

# Health Policy NEWSLETTER

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FROM THE EDITOR

## A Blink in Healthcare

Malcolm Gladwell has done it again! In June of 2001, in this space, I wrote, "Occasionally... I have reviewed a book that is relevant to our readership. Rarely, have I read a popular book that has more relevance to health care than Malcolm Gladwell's, *The Tipping Point* published late in 2000. The central thesis of *The Tipping Point* contends that ideas, behavior, messages, and products are often spread like outbreaks of an infectious disease."<sup>1</sup>

Gladwell's newest book, *Blink*, has as its central thesis that great decision makers aren't those who process the most information or spend the most time deliberating but those who have perfected the art of "thin-slicing" – filtering the very few factors that matter from an overwhelming number of variables.<sup>2</sup> As with *The Tipping Point*, I believe that *Blink* is more than just pop-cognitive psychology but rather could serve as a cleverly presented blueprint to implement much needed changes in health care. Let's examine more closely the concepts of thin-slicing, less is more, and the ability to know our own minds.

Gladwell relates compelling examples to draw parallels between thin-slicing and the malpractice crisis. For example, imagine you are given two choices. "The first is to examine the physician's training and credentials and then analyze their records to see how many errors they have made over the past few years. The other option is to listen in on very brief snippets of conversation between each doctor and his or her patients."<sup>2</sup> Gladwell's challenge to the reader is to figure out whom among the physicians covered by an imaginary insurance company is most likely to be sued.

The answer, of course, is the option to listen in on very brief snippets of conversation. How could this be true? Gladwell reports on research from around the nation including some in the medical literature that is very counterintuitive to the scientific model. It is possible, using videotapes and computer analysis, to zero in on the conversation between surgeons and their patients. After these videotapes have been so-called "content filtered," all that remains is a kind of garble that preserves intonation, pitch and rhythm but erases content. Using that slice and that slice alone, Gladwell reports that if the surgeon's voice was judged to sound dominant, the surgeon tended to be in the group that was sued significantly more often. If the voice sounded less dominant and more concerned, the surgeon tended to be in the non-sued group.

He goes even further. While explaining that "malpractice sounds like one of those infinitely complicated and multidimensional problems, but in the end, it comes down to a matter of respect, and the simplest way that respect is communicated is through tone of voice, and the most corrosive tone of voice that a doctor can assume is a dominant tone."<sup>2</sup> Gladwell admonishes readers to thin slice new physicians and, if you get the feeling a physician is not listening to you, listen to that feeling!

What about the notion of "less is more." Here, Gladwell relies upon the work of Lee Goldman, a well-known researcher and currently Chief of Medicine at UC San Francisco. The so-called "Goldman criteria" are a well-established set of algorithms for assessing patients presenting with chest pain and sorting out those at the highest risk for myocardial infarction. Gladwell brilliantly weaves these Goldman criteria, derived largely from Bayesian logic, into a story about the chaotic Cook County Hospital Emergency Room in Chicago, Illinois. By applying less is more (the Goldman criteria) to patients presenting with chest pain, the Cook County ER noted a dramatic improvement in their diagnostic accuracy and ability to triage patients more appropriately. This is probably of no great surprise to our readers, but it was the context in which Gladwell put this that resonated with me. He noted that, "Extra information is more than useless; it's harmful; it confuses the issues. What screws up doctors when they are trying to predict heart attacks is that they take too much information into account."<sup>2</sup>

*continued p.2*

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Gladwell goes on to describe the resistance to Goldman criteria even decades after they have been relentlessly retested in different environments. He understands our cultural resistance to the standardization of care and acknowledges the fact that many doctors believe algorithms just don't "feel" right. Gladwell notes that truly successful decision making relies on a balance between deliberate and distinctive thinking. We are the beneficiaries of years of Goldman's painstaking deliberate decision making using computers and large patient populations. The second lesson is that in good decision making frugality matters. Goldman's research proved that in picking up patterns, less is more. I think the less is more concept is actually firmly rooted in modern cognitive psychology. Cognitive psychology is the science that examines how we reason, formulate judgments, and make decisions.

Physicians are exposed to certain short cuts in reasoning at the bedside, often called heuristics.<sup>3</sup> Sometimes, something called the "availability heuristic" leads us to make an inappropriate diagnosis. The availability heuristic is driven by the ease with which examples spring to mind. In other words, in the Lee Goldman example, we are sometimes hampered by cases with which we have had experience and lack ability to integrate information about new cases. A second shortcut in reasoning, the "anchoring heuristic," may also be occurring. This heuristic leads people to stick with initial impressions once they are solidly formed and ignore competing facts.<sup>3</sup> In any event, I think Gladwell has translated the heuristics of cognitive psychology and the heuristic of a missed diagnosis into language we can more readily process and understand.

As for our ability to know our own mind, this was probably the toughest healthcare lesson I distilled from *Blink*. It goes something like this. Imagine if you were asked to describe the characteristics of your favorite jam and to rank all of the jams you may be given in a taste test. Most people would find this mundane example to be very trying, and we would claim that we know unconsciously what good jam is. We simply can't define it on paper. In fact, cognitive psychologists, according to Gladwell, have shown that we can be readily influenced about our ranking of the jam we prefer. In fact, we can adjust our true preference to be in line with a plausible sounding reason; for example, the idea that the texture of one jam is superior to that of another. What does all of this jam have to do with medicine?

It struck me that this ability to know our own mind plagues us when it comes to our conversation about the quality of medical care. Here's how it works. Gladwell contends that introspection messes up our reactions. If one were to ask, who is the best doctor or worst doctor on a particular medical staff, we might instantly jump to a conclusion but be bedeviled by the challenge to write our reasons for those choices on a piece of paper. Gladwell goes on to explain that, "This does not mean that when we are outside our areas of passion and experience, our actions are invariably wrong. It just means that they are shallow. They are hard to explain and easily disrupted. They aren't grounded in real understanding."<sup>2</sup> Luckily, he draws upon research from around the world that says people who had a way to structure their first impressions, the vocabulary to capture them, and the experience to understand them usually make better decisions. I believe this ability to know our own mind, or lack thereof as the case may be, is a major roadblock to our collective attempts at internalizing a workable definition for the quality of medical care. Once we have solid evidence-based tools, we will be able to overcome this lack of ability to know our own minds.

Like *The Tipping Point*, *Blink* is not for everyone. Its provocative message regarding how we think challenges many of the tightly held, seemingly scientific aspects of our clinical decision making at the bedside. Whatever one's thoughts about *Blink*, I believe that if we would enhance our individual and collective ability to rapidly recognize and respond to the unexpected, we could go a long way toward improving quality and reducing medical errors. Gladwell has probably unknowingly looked into the soul of clinical practice and has given us a language to begin to understand its unfathomable complexities and stark humanity. As usual, I am interested in your views and you can reach me at david.nash@jefferson.edu.

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## Letters to the Editor

Thank you for spotlighting the recent Pennsylvania Health Care Cost Containment Council (PHC4) report on total hip and knee replacements in your September newsletter. I deeply appreciate the kudos you gave to this report, and to PHC4's capabilities in general. And as the longtime chairman of PHC4's Technical Advisory Group, you have the heartfelt gratitude of the staff and Council members for the quantity of time and quality of expertise that you have brought to PHC4's efforts.

As you noted, Pennsylvania has produced another first – no other state in the nation has produced a physician-specific report on any treatment category other than heart care. In addition, we have now become the first state to put some hard figures around the astounding patient safety and cost consequences of hospital-acquired infections (HAIs).

I am, however, troubled by an emerging theme in the literature on public reporting: “the unintended consequences of public reporting.” This theme has appeared in recent critiques and suggests that public reporting may negatively impact health care quality. Unfortunately, this argument is largely supported by shoddy research, antiquated data, and often is opinion masquerading as fact – you referred to this theme as the “dark side” of public reporting in your newsletter. The “guidance” issued earlier this year from the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) uses the same phrase when warning of the potential consequences of mandatory reporting for HAIs: deflecting resources from patient care and prevention, misleading stakeholders if inaccurate data is published, and causing some physicians to avoid treating sicker patients. Déjà vu all over again!

I take umbrage with this film-noir view of public reporting as other researchers, like Judith Hibbard et al., have clearly shown the value of public information. In 2003, Hibbard found that Wisconsin hospitals with publicly reported performance results were significantly more likely to improve quality than two comparison groups where private reporting or no reporting was done. In 2005, this same group found that public performance data led to improvements in two particular clinical areas, obstetric and cardiac care.

Since PHC4 began reporting patient mortality rates for Pennsylvania hospitals, these rates have dropped from above the national average in 1993 to below the national average in 2003. Similarly, mortality rates for CABG in Pennsylvania have dropped 48 percent in the past ten years, mirroring the years of public reporting by the Council. While CABG mortality rates have dropped nationally, research reveals that they have dropped more significantly in states with public reporting, like Pennsylvania, New Jersey and New York.

Whether it be the clinical outcomes of bypass or hip and knee patients, or the staggering quality and cost implications of hospital-acquired infections, sunshine, and not the “dark side” of an unlit moon, will produce intended consequences: lives saved, costs restrained. I find these outcomes of public reporting far more convincing.

Finally, I want to commend you, Dr. Nash, for urging the Centers for Medicare and Medicaid Services and other states to rethink the way they are defining, reporting and paying for “quality performance.” I would also urge them to take the inevitable criticisms of public reporting with a grain of salt. No, we are not there yet...there are no perfect quality assessment tools or report cards. But, as you are often fond of saying, when it comes to data collection and quality measurement, “We cannot let the perfect be the enemy of the good.”

**Marc P. Volavka**

*Executive Director*

*Pennsylvania Health Care Cost Containment Council*

As a guy who cares a lot about quality, I was blown away by your September 2005 Health Policy Newsletter article, and the info about total joints, as well as PHC4. In California, we have reporting on heart surgeons, and I have been telling all my surgeons that anybody who does major elective procedures is going to be scrutinized. There's just too much at stake. And I hear the whining that “all the sick people will not be served”, and “anybody can have good results” by choosing the easiest patients. Yes, I would pick a guy with significant volume, and I would strongly consider the public reports of high rates of complications. It appears this work was done carefully and skillfully, and I congratulate you.

**Michael P. Kern, MD**

*Senior Vice President & Medical Director*

*John Muir/Mt.Diablo Health Network*

I read with interest the September 2005 Health Policy Newsletter. Although, I agree with some conclusions in the article on “Hips and Knees”, there are a number of areas where the editor could have done a better job putting the overall issues in context. For example, when you comment on the untoward consequences of readmission rates due to deep joint infections or device problems, you point out the “cost” of \$30 million dollars in charges. As I'm sure you are aware, charges do not relate to either the payments to hospitals and physicians nor the actual cost of providing services. Your use of charges overstates by a significant amount the cost consequences of these readmissions. It is clear that all of us can, should, and will strive to do better tomorrow than we are doing today. However, it is incumbent on the individuals writing about healthcare quality issues to make sure that context of information is clear.

**Gerald Miller**

*President & CEO*

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*Please note: The comments expressed by the authors in this publication do not necessarily represent the views of the Editorial Board, Thomas Jefferson University, Jefferson Medical College, Jefferson Health System or of the Department of Health Policy.*

# Hospital Quality Report Cards: Ready for Prime Time?

For generations, hospital administrators and doctors have closely guarded information about hospital outcomes and physician effectiveness, if they measured them at all. Sharing this information with the public would be unheard of. Patients were expected to do what they were told and not ask questions. In the absence of other sources, patients came to rely almost completely upon physician recommendation or word-of-mouth from friends and family when choosing options for care. Lacking hard data on clinical outcomes or safety, most patients would choose doctors or hospitals based on bedside manner, or the friendliness of staff, or a vague sense of a doctor's or hospital's reputation.

The shift in this paradigm—only now gathering steam—began just over a decade ago, when a few states (Pennsylvania, for one) began to collect and publish outcome data for doctors and hospitals, and popular media such as *US News & World Report* started publishing “top hospital” listings.

Since that early trickle of hard data, however, a confluence of factors have gathered force and created an increasing stream of hospital and doctor effectiveness data now available to any patient. Aging, health-conscious Baby Boomers, the internet, concerns over safety and cost, and a growing public expectation for “transparency” from businesses and institutions have made hospital and physician quality report cards a growth industry.

Google the phrase “healthcare quality report cards” and more than 1.5 million references appear. In addition to *US News & World Report*, one can visit the Leapfrog Group, HealthGrades®, Consumer Checkbook, Select Quality Care, and the federal government's Hospital Compare site, just to name a few. Almost every one of these programs touts the value of creating better-informed patients who will make better decisions about purchasing healthcare, which will lead to lower costs and better clinical outcomes. “Our goal is to educate and empower members to make informed and appropriate healthcare decisions and engage in practices that support the development of their prevention and treatment plans,” stated one health insurance executive, describing the quality data on physicians and hospitals now available to subscribers.<sup>1</sup>

Given their growth and the increasing attention they receive from hospital administrators, doctors, payors, and politicians, it is reasonable to ask: does public reporting of quality data change patient behavior about hospital and doctor selection?

The short-term answer: not yet. The long-term answer: maybe.

Our own research among consumers who use Main Line Health hospitals has consistently shown that—even after a decade of hospital report cards—word-of-mouth remains by far the most popular and important source of information for patients choosing a hospital. This includes recommendations from the patient's physician.

Main Line Health's findings are consistent nationally. In a 2004 survey by the Kaiser Family Foundation, 65 percent of respondents listed word of mouth as their likeliest source of information, while 76 percent said the convenience of the hospital's or doctor's location would influence their choice “a lot.” To be sure, some healthcare consumers are very interested in and influenced quality data (up to 18 percent, according to a study by Solucient.<sup>2</sup> Nevertheless,

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while the number of consumers who report seeing this kind of information has increased, the “vast majority are still not using quality information to make health care decisions.”<sup>3</sup>

Why does information that seems so powerful to payors and regulators, have so little influence on most consumers?

For one thing, health report cards are seeking to change behaviors that have been engrained in the public for over a century. These attitudes will not change quickly.

More problematic is that consumers lack the medical vocabulary to understand much of the information presented in quality report cards. Hospital Compare, the Medicare quality web site, for example, lists as one of its quality measures “Percent of Heart Attack Patients Given ACE Inhibitor for Left Ventricular Systolic Dysfunction (LVSD).”<sup>4</sup> Most patients have no idea what an ACE Inhibitor is, what LVSD is, or that the latter requires the former.

When the Kaiser survey asked respondents to list what is most important to them in defining healthcare quality, only two percent identified “patient outcome.” Almost a quarter (23%) said they did not know, while 14 percent (the next highest result) listed cost and affordability.

Another impediment to the effectiveness of report cards is the sheer number of health issues for which patients turn to doctors and hospitals for care. Medicare alone lists more than 500 different diagnostic related groups, which only begins to hint at the number and variety of diseases and injuries to which patients are subject.<sup>5</sup> A hospital may score well in treating heart disease, but that might not mean much to the patient with cancer or in need of a hip replacement, to say nothing of the patient suffering from some obscure disorder. Report cards will not be fully effective until they can find a way to be more comprehensive, in a way that patients and the public can readily understand.

Even with a decade or more behind them, healthcare report cards are still in their infancy, as is public awareness of and appreciation for the data. We anticipate in the coming years that quality ratings and rankings will become better understood and more widely accepted by patients. Reporting agencies will continue to refine their analyses and the public should become more sophisticated and comfortable using report card information in the decision making process. Word-of-mouth will remain powerful, but rather than neighbors trading stories about the doctor with the great bedside manner or the hospital with the great nurse, they may also swap mortality rates, error rates, and costs. Whether this shift will actually lead to greater efficiency and lower costs, as some predict, at this point is unknown.

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# Jefferson College of Health Professions Conducts Second e-Health Promotion Summer Institute

More effective and efficient delivery of healthcare services to individuals who are underserved has long been a recognized national need. One approach to addressing this issue is through more effective use of Internet technology. While the field of medicine, has already embraced this technology, many disciplines comprising the allied health professions have not taken full advantage of the Internet to provide services to those who are underserved. e-Health encompasses many online healthcare-related functions. One function is to provide health promotion services. e-Health promotion is a web-based application in which consumers are helped to understand their health conditions and become actively involved in managing their health. However, it appears that the larger allied health community is not aware of the potential of this approach. There also does not appear to be much funding for allied health initiatives in this area. If e-Health approaches can be demonstrated to be successful in reaching underserved population, it suggests health policy implications for both the professional communities and funding agencies.

As reported in the June 2004 *Health Policy Newsletter*, the Center for Collaborative Research at Thomas Jefferson University received a three-year grant from the Bureau of Health Professions to implement a Center for Excellence in e-Health Promotion Programs. The major goal of the project is to plan and conduct an e-Health Training Institute in which teams of allied health faculty and clinicians learn to develop and implement a website designed to address a problem in an underserved population. The project is a collaborative effort among the Departments of Occupational Therapy and Physical Therapy in the College, the American Speech-Language Hearing Association and Journey Home, a non-profit agency in Philadelphia dedicated to working with the homeless community and other underserved populations.

Interdisciplinary teams of allied health professionals from across the country can apply to attend the Institute. Each

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team that is accepted is required to bring a plan for a health intervention in an underserved community. By the completion of the training, each team is expected to have learned how to design a web site that incorporates this plan. They also learn how to address issues of health and computer literacy as well as attend to the cultural characteristics of the population.

Six teams composed of faculty and clinicians attended the first Institute in the summer of 2004. These teams addressed a wide range of problems and populations. One project conducted by a team from Creighton University has developed a website focused on a campus-community

partnership to promote a comprehensive health and wellness program in an American Indian reservation. Another, Holy Redeemer Home Care, in Philadelphia, developed a website to address the needs of the frail elderly in the City. A third group from Washington, DC, is developing a website using photo novellas for low literacy Hispanic and African Americans in a speech pathology clinic.

The second Institute was held on the campus of Thomas Jefferson University from June 20 to June 25. The proposed team projects included topics such as developing an informational and self-management strategy website for women with connective disease disorders, a health promotion program for the underserved minority elderly in the City of Chicago, and an interactive health lifestyles' website for employees of the Louisiana Department of Labor. The motivation of another project was explained by one of the team members. "There is a shortage of healthcare providers in rural South Carolina, and we are developing an information-sharing network for them," said Ms. Kelly Musick, a team member working on filling gaps in services to therapists and families of children with disabilities, from the Center for Disability Resources at the University of South Carolina. "The Institute faculty is phenomenal...the resource structure is strong, and the connections with people from across the United States are great."

Although not all teams have been successful in completing their proposed website, progress is being made. Data from the first Institute suggests that developing websites is a much more labor intensive and time-consuming endeavor that most participants expected. However, approximately 50 percent of the teams have been successful in implementing their proposed programs, either as a whole or in part. While it is too early to determine the overall impact of the websites on the underserved communities for which they are designed, the success of some of the participants suggest that this can be a valuable approach in providing health services to members of these communities.

## Research Faculty, Project Manager, and Analyst Positions

The Department of Health Policy of Jefferson Medical College has several new openings for its rapidly growing research program. We seek individuals with interest/experience in outcomes research, statistical analysis, pharmacoconomics, and/or health services research.

See [www.jefferson.edu/dhp](http://www.jefferson.edu/dhp) for information on our exciting activities. Email resume to Neil Goldfarb, Director of Research, [neil.goldfarb@jefferson.edu](mailto:neil.goldfarb@jefferson.edu)

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# Consumer Driven Health Plans: Wave of the Future?

Consumer Driven Health Plans (CDHPs) are emerging as the new health benefit option that promises to give employees and consumers more choices in how they select and use health care. It is important to examine the lessons learned from innovators and consider the designs of the newer CDHP options being launched in the near future.

**SARA L. THIER, MPH**  
PROJECT DIRECTOR  
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## *Consumers' Use of Information*

Consumer advocates are adamant in their belief that consumers are wise enough to interpret quality data and to choose providers and services on that basis.<sup>5</sup> Although this

sounds like a promising strategy for transforming health care into a market-driven product, the information is very limited, and in the case of physician-specific quality data, almost nonexistent. While many organizations around the country are working to create consumer-friendly information, there are concerns that consumers cannot interpret the information provided. Additionally, even if consumers can understand the data, there is still the concern that consumers are more interested in information, such as office hours and the friendliness of office staff, which is not directly related to the common clinical measures of quality of care typical collected.

## **What are Consumer Driven Health Plans?**

Consumer Driven Health Plans (CDHPs) are the newest iteration of healthcare benefits that some employers are now offering to employees as a coverage option. (See Box for Common Elements of CDHPs) The dual aims of CDHPs are to put provider choice in the hands of consumers and to make the direct cost of health care more transparent. The CDHP design is based on the belief that increasing consumers' financial and decision-making responsibilities will lead to their reduced utilization of healthcare services, particularly those of limited or questionable value; those often classified as "overused."<sup>1, 2</sup>

With the push toward measurement of performance, efficiency, and patient-centeredness, the amount of data on health care is growing. This information -- analyzed, formatted and distributed appropriately -- promises to be a key factor in pushing the healthcare system toward a market-driven model. Existing CDHP products are predicated not only on the assumption that consumers will make wiser healthcare decisions when faced with paying the entire bill for a visit out of pocket (not simply a \$20 co-payment, but the contracted cost of the visit), but also will base these decisions on quality and cost (value) information available on particular providers, procedures, or medications.

## **Lessons Learned Can Direct CDHP Designs Moving Forward**

### *Who is likely to Enroll in a CDHP?*

Until recently, healthier and wealthier employees have been more likely to enroll in a CDHP. Such disparity in enrollment has the potential to create adverse selection, leaving options with lower premiums, such as HMOs or PPOs, and employers with the brunt of the healthcare costs. To date, sicker employees and those with lower incomes have been less likely to enroll in CDHPs, since the potential outlay of "employee gap" dollars (i.e., costs to meet the deductible paid out of pocket by the employee after the employer contribution is exhausted) may cause financial hardship.<sup>3, 4</sup> Premium payments and co-payments are more predictable and budgetable, and more traditional coverage does not place significant risk sharing on consumers. Employers designing CDHPs are looking to address this issue by offering competitive cost-sharing and cost-saving options for employees, e.g. tiered provider network with no cost to employees for using a selected primary hospital or health system.

### **Common CDHP Elements**

- High Deductible Health Plan (HDHP)
- Health Reimbursement Arrangements (HRAs), employer-funded; or Health Savings Accounts (HSAs), can be both employee/ employer-funded.
- Catastrophic Coverage
- Preventive Care Coverage
- Health Management Tools (e.g., online information, call centers)

## *Health Care Utilization*

The RAND Health Insurance Experiment (HIE) in the 1970s and 1980s set the stage for many of the cost-sharing practices that are now the foundation of the CDHPs model. Its landmark findings suggested that increased cost sharing (i.e., greater out-of-pocket costs) reduces the use of services. The decrease in utilization seen in this and other studies did not differentiate between essential and non-essential care. A closer look at these results also revealed some negative effects of these new utilization patterns on health outcomes.<sup>6</sup> There remains an underlying concern that those hoping to save out-of-pocket costs in their CDHP plans may delay or forgo needed care. Moving forward, employers plan to promote the use of call centers and online condition and treatment specific data by their employees to encourage them to receive appropriate and timely care.

## **Planting the Seed for Change: Two Additional Considerations**

*Pharmacy Benefits:* Where allowable, employers may carve out prescription drug plans from the CDHP - how will this affect the cost and out-of-pocket costs for consumers? The alignment of prescription drug benefits will be an essential consideration for creating a strong benefit.

*Providers:* While hospitals and health plans have become more adept at reporting data to their respective accreditation organizations, physicians have not. Performance measures, including patient satisfaction measures such as physician-level CAHPS, continue to evolve.<sup>7</sup> However, with less than 15% of physician offices using electronic medical records (EMR), data collection of performance measures for non-EMR offices will remain onerous.

## **The Bottomline**

CDHPs are expected to proliferate over the next few years. Will employers heed the lessons of past experiences? And how will future design modifications effect enrollment, service utilization, the threat of adverse selection, employers' health benefit costs, and ultimately employee health and productivity? At this time, CDHPs may not be the right choice for all employees, or even employers. Yet, employers who are willing to be the early adopters should be commended, as should enrollees who will assist in demonstrating the potentials of market-driven care.

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## Department of Health Policy Fellowship Programs: A Tradition of Excellence

Since 1994, the Department of Health Policy has offered post-doctoral fellowships in outcomes research and pharmaco-economics. This past June, we proudly celebrated the graduation of our 23rd and 24th fellows, Christopher Salvador, PharmD and Vanja Sikirica, PharmD.

The skills that are required to measure the value of medical interventions and understand the development of healthcare policies are best acquired through a combination of experience and didactic training. The fellowship program provides these skills through a unique model, where the first year is spent working as a researcher in the Department, and the second year is spent working as a researcher at the sponsor's site.

Since the program's inception, the Department has worked with several fellowship sponsors, including major pharmaceutical manufacturers and a health insurer. Current sponsors include Ortho-McNeil Janssen Scientific Affairs LLC, GlaxoSmithKline, and Cephalon.

The objectives of the program are:

- To educate the fellow on health economic and epidemiological principles, and to demonstrate the application of these principles in evaluating the costs and outcomes of medication therapy and healthcare services
- To provide the fellow with practical experience and opportunities to apply research methodologies in the assessment of economic, clinical, and humanistic outcomes
- To expose the fellow to a variety of perspectives on the economics of drug development, including that of the pharmaceutical industry, health insurers, and providers
- To foster the leadership skills required for the fellow to effectively manage projects in a variety of healthcare settings

Although many fellows have completed the program with the goal of obtaining a position in the pharmaceutical industry, several graduates are working for health insurers or outcomes research consulting firms. Through the years, many of our fellows have successfully climbed the career ladder, from entry-level to mid- or upper-management level positions. In many cases, sponsors have hired our fellowship graduates, with 10 graduates currently employed by a current or former sponsor or

**Laura Pizzi, PharmD, MPH**  
Associate Director, Research  
Department of Health Policy  
Jefferson Medical College

corporate subsidiary of the sponsor.

We are greatly appreciative to our sponsors for their continued support, and to you, our colleagues, for providing us with feedback about the program.

In addition to the pharmacy fellowship program, the Department of Health Policy also offers a Physician Fellowship program (see notice below). To inquire about sponsorship opportunities or apply for one of our fellowships, please contact Laura Pizzi, Fellowship Director, at (215) 955-1159 or e-mail [laura.pizzi@jefferson.edu](mailto:laura.pizzi@jefferson.edu). Each position begins in June 2006.

### Department of Health Policy Offers **PHYSICIAN FELLOWSHIP** in Outcomes Research

**For over a decade, the Department of Health Policy (DHP) has offered outcomes research fellowships for doctoral graduates.** Through the program, fellows learn to design, implement, and communicate the results of outcomes research studies and develop an understanding of policy implications.

In 2004, DHP partnered with GlaxoSmithKline to offer a physician outcomes research fellowship. The program consists of two years of post-graduate training. During the first year, the fellow will work under the mentorship of Dr. Nash at our office in Center City, Philadelphia. The fellow's primary role will be to serve as a member of the DHP Research Group. The fellow will also be encouraged to take classes in epidemiology, biostatistics, research design, and health policy and will have the opportunity to attend and present at DHP's short courses, research meetings, journal clubs, health policy forums, and sponsored educational programs. Writing skills will be developed through publication of the fellow's research projects and authorship of articles for the peer-reviewed journals. During the second year, the fellow will work as a researcher within the Global Health Outcomes department of GlaxoSmithKline, located in the Philadelphia area. A competitive stipend is provided.

Recruitment is underway for the 2006-2008 fellow, who will begin in June 2006. Applicants must be U.S. board eligible or already have U.S. medical licensure. Experience in health services research and/or health policy is preferred.

To apply, please contact Laura Pizzi, PharmD, MPH, Associate Director of Research, at **215-955-1159** or [laura.pizzi@jefferson.edu](mailto:laura.pizzi@jefferson.edu).



## New Publications from the Department of Health Policy

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# A Medical Student's Experience in the Dean's Summer Research Program

During the summer of 2005, I participated in the General Medicine Summer Research Program, a research experience funded by the Office of the Dean at Jefferson Medical

College (JMC). The program offers five students the opportunity to conduct ten-week research projects in diverse fields that might include dermatology, embryology, neurosciences, orthopedics, and radiation oncology. As one of these five students, I chose to work with Dr. David Nash in the Department of Health Policy. Under his guidance, I completed four projects that contribute to the Department's goal of improving the quality and safety of medical care, and thereby the health of the public. The experience offered me a unique perspective on policy issues that will affect my career as a physician in the future.

For my first project, I developed a teaching agenda on current and future prospects for the safety of ambulatory medical care. This project sought to investigate issues of patient safety in the ambulatory setting that have yet to receive significant attention despite the Institute of Medicine's groundbreaking report *To Err is Human*. In conducting this research, I gained a profound understanding of a systems-oriented approach to analyzing medical errors. This type of analysis introduced me to a variety of developing strategies to improve the safety of ambulatory care, such as the implementation of electronic medical records and computerized physician order entry systems. This teaching agenda will serve as the basis for a presentation to the Jefferson University Physicians (JUP) Clinical Care Committee, the Jefferson medical group piloting several outpatient improvement projects.

Together with Jon Veloski, Director of Medical Education Research, in JMC's Center for Research in Medical Education and Health Care, I drafted a manuscript assessing whether third-year medical students' participation in the Department of Health Policy's 2005 Interclerkship Day changed their attitudes and beliefs related to medical errors and patient safety. Interclerkship Day is an annual, full-day program in the middle of students' third year that includes plenary speakers, a presentation by the Dean, and a choice of 2 of 9 afternoon workshops related to patient safety. This manuscript has been submitted for publication in a scholarly journal.

In addition, I created an annotated bibliography and wrote a book review. The annotated bibliography covered the last ten years' worth of literature specifically focused on practice-based learning and systems-based practice, the newest of the six Accreditation Council for Graduate Medical Education's (ACGME) core competencies. The bibliography should provide physicians and educators with a useful reference for teaching and evaluating these two core competencies. My book review examined *The Public Financing of Pharmaceuticals: An Economic Approach*, edited by Jaume Puig-Junoy. The review can be found in *PharmacoEconomics*.<sup>1</sup>

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Furthermore, I gained greater insight into these and other policy issues by attending conferences with national thought leaders, including the Jefferson Industry Advisory

Council, the Disease Management Colloquium, the 11th Annual Department of Health Policy Summer Seminar on Pay for Performance, and the Pennsylvania eHealth Technology Summit. I also sat in on JUP Clinical Care Committee and management update meetings within our own institution.

Overall, this program developed and expanded my understanding of current issues in health policy. The knowledge I have gained throughout this experience has further motivated me to become an effective leader in the medical field. I am fortunate that Jefferson Medical College is one of a few institutions to offer medical students hands-on experience in health policy, experience that all future physicians in our healthcare system should have.

## REFERENCES

1. Moskowitz E. Book Review. *Pharmacoeconomics*. 2005;23(9):965.

## Senior Scholars Program:

Building Connections with the Department of Health Policy

The Department of Health Policy of Jefferson Medical College created the Senior Scholar program as an alternative to traditional faculty affiliations (i.e., adjunct or secondary status). The Senior Scholars program provides the opportunity for individuals to benefit from an association with the Department while contributing meaningfully to current Department research, mentoring, teaching, funding, and/or publication activities. Professionals from government, industry, business, marketing, academia, and medicine are encouraged to apply. For further information, visit the Department website at [www.jefferson.edu/dhp](http://www.jefferson.edu/dhp) or call **215-955-6969**.

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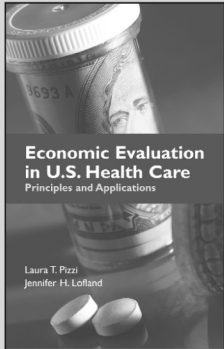


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*Do you have an opportunity for medical students? For more information or to become a host for a medical student as part of the the Dean's Summer Research Program in General Medicine or one of the other research opportunities available to medical students, contact Karen Novielli, MD, Associate Dean for Faculty Affairs, Associate Professor of Family Medicine, at [karen.novielli@jefferson.edu](mailto:karen.novielli@jefferson.edu), or visit [jeffline.tju.edu/Researchers/student\\_research/jmc.html](http://jeffline.tju.edu/Researchers/student_research/jmc.html).*

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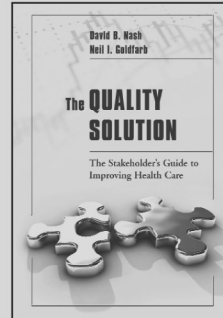
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# NOTICES

## College for Advanced Management of Employee Benefits

As reported in the December 2004 issue of the Health Policy Newsletter, this four-day training program is designed to improve employers' skills in obtaining value (improved quality and/or lower cost) when purchasing health benefits. Upcoming programs are scheduled for:

**February 21-24, 2006**  
Las Vegas, NV

**April 25-28, 2006**  
Philadelphia, PA

**September 18-21, 2006**  
Charlotte, NC

## The Health Policy Forum: Upcoming Speakers Winter 2006

*We are pleased to announce our January – April 2006 schedule for the Health Policy Forum. The Forum meets on the second Wednesday of each month 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.*

**January 11, 2006**  
*Stanley Music, MD, DTPH (Lond.)*  
Safety Surveillance Physician  
Benefit-Risk Management  
Johnson & Johnson  
Small Pox and Beyond

**February 8, 2006**  
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Professor of Management  
Wharton School,  
University of Pennsylvania  
Emergency Action Teams

**March 8, 2006**  
*David St. Clair*  
President  
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Quality of Medical Care

**April 12, 2006**  
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**For more information on any of these programs please contact David B. Nash, MD, MBA at (215) 955-6969 or [david.nash@jefferson.edu](mailto:david.nash@jefferson.edu)**

## Jefferson Alumnus Dr. John P. Whitecar Designates his Annual Donation to the Department of Health Policy

Dr. David B. Nash, MD, MBA would like to formally acknowledge John P. Whitecar, Jr, MD for his generous contribution to the Department of Health Policy at Jefferson Medical College.

Dr. Whitecar, a native Philadelphian, graduated from Jefferson Medical College in 1964. He is a medical hematologist-oncologist in Columbus, MS. His older daughter, Linnane Batzel, MD, MBA, an emergency room specialist, graduated from Jefferson Medical College in 1999. Though she ultimately received her MBA from Penn State, she was in the first class of the Jefferson MD, MBA program. His younger daughter, Colleen Whitecar, is currently a senior at Jefferson Medical College.

Dr. Whitecar has served as a role model and leader for others. At Jefferson Dr. Whitecar was president of Alpha

Omega Alpha (AOA) Honor Medical Society (1963-64). He established the Medical Oncology Program at Brooke Army Medical Center in Houston, Texas. A solo practitioner since 1970, Dr. Whitecar is a Platinum Member of the Hope Foundation, whose mission is to support clinical cancer research all over the world. He is also a member of the Southwest Oncology Group (SWOG), one of the largest of the National Cancer Institute-supported cancer clinical trials cooperative groups in the United States. SWOG's primary mission is clinical research in the prevention and cure of cancer in adults.

Once again, the Department of Health Policy would like to express its gratitude for Dr. Whitecar's gift, which will support ongoing departmental activities such as the Health Policy Newsletter.



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