be like for a patient wheeled into an operating room – nervous, cold, and consumed with anxiety – to be comforted by a special architecture designed to be soothing and safe.

In the mockup of the typical future inpatient room, there were several highlights that I also found exciting, including patient bathrooms at the head of the bed with hand rails leading into the bathroom to reduce the risk of inpatient falls, and family areas with a sleeper sofa and Internet access to facilitate family involvement and heighten the patient-centered aspect of care. There are plans to put a screen saver on every hospital staff computer with a bright background that asks, “How many days have passed since we last harmed a patient?” Apparently, this is underway in other institutions already.

The Charles E. Schmidt Medical Center at Boca Raton Community Hospital has made a major commitment to be transparent with regard to the safety agenda, which follows naturally from the commitment to the bricks and mortar. There is an evolving scholarly literature focused on safety by design. We have been privileged to hear John Reiling and Blair Sadler at departmental sponsored activities this past year. I would submit, however, that those lectures could not capture the tangible, tactile aspects of safety that I saw throughout the numerous mocked-up rooms in a warehouse blocks from the current

hospital. I am jaded, as I recognize that bricks and mortar will only go so far. Boca Raton Community Hospital has a huge cultural challenge, like every other institution, to commit every staff member to the safety agenda. We all have a lot of work to do in this arena and I am confident that the Boca Raton example may serve as a bellwether for all new hospital and healthcare related construction.

I would like to start a more detailed conversation about *safety by design* and I hope that you will contact me with your own experience in this area, at my email address, which is david.nash@jefferson.edu. I also hope that you will visit my new blog at <http://departmentofhealthpolicy.blogspot.com/>. What is your institution doing to create the safest possible environment for our patients in the future?

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## UPCOMING PUBLIC HEALTH PROGRAMS

### National Public Health Week

*Climate Change: Our Health in the Balance*  
April 7, 2008 - April 11, 2008  
[www.nphw.org](http://www.nphw.org)

### National Public Health Week Luncheon

*The Public Health Response to Climate Change in Philadelphia*  
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Thomas Jefferson University, Alumni Hall  
For more information contact:  
Mona Sarfaty at (215) 955-2797 or  
[mona.sarfaty@jefferson.edu](mailto:mona.sarfaty@jefferson.edu)

### Public Health Informatics Symposium

*Technology Linking Healthcare, Consumers, and Public Health*  
April 28, 2008 • 9:30 am - 11:30 am  
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Lisa Chosed at (215) 503-0174 or [lisa.chosed@jefferson.edu](mailto:lisa.chosed@jefferson.edu)

## DHP ON LINE

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# Spirituality and Patient Care

Spiritual care is integral to the science and art of healing, and therefore a critical component in the quality of care. As stated in the Association of American Medical Colleges' 1999 Medical School Objectives Project Report on Communication in Medicine:

*"Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism and the arts. All these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another."*<sup>1</sup>

Academic medical programs are beginning to address patients' spiritual needs. In the past decade, the number of medical schools that offer courses on spirituality has increased from three schools in 1992 to 84 in 2004.<sup>2</sup> For many patients, life-threatening illness may serve as a catalyst to question meaning and purpose in life, raising questions such as, "Why? Why me? Why now?" Healing, in this context, becomes more than a technical cure or fix, and includes a journey to integrate these questions into one's life. Optimally, spirituality provides a foundation for patients to move from a sense of brokenness to a sense of wholeness, allowing them to find meaning and purpose. In this way, spirituality is integral to whole patient care and helps to address patients' understanding of illness.<sup>3,4</sup>

Spirituality may be differentiated from religion. Spirituality is often framed as a more personal search for transcendent understanding that may or may not include activities within organized groups, whereas religion is often regarded as a social institution with a set of specific belief systems and rituals.<sup>5</sup> Spirituality may be framed as an understanding of "something bigger than oneself" – it may include a reverent respect for God, a higher power, or equally felt as awe when walking in nature. The common ground that religion and spirituality share is a search for the sacred through the experience of subjective feelings, thoughts, and behaviors.

Providers in medical settings may have differing opinions as to whether spiritual care is part of their care domain. Chaplains and pastoral care counselors explicitly provide spiritual and emotional care to patients, and are often included in palliative care teams and other acute care settings. Clinical Pastoral Education (CPE) trains chaplains of all faiths to provide spiritual and emotional care in health care settings. This training is conducted by supervisors accredited by the Association of Clinical Pastoral Education (ACPE), and includes duty time as chaplains on call, detailed reporting and evaluation, and peer group learning and supervision.<sup>6</sup>

Spirituality provides a context for the many decisions that must be made in health care encounters. Nurses, social workers, and physicians often interact with patients at intimate times when spiritual support may be helpful. In addition, spiritual care often supports patient and family coping and even the patient's will to live. Responses to spiritual needs may take myriad forms, ranging from formal prayer to less structured but equally empathic gestures and words that support patients' and families' emotional and spiritual well-being. In responding to these needs, the clinician must consider his or her own personal understanding of spirituality, so that interactions are genuinely heartfelt and not simply another "task" to be done.

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Basic information on patients' spiritual and emotional needs can be gathered by taking a spiritual history. Questions in a spiritual history help providers understand patients' spiritual beliefs, and the role that they play in patients' coping, as well as identify any spiritual needs that need to be

addressed. Domains within such a history include:

- Does the patient use religion / spirituality to help cope or is it a source of stress?
- Is the patient a member of a supportive spiritual community?
- Does the patient have any troubling spiritual questions or concerns?
- Does the patient have any spiritual beliefs that might influence medical care?
- Are there ethical boundaries?

Beyond being aware of patients' spiritual needs, the health care provider's extension of caring through personal empathy is key. Physicians and others have an obligation to respond to suffering, provide compassionate care, and to recognize the spiritual needs that are important to patients. Research has demonstrated that physician empathy may be related to patient and physician satisfaction, better therapeutic relationships and clinical outcomes, and a reduction in malpractice claims.<sup>7</sup>

There are of course ethical boundaries to this involvement, which may include lack of knowledge, training, or time; discomfort with the subject; fear of imposing religious views; consent and confidentiality; and religious conflicts.<sup>8</sup> Spiritual care is by nature interdisciplinary, and often involves referral to and collaboration with pastoral care counselors or chaplains.<sup>9</sup>

Although a range of methodologies have been suggested for health care providers to identify and address spirituality in the context of patient care, it is equally important to determine when a conversation regarding spirituality can happen, and to acknowledge the impact of health care providers' involvement in attending to patients' spiritual and medical needs.

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# A Culture of Comfort

## Palliative Care at Thomas Jefferson University Hospital

To say that Yolanda never had much of a childhood is too easy. She was diagnosed with sickle cell disease at birth. Her mother died when she was a girl and her father never took an active role in her life. She moved into adulthood with pain requiring intravenous narcotics. And then things got worse. Her kidneys failed four months ago. Her life was constrained by her three-day-a-week dialysis appointments. Recently, she was admitted to intensive care for seizures. Today she spends more time in the hospital than home. She knows she faces an early death. And she is terrified.

Yolanda, not her real name, is a 38 year-old patient on the Palliative Care Service at Thomas Jefferson University Hospital. Palliation is synonymous with comforting; therefore palliative care optimizes quality of life by addressing physical, emotional and spiritual needs. The skill set of palliative care professionals includes pain and symptom management, communication, and finesse at planning health care post-hospitalization. Doctors and nurses on the Palliative Care Service come from family and internal medicine, geriatrics, and oncology. Jefferson physicians have consulted the team for nearly 400 hospitalized patients since the inauguration of the service in March, 2006.

The Palliative Care Service visits Yolanda to offer support and monitor her pain regimen. The team has earned her trust by being there on good days and bad. Visits from a massage therapist are arranged; scented oils and a gentle touch provide some relief. A social worker provides supportive counseling. An art therapist helps to reduce stress by providing an outlet for creative expression. Conversations with Yolanda reveal fears and wishes about the end of her life.

Many physicians avoid frank talks with patients about their prognosis so as to “keep hope alive.” Without a forecast of the chances for long-term recovery, seriously ill patients and their families often choose aggressive and futile medical treatments. Surveys report that surviving family members regret their lack of preparation for death and the memory of a “medicalized”<sup>1,2</sup> death rather than a more peaceful passage for their loved one. Palliative Care Service members navigate these touchy conversations during family meetings. They help primary physicians relay the bad news with compassion, and support goals that are both realistic and consistent with the patient’s wishes.

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Palliative Medicine, recently deemed a medical subspecialty, grew out of the hospice movement<sup>3</sup>. The common thread linking palliative care and hospice is the focus on relieving symptoms of chronic illness and supporting patients and families.<sup>4</sup> Palliative care supports individuals during medical treatment while hospice care targets patients in the final months of life. Outreach to grieving families closes the care loop.

Though new to Jefferson, palliative care is growing nationwide. According to the Center to Advance Palliative Care, 1,240 hospitals now have interdisciplinary palliative care teams, most often in academic medical centers.<sup>5</sup> Training for health care professionals, from continuing education programs to palliative care fellowships and certification, is available at centers such as the Harvard Medical School Center for Palliative Care.

Palliative medicine administers a dose of humanity to a health care system criticized for not caring. And it cuts hospital costs, perhaps as much as \$3,000 per patient, by facilitating transitions out of acute or intensive care to more appropriate and less costly settings.<sup>3</sup> However, hospitals will have to find a way to support this important work until a time when reimbursement for palliative care is better established.

For now, Yolanda wants to continue aggressive care. However, at the point at which medicine offers her longer life without quality, she has asked her doctors to change gears in accordance with her wishes. She relies on the Palliative Care Service to prevent pain and suffering at the end. She deserves that final dignity.

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## COLLEGE FOR ADVANCED MANAGEMENT OF HEALTH BENEFITS

This 4-day training program is designed to help employee benefit managers meet the growing challenges of providing high-quality health benefits and managing rising benefit costs. For more information contact: Melissa Horowitz at (215) 955-9817 or [melissa.horowitz@jefferson.edu](mailto:melissa.horowitz@jefferson.edu).

A complete description may be located at: <http://www.jefferson.edu/dhp/CAMHB.cfm>.

June 2-5, 2008 • Orlando, FL

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# The Missing PEACE of the Puzzle

In recent years, medication costs have been rising at alarming rates, leaving hospitals in search of ways to control pharmaceutical spending. Typically, a hospital's Pharmacy and Therapeutics (P&T) committee would lead this process; however, this task becomes a greater challenge at larger institutions. Here at Thomas Jefferson University Hospital (TJUH), we've found another way to combat rising drug costs – through the PharmacoEconomics and Clinical Effectiveness (PEACE) committee. PEACE has undertaken the charge to achieve quality outcomes while optimizing dollars spent.<sup>1,2</sup>

PEACE was established by hospital administration in 2003 with the goal of addressing high cost and high volume medications and disease states. It runs parallel to the P&T Committee, and reports directly to hospital administration. In contrast, the P&T committee reports to the medical executive committee. Members of the committee include the Chief Medical Officer, the Chief Financial Officer, administrative representatives from the pharmacy and nursing departments, and the medical staff. The PEACE committee, through various benchmarking reports and internal analysis, identifies items that match the committee's goals. Following data collection and discussion, PEACE then forwards the analysis to the appropriate P&T subcommittee for further insight and guideline development.

One of the first undertakings of the PEACE committee was to address the use of erythropoiesis-stimulating agents (ESAs). Erythropoietin is a high cost medication used for red blood cell stimulation in patients with anemia. Given that the cost of this medication was greater than any other at the time, it became one of the committee's first projects. After identifying committee members with expertise in the area and gathering information from other institutions, PEACE chose the most appropriate agent from the class and developed evidence-based guidelines for the medication. The outcome was savings amounting to greater than half a million dollars per year.

Within the past year, the committee began to address the nationwide increase of a potentially life-threatening infection, *Clostridium difficile* (C. diff). While the effort had very little to do with financial implications, it focused on another of the committee's key goals: optimizing appropriate patient care.

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Recent literature suggests risk factors for C. diff may include the use of broad spectrum antibiotics (BSAs) in combination with gastric acid suppressants (GASs), which include proton pump inhibitors (PPIs) like esomeprazole or H2 antagonists like famotidine.<sup>3,4</sup> Although

much attention has been given to BSAs, it is equally important to focus on the GASs. The committee learned that 62% of TJUH patients were receiving one of these agents, with the PPI group comprising greater than three-quarters of the use. When benchmarked against use of PPIs in other University HealthSystem Consortium (UHC) hospitals, use at TJUH was double that of other similarly sized institutions.

PEACE committee representatives worked with the Gastroenterology subcommittee of the P&T Committee to develop an action plan to effectively decrease unnecessary use of GASs. A three-step procedure was designed, and is now in various stages of implementation. It includes education to all medical staff, an alert indicating when a GAS is being ordered for a patient already on a BSA, and lastly, a stricter ordering process for these medications. The impact of these actions is still under evaluation; however, early data shows a 6% decrease in PPI use in the past quarter.

Since its inception, PEACE has addressed numerous topics, including topical thrombin, inhaled nitric oxide, and chemotherapy. The committee continues to show promising results in meeting its charge to optimize patient care in a cost-effective manner. The examples provided in this article are surely just the beginning of PEACE's role in positively impacting patient care at TJUH.

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## USE OF BIOLOGICS IN IMMUNOTHERAPY

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*This program is supported through an unrestricted educational grant from Genentech.*

# Health Education: An Essential Part of Public Health and Health Care

Given the increasing complexity of our public health and health care systems, the public health profession has a more important role to play than ever in helping consumers/patients achieve and maintain optimal health. At the population level, public health professionals are at the forefront of research and education, forging multi-disciplinary alliances as never before. As a result, graduate degrees in public health are proliferating nationally.

The need for health education in community and clinical health environments is great, and growing. This includes education about personal and community health issues; strategies to reduce risk and improve health; specific resources and tools to help consumers to take appropriate pro-health actions; and support systems (access, financial assistance, health information resources, etc.) to sustain such actions. The goals of health education are two-fold: to provide information to enhance consumer or patient knowledge; and to help effect positive and long-term change in health behaviors.

This article provides a brief background of health education and health promotion, including an overview of its leading professional organization, the Society for Public Health Education (SOPHE); and explores the unique and critical role of the health educator in helping individuals internalize positive behavior-change, the ultimate goal of public health education.

Health education was first defined in the 1940s as "...requiring careful and thorough consideration of present knowledge, attitudes, goals, perceptions, social status, power structure, cultural traditions, and other aspects of whatever public is to be addressed."<sup>1</sup>

Health education and health promotion are often referred to interchangeably, as "...any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to health of individuals, groups, and communities."<sup>2</sup>

Although it is an important first step in the health education process, knowledge alone does not lead to positive health behavior change. Guy Steuart, a health education leader during the 1960s through the 1980s, described public health services and health education as natural adjuncts to good quality medical care. He defined the role of the professional health educator as an agent of social change and a generalist whose skills are applicable in a variety of settings, cultures, and topics.<sup>3</sup>

There are an estimated 58,000 professionally-trained health educators working in a wide variety of private and governmental settings, promoting healthy lifestyles.<sup>4</sup>

Professional health educators typically possess graduate-level training, such a Master's of Public Health (MPH), and the ability to:

- Promote behaviors that help individuals, families, and their communities maximize and maintain the quality of their life and health

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- Facilitate collaboration between the individual and health service organization to address the growing demand for comprehensive public health education
- Design and deliver evidence-based, cost-effective health education programs
- Assess health education needs and the impact of health service organizations in the community
- Effectively incorporate the teaching learning process to change behavior and improve patient outcomes
- Evaluate the effectiveness of health education programs, products, and services
- Advocate for and implement changes in policies, procedures, rules and regulations to advance the public's health
- Partner with clinical providers to plan, conduct, and evaluate programs designed to improve patient outcomes
- Develop programs and policies that not only take into account individual knowledge, attitudes, beliefs, and behaviors but those behaviors and policies of key systems such as education, business, government, health care, civic organizations and societal norms and values.<sup>5</sup>

Certification of health educators, while not required, is integral to continuing education, professional development, and standards of practice. The profession of health education has evolved over the past generation, with a defined code of ethics,<sup>6</sup> competencies and credentials. Responsibilities and competencies of a Certified Health Education Specialist (CHES) include:<sup>7</sup>

- Access individual and community needs for health education
- Plan health education strategies, interventions, and programs
- Implement health education strategies, interventions, and programs
- Conduct evaluation and research related to health education
- Administer health education strategies, interventions, and programs
- Serve as a health education resource person
- Communicate and advocate for health and health education

SOPHE, the leading national health education professional organization,<sup>8</sup> was founded in 1950 and is affiliated with the International Union for Health Promotion and Education (IUHPE). It consists of over 2000 national members and an additional 2000 members of local chapters in the United States. Its purpose is to: provide leadership to the profession of public health education; contribute to the health of all people; eliminate disparities in health through advances in health education theory and research; promote excellence in professional preparation and practice; and advocate for public policies conducive to health. Its members work in schools, universities, health care settings, corporations, voluntary health agencies, health foundations, international organizations, and federal, state, and local government. Its two principal scholarly journals are *Health Education & Behavior* and *Health Promotion Practice*. SOPHE is a partner with the American Public Health Association, the U.S. Centers for Disease Control and Prevention (CDC), the Society of Behavioral Medicine, the National Public Health Partnership,

and numerous other national and international health organizations that advocate and promote preventive health initiatives and resources to improve the health of our society.

Thomas Jefferson University's Master of Public Health (MPH) Program embodies the principles of health education within its core curriculum, including two required community-based experiences, a clerkship, and a capstone research project. The program is aimed at both current health professionals seeking to expand their clinical practice to incorporate public health and those entering the public health profession for the first time. The degree can be pursued full-time or part-time, and a number of dual degree programs are available. Further information regarding Jefferson's MPH program is available at [www.jefferson.edu/mph/jcgs/msph](http://www.jefferson.edu/mph/jcgs/msph).

Regardless of job title or training, we are all consumers of health information and, formally or informally, serve as health educators on behalf of our family, work colleagues, and community. It is vital that we strive to be the best "health educators" possible, to improve the health of our nation, our community, our family and ourselves.

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## Department of Health Policy Presentations

Feudtner C, Kang TL, Feinstein JA, Hexem K, **Reifsnnyder J**, Maxwell T. *Hospice Use by Pediatric Patients*. Paper presented at the Annual Assembly of the Academy of Hospice and Palliative Medicine, February 2, 2008, Tampa, FL.

Kairys JC, McGuire K, **Crawford AG**, Yeo CJ. *Cumulative Operative Experience is Decreasing During General Surgery Residency: A Worrisome Trend for Surgical Trainees?* Prepared for the Journal of the American College of Surgeons, December 2007, and presented at the 119th Annual Meeting of the Southern Surgical Association, December 2-5, 2007, Hot Springs, VA.

**Leas B**, **Goldfarb NI**. Rupnow MFT, Gagne JJ. *Developing a Migraine Quality of Care Measurement Set*. Poster presented at the American Society of Health-System Pharmacists Midyear Clinical Meeting, December 2-6, 2007, Las Vegas, NV.

**Maio V**, Donatini A, Louis DZ, Gavin E, Robeson M, **Yuen E**, Fabi M, Lazzarato M. *Physician Practice Profiling in Primary Care Groups in Parma Local Health Unit, Italy*. 23rd Classification System International Conference, November 8, 2007, Venice Italy.

Maxwell T, Huban T, **Reifsnnyder J**. *Quality Outcome Data Collection in Hospice: Collection of Patient Caregiver Reported Symptom Assessments via Outbound Calling*. Paper presented at the Annual Assembly of the Academy of Hospice and Palliative Medicine, February 2, 2008, Tampa, FL.

**Sarfaty M**. *Colorectal Cancer Screening: Tools for Your Practice and the Evidence for Them*. Train the Trainer Webcast, January 22, 2008. Sponsored by the American Cancer Society of New Jersey and New York.

**Yuen EJ**, Louis DZ, Cisbani L, Rabinowitz C, **Maio V**, Marangolo M. *Using Administrative Data to Assess Patterns and Quality of Cancer Care*. Paper presented at Patient Classification Systems International 23rd Annual Meeting, November 8, 2007, Venice, Italy.

**Yuen EJ**. *Power and Conflict in Buddhism*. Presentation at Robert A. Fox Leadership Program, University of Pennsylvania, November 13, 2007, Philadelphia, PA.

**Yuen EJ**. *Risk Adjustment in Italy*. Presentation at Center for Medicare and Medicaid Services, November 29, 2007, Baltimore, MD.

## New Publications from the Department of Health Policy

**Clarke JL**. Chronic care at the crossroads: exploring solutions for chronic care management. *Dis Manage*. 2007; 10, Suppl 2:S3-S14.

**Lee SP**, Bain KT, **Maio V**. Appropriate discontinuation of medications at the end of life: a need to establish consensus criteria. *Am Journal of Med Qual*. 2007;22(6):393-4.

**Meiris DC**. Reactor panel: bridging the gap between the vision and the implementation. *Dis Manage*. 2007; 10:324-327.

**Meiris DC**. Redesign of health care for an older America. *Dis Manage*. 2007; 10:322-324.

**Meiris DC**. Healing and health and long-term care system. *Dis Manage*. 2007;10:320-322.

**Nash DB**. The biotech detail rep of the future. *Biotechnology Healthcare*. 2007;4(6):9.

**Nash DB**. The "crossroads" and beyond. *Dis Manage*. 2007; Suppl 2: S1-S2.

**Nash DB**. Better. *P&T*. 2008;33(1):7.

Royo MB, **Nash DB**. Commentary: Sarbanes-Oxley and not-for-profit hospitals: current issues and future prospects. *Am Journal Med Qual*. 2007;23(1):70-71.

**Yuen EJ**. Meditation, Emotions, and Female Offenders. In: *Female Offenders*, 2nd Edition, Zaplin R (ed), Sudbury, MA: Jones and Bartlett, 2007.

## HEALTH POLICY FORUMS: SPRING 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.

### March 12, 2008

*Leadership Training-What can Medicine Learn from the Military?*

Reed R. Bonadonna, PhD  
Commander, US  
Maritime Service  
Director, Ethics and  
Character Development  
US Merchant Marine Academy  
ACPE No: 079-000-08-003-L04-P

### April 9, 2008

*The World of Healthcare/Pharma Blogging*

Ed Silverman  
Editor, *Pharmalot.com*  
ACPE No: 079-000-08-004-L04-P

### May 14, 2007

*Barker Hypothesis*

Stephen Snyder, PhD  
Assistant Professor  
of Economics  
Lehigh University  
ACPE No: 079-000-08-005-L04-P

### June 11, 2008

*Physician Quality Reporting Initiative (PQRI) Update*

Barbara J. Connors, DO, MPH  
Chief Medical Officer,  
Region III  
The Centers for Medicare  
and Medicaid Services  
ACPE No: 079-000-08-006-L04-P



# Department of Health Policy Forums

## PA Budget and Health Care Reform

**Barbara Holland, JD, MPH**

*Deputy General Counsel*

*Governor's Office on Health Care Reform and the Patient Safety Authority*

*Commonwealth of Pennsylvania*

*December 12, 2007*

The need to decrease costs while increasing health care coverage is a dominant theme in Pennsylvania. Barbara Holland, Deputy General Counsel representing the Governor's Office on Health Care Reform, described the numerous programmatic updates and legislative challenges affecting the future of healthcare in Pennsylvania.

MCARE (Medical Care Availability and Reduction of Error) Fund abatement is part of the Governor's Medical Malpractice Reform Proposal and the Health Care Provider Retention Account. It is designed to impact insurance affordability and availability, and patient safety by providing excess limits of malpractice coverage to health care providers, with 100% abatement to certain specialty providers and 50% for all other physicians.

Scope of Practice Reforms and the elimination of practice barriers continue to be on the forefront of proposed change. For example, there is much discussion regarding reforms for Certified Registered Nurse Practitioners (CRNPs). A recent proposal would have given CRNPs additional practice authority. However, CRNPs are currently not allowed to participate in MCARE and, if they are employed, do not have to maintain separate coverage. Further clarification will be necessary before reforms can be implemented. Scope of Practice bills for pharmacists and physician's assistants (PAs) are being considered.

The Governor's office is particularly concerned with the high rate of health care-associated infections (HAIs) and medical errors in Pennsylvania and has set forth proposals that aim to significantly impact patient safety, including: electronic surveillance of HAIs; reporting of HAIs for all patients in the entire facility; reporting requirements for nursing homes; and quality improvement payments.

Pennsylvanians also have a high rate of avoidable chronic disease hospitalizations that resulted in significant hospital charges. Governor Rendell recently established a Chronic Care Commission to develop and implement a management model of chronic care to increase quality outcomes and cost-effective treatments.

## Building a Comprehensive Health Database for Use in City-Wide Health Management Systems

**Jeffrey Brenner, MD**

*Clinical Instructor*

*Department of Family Medicine*

*Robert Wood Johnson Medical School*

*January 9, 2008*

Jeffrey Brenner, MD, a Camden, NJ family physician, discussed his experience building a comprehensive health database for the City of Camden and assembling a coalition of healthcare stakeholders, with an eye toward improving the quality, capacity, and accessibility of the healthcare system for the city's vulnerable populations.

The database was created from a local dataset using billing data from all of the Camden hospitals. Analysis showed that in 2003, 50% of Camden's population used an emergency department (ED) or hospital, double the national rate; and that many of the ED and hospital visits were for minor or preventable problems that could have been avoided through improved access to primary care. The report is available at [www.camconnect.org](http://www.camconnect.org). Research is ongoing.

Among its goals, the Camden Coalition of Healthcare Providers ([www.camdenhealth.org](http://www.camdenhealth.org)) provides practice management assistance to individual primary care practices to improve their capacity, and works to address the complex needs of "super-utilizers" targeted by Brenner's research – patients who repeatedly visit the hospitals or EDs in Camden.

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## MedMining and Electronic Health Record Data

**James Peters, MBA**

*Chief Executive Officer, MedMining*

*February 13, 2008*

Mr. Peters' presentation focused on the capabilities of MedMining, a Geisinger Health System (GHS) company that utilizes real-world electronic health record data to address specific health research questions. GHS, located in central Pennsylvania, was an early adopter of an electronic health record (EHR), having initiated its use in 1997. Over the course of the last decade, GHS' use of the EHR technology has been expanded to include data from its related outpatient practices. As a result, GHS has one of the most complete healthcare datasets in the country.

Most of the electronic data that has been used to conduct health care research consists of claims data, which is often incomplete and delayed while claims are processed. EHR-based data can provide a more complete picture – especially when it includes access to 10 years of longitudinal, episodic encounter data for both the ambulatory and inpatient setting. Information of this type can be particularly helpful in conducting specialized health care research about certain diseases, patient demographics, and treatments.

# 5th Annual Interclerkship Day: Improving Patient Safety January 7, 2008

For the fifth year in a row, Jefferson Medical College third-year students received a proverbial “crash course” in patient safety on January 7 at Interclerkship Day. Designed to change medical students’ attitudes and beliefs about medical errors and patient safety,<sup>1</sup> the annual event delivers lessons based on the aviation safety model of crew resource management and provides training in how best to avoid medical errors. Sponsored by the Dean’s Office and organized and moderated by David B. Nash, MD, MBA, Chair of the Department of Health Policy, the program features nationally recognized speakers and focused workshops.

The two keynote speakers were John J. Nance, JD, a national aviation safety expert and founding board member of the National Patient Safety Foundation; and John-Henry Pfifferling, PhD, director and founder of the Center for Professional Well-Being in Durham, North Carolina. In the afternoon, students chose from among a selection of 8 breakout sessions, each featuring a topic germane to safe medical practice. The day concluded with a discussion by Jefferson Medical College Associate Dean, Charles Pohl, MD, on preparing for the residency match.

John Nance, a former airline pilot and ABC News aviation analyst, provided a compelling overview of the airline industry’s safety record, while drawing a convincing parallel with medicine, in terms of the professions’ priority on safety. (The airline industry has long been recognized as a leader in safety initiatives and its example is being replicated in medicine. For example, the airlines’ “LifeWings”<sup>2</sup> patient safety program has been adopted locally by Methodist Hospital, and was the subject of a workshop at Interclerkship Day, led by Dr. Melvin Moses, Chief of Surgery at TJU/Methodist Hospital.)

Nance’s talk emphasized the importance of creating a “safe” professional environment in which all members of the care team are encouraged to share safety concerns. The optimal environment would allow the most junior member of the team to speak up and point out a potential error. Nance concedes this can be difficult under the best of circumstances, but that it shouldn’t be, providing that the right organizational culture is established. Nance maintains that communication is the cornerstone of an open, non-fear-based learning culture.

Following Nance, Dr. Pfifferling’s presentations advocate a learning culture that supports error reporting transparency and a team-based approach. A medical anthropologist who has long studied stress among medical residents, Dr. Pfifferling examined these themes from a psycho-social perspective, focusing on the role of self-care in well-being and professional performance. Given the intense stressors medical students and physicians experience, they are particularly vulnerable to stress-related sequelae. As a result, patients stand to suffer. Pfifferling discussed how the typical medical school culture affects well-being, and provided ample examples of stress-combating techniques, including increasing awareness of – and letting go of – potentially damaging mindsets, such as perfectionism.

Included in the afternoon program were breakout sessions devoted to discussing a medical error with a patient; standardizing order sets to improve safety; apology and disclosure; and case studies about near misses.

The Department of Health Policy thanks Michael Vergare, MD Interim Dean of Thomas Jefferson University; Susan L. Rattner, MD, Clinical Associate Professor, Department of Internal Medicine; and the members of the JMC Curriculum Committee for their work on behalf of Interclerkship Day. In his opening remarks, Dr. Nash acknowledged the passing of Philip J. Wolfson, MD, Professor of Surgery, who is remembered for his enduring commitment to the students of Jefferson Medical College, and to this program.

## REFERENCES

1. Moskowitz E, Veloski JJ, Fields SK, Nash DB. Development and evaluation of a 1-day clerkship program for medical students on medical errors and patient safety. *Am J Med Quality*. 2007;22:13-17.
2. George, John. Patient-safety program takes flight at Methodist Hospital. *Philadelphia Business Journal*, March 23, 2007.

## More Health Policy News

Look for David Nash’s new column, *Focus on Policy*, online at MedPage Today. The column will appear monthly at [www.medpagetoday.com/Columns/](http://www.medpagetoday.com/Columns/), covering timely topics of interest to clinicians and consumers. The goal is to provide readers with knowledge and information to help them better understand the implications of the news and engage in an informed dialogue about the latest medical breakthroughs.

And don’t forget to visit our blog, *Nash on Health Policy* at <http://departmentofhealthpolicy.blogspot.com/>.

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Raymond J. Fabius, MD, CPE, FAAP, FACPE, President and Chief Medical Officer, CHD Meridian/I-trax

Neil F. Gordon, MD, PhD, MPH, FACC, Chief Medical and Science Officer, Nationwide Better Health

Matthew Holt, The Health Care Blog

Al Lewis, President, Disease Management Purchasing Consortium International, Inc., Founder and Past President, Disease Management Association of America

Ronald Loeppke, MD, MPH, Chief Strategy Officer, Executive Vice President, Matria Healthcare, Inc.

John Mahoney, MD, Corporate Medical Director, Pitney-Bowes, Inc.

Soeren Mattke, MD, DSc, Senior Scientist, The RAND Corporation

Nancy McCall, ScD, Principal Scientist, RTI International Division of Health Economics Research

Dwight McNeill, PhD, MPH, Senior Fellow, National Quality Forum

Peter Miller, Co-Founder, President and Chief Executive Officer, Take Care Health Systems<sup>SM</sup>

Tracey Moorhead, President and Chief Executive Officer, DMAA: The Care Continuum Alliance

Charles Peck, MD, Chief Medical Officer and Medical Director, Take Care Health Systems

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