

Population Health *Matters*

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GUEST EDITORIAL

Tightening Our Belts in the New Healthcare Economy

Coming soon: austerity in healthcare. During the “Great Recession” of recent years, those of us employed in healthcare have largely avoided the tumult experienced in other sectors, like housing and finance. Jobs have actually been added to the healthcare sector, payments for healthcare services have remained stable enough to sustain the system, and new opportunity presents itself with more Americans likely to obtain coverage as a result of the Affordable Care Act (ACA). Let’s face it, we’ve been quite fortunate.

However, from a budgetary standpoint, we face unprecedented challenges. The fiscal cliff legislation, passed at the 11th hour on January 1, preserves payments to physicians but cuts payments for end-stage renal disease (estimated savings \$4.9 billion), resets the base for certain types of Medicaid payments to hospitals (estimated savings \$4.2 billion), and recoups past overpayments to hospitals through documentation and coding adjustments (estimated savings \$10.5 billion). Additional healthcare spending reductions are likely in coming months when Congress renews its battle over increasing the debt ceiling, and tradeoffs in the form of more spending cuts are already part of the political discussion.

The addition of newly-covered patients under ACA, coupled with these budgetary challenges, means the system will have to provide more care for less money. Meanwhile, the overhead cost of simply “doing business”—compliance with regulations, performance measures, and accreditation standards—seems to be going up. As someone who has grown accustomed to stability, these changes are fast, furious, and frightening. What will be the key to our success in this new era of healthcare? I’ve thought about this and keep coming back to the same word: efficiency. Never has there been a greater need to understand how to best spend our healthcare dollars. We need to recognize what are the most resource intensive components of care, and determine whether there are ways to deliver those components more cheaply or quickly—all while maintaining our shared priority of excellence in patient care.

As an applied health economics researcher for 15 years, I’m seeing the “efficiency” theme play out every day in my work. The overall demand for cost data is increasing, but the nature of the questions to be answered by these data is changing. A decade ago, a common question was: “Is

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the treatment cost effective?” Now, the usual questions are: “What will it cost to implement this treatment?”, “How can the treatment be implemented most efficiently?” and “What will be the return on investment if we implement this treatment?” In other words, the conversation is shifting away from a willingness to accept increased costs for treatments that are more effective, and towards purely budget-based and operational decision making aimed at determining how to do things more affordably. From a scientific perspective, this shift suggests that cost-benefit analyses will emerge as the most relevant type of cost analysis (the goal being to determine whether investment in a treatment results in net financial benefits, i.e., savings, elsewhere in the system), with the more traditional cost-effectiveness analyses (where one considers the incremental cost per incremental health benefit compared to the standard of care) potentially falling out of favor.

Consider, for example, a key area of pharmaceutical innovation -- the new oral

anticoagulants dabigatran, rivaroxaban and apixaban. While real-world evidence on the effectiveness and safety of these drugs is still emerging, from an economic standpoint the key question is whether the higher price of these drugs is offset by measurable efficiencies in the form of reduced patient monitoring and counseling requirements when compared to warfarin. Next, consider improved testing for diagnosis and staging of prostate cancer. Here the question is also whether the additional costs of the test are offset by more efficiently targeting men who need treatment, and avoiding unnecessary treatment in men who are unlikely to benefit. Finally, consider patient support programs for seniors with mild-to-moderate dementia. Again, the key question is whether investment in coaching the patient and their family caregivers -- perhaps even making infrastructural improvements to the home -- could delay formal paid caregiving and admission to long-term care. Just start looking around at the innovations being considered in

your area of healthcare and you will notice this shift which now spans across drugs, devices, diagnostic assays, and patient support programs.

Members of the healthcare community, we need to collectively acknowledge this new reality and embrace it because, short of a miraculous economic recovery, healthcare budget cutting will present very difficult challenges. It may be politically unpopular for the government to formally support or mandate cost analyses, but we desperately need these data in order to understand how to treat patients most efficiently. Those of us in the trenches can and will be doing this work—we no longer have a choice. I hope you will join me in supporting it as a key component of the critical real-world evidence necessary to inform healthcare decisions. ■

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The Jefferson Longitudinal Study of Medical Education: Five Decades of Outcomes Assessment

The year 2013 marks the matriculation of the 50th cohort of medical students whose careers are followed in the Jefferson Longitudinal Study of Medical Education. Over 11,000 individuals have been tracked since the first group entered in 1964, accumulating hundreds of pieces of data on each as medical students, house officers and medical professionals throughout their careers. Conceived based on a belief that medical schools have a professional and social obligation to monitor the quality of their educational products, the Longitudinal Study is a resource for faculty development, professionalism, academic management and institutional research to support accreditation requirements.

The Study supports faculty development by enabling faculty members to evaluate educational efforts scientifically, and to produce peer-reviewed publications and presentations to foster their scholarship and careers. After nearly five decades the

Study, which now comprises millions of pieces of data, has produced more than 185 peer-reviewed publications. The majority of these studies involved Jefferson faculty outside the Center for Research in Medical Education and Health Care.

The Study has established Jefferson’s leadership in monitoring important professional career outcomes not routinely tracked by national organizations. New, psychometrically sound tools have been developed to measure lifelong learning and other aspects of professionalism through periodic follow-up surveys of graduates. For example, in a recent study supported by an invitational grant from the Edward J. Stemmler, MD Medical Education Research Fund of the National Board of Medical Examiners, we developed the *Jefferson Scale of Physician Lifelong Learning* to assess physicians from the classes of 1975 through 2000.¹ The responses of these 3,195 physicians, whose ages at follow-up

ranged from 29 to 66 years, indicated that lifelong learning in medicine is a function of three factors: personal motivation, information-seeking skills and attention to learning opportunities. High scores on lifelong learning were associated with career satisfaction and indicators of valued professional accomplishments such as research, publication, participation in professional groups and appearing in the media and appearing before community groups. As expected, the academic clinicians scored higher on measures of lifelong learning than full-time clinicians. Examples of other professionalism tools that we have developed for the Study include the *Jefferson Scale of Empathy*, the *Jefferson Scale of Attitudes toward Physician-Nurse Collaboration*, and the *Jefferson Scale of Attitudes toward Physician-Pharmacist Collaboration*.²

The Longitudinal Study provides systematic empirical data on the short-term

and long-term outcomes of admissions policies, curricular innovations and complex decisions on students' academic progress. For example, the Admissions Committee has used data from the Study to review the predictive relationships between admissions criteria and academic performance. The Curriculum Committee has used data to study the impact of options such as the Penn State Accelerated Program and Physician Shortage Area Program on graduate outcomes. Formal outcome reports drawn from the Study provide solid evidence and remind students of the highly successful track record and diverse career paths of their predecessors.

The Study provides a solid foundation for institutional research on educational outcomes, enabling the faculty and administration to provide information required by accrediting bodies such as the Liaison Committee on Medical Education (LCME) and the Middle States Commission on Higher Education.

The confidential electronic database includes students' demographics, personal characteristics and academic qualifications before medical school, and extends through their undergraduate and graduate medical education. It includes comprehensive measures of academic and clinical performance at Jefferson based on objective tests, faculty ratings of clinical performance in core clerkships, scores on licensing examination, and clinical performance involving simulated patients and various simulation devices. Several aspects of the Study's database distinguish it from other attempts reported in the literature.³ First, it includes competence ratings provided over the decades by thousands of residency program directors throughout the country that have observed the performance of Jefferson graduates in their first year after earning their MD degree. Second, throughout every graduate's career the Study tracks their key professional outcomes, which are continuously monitored and reported by national professional groups. These

outcomes include faculty appointments at all LCME-accredited medical schools available from the Association of American Medical Colleges, board certification awarded by the member boards of the American Board of Medical Specialties, and individual career attributes such as employment, practice setting and geographic location surveyed by the American Medical Association. ■

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Readers interested in learning more about the structure and function of the Study can refer to a succinct one-page outline published recently in Academic Medicine: http://journals.lww.com/academicmedicine/Fulltext/2011/03000/AM_Last_Page_The_Jefferson_Longitudinal_Study_of.34.aspx

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JSPH Online Information Sessions

Learn More About Our Academic Programs

Healthcare Quality and Safety / Healthcare Quality & Safety Management / Health Policy
Wednesday, March 6, 2013 from 12 noon – 1 pm Eastern

Applied Health Economics and Outcomes Research
Wednesday, March 20, 2013 from 12 noon – 1 pm Eastern

Healthcare Quality and Safety / Healthcare Quality & Safety Management / Health Policy
Wednesday, April 3, 2013 from 12 noon – 1 pm Eastern

Applied Health Economics and Outcomes Research
Wednesday, May 15, 2013 from 12 noon – 1 pm Eastern

For more information call (215) 503-6125 or visit:
http://www.jefferson.edu/population_health/campus-events-open-houses.html

Jefferson Interprofessional Clinical Rounding Project: An Innovative Approach to Patient Care

The complexity and risks associated with chronic conditions related to the aging population in the US pose a challenge to managing chronic illness care. Emerging research has suggested that improved collaboration among health care providers can mitigate many risks to patients. Numerous reports over the past two decades have made strong recommendations for the inclusion of interprofessional practice in today's health care system.^{1,2,3} Given the increased recognition of the benefits of interprofessional approaches, educators are encouraged to re-examine the educational practices of pre-licensure health professional students in clinical settings. Evidence suggests that education in clinical settings is one of the more effective strategies to promote realistic and meaningful interprofessional interaction.⁴

Bedside rounding has been an historical clinical model that brings together care providers and the patient to discuss the plan of care, treatment adjustments, and discharge planning goals. Interprofessional clinical rounding is an approach that uses this historical model to involve students from multiple health professions. Given the complexity of patient conditions, this approach has the potential to have a positive impact on patient safety through increased collaboration and communication, which could potentially improve patient care while reducing hospital costs and length of stay.

The team of the Jefferson Center for Interprofessional Education (JCIPE), along with Jefferson Medical College (JMC) and Jefferson School of Nursing (JSN) faculty in collaboration with the colorectal surgery service at Thomas Jefferson University and Hospitals (TJUH), initiated a pilot project in the Spring of 2012 to re-design the bedside rounding format as an educational clinical training venue for pre-licensure students. Eight sessions were held during the spring. The number of patients seen varied from 1 to 3 per session.

This pilot project brought together medical and nursing students in collaboration

with Dr. Gerald Isenberg, colorectal surgeon and director of undergraduate surgical education in JMC. The purpose of the project is to provide a real-time, collaborative practice experience for health professional students to “learn with, from and about each other.”⁵

Each team consisted of 3rd and 4th year medical students, senior nursing students and those in the Facilitated Academic Coursework Track (FACT) along with their instructors. Interns, residents and fellows comprised the team of the attending physician (AP). In addition to the team of the AP at least one nursing student and one medical student participated in each of the patient encounters. Students met as a team early in the day to review patients' data from their discipline-specific perspective, discuss the case with each other, and then round with the AP, Dr. Isenberg, and his team. Prior to entering the patient's room, each student made a presentation of the patient case. The AP used these presentations as an educational opportunity, asking probing questions regarding the patient's care, based on the chart and the reports by the team members. At the conclusion of the visit to the patient's room, additional questions were asked based on any new observations, and to prioritize the care plan of the patient and make any necessary modifications.

Evaluators from JCIPE used a structured observation form designed to assess the team members' interaction during the process. Observers noted whether there was a sharing of information from all those involved in the case, whether participants paid attention to each other and if students supported each other's ideas. A debriefing of students and faculty followed at the conclusion of the round to gain insight into the student and physician experience. The debriefing protocol consisted of open-ended questions designed to learn about the things that students valued from the experience, what they learned about interprofessional approaches and what skills were needed to be successful in this experience.

Observations

The students seemed comfortable in the process and there appeared to be open and honest interaction among team members. For example, in one case a student admitted not knowing the answer to a question and seemed to feel comfortable admitting it. All of the students seemed to be well prepared to discuss each case and the entire group was very attentive during all of the interactions. The AP did a thorough job throughout, asking questions and getting all of the participants involved.

Debriefing

Summaries of the debriefing sessions at the conclusion of the rounding project revealed a high level of satisfaction on the part of all members of the team. Students reported that meeting and getting to know other students was very helpful and stimulated the building of bridges between the disciplines. They reported that the interprofessional approach opened the lines of communication and increased the interaction among members of the team. They indicated that input from different professions gives everyone a new perspective and results in a more integrated care plan. For example, using first names removes some of the barriers to communication and supports a more friendly environment.

Students claimed that even in routine cases, Interprofessional care IPC is valuable because it provides members of the care team with additional information which makes the process more efficient. Decision making moves down to lower levels and care is managed at the resident level with “protection” from above. Students also perceived the approach to be more patient centered because of the multiple disciplines providing different perspectives of the situation. Some of the students claimed that they were able to gain more in-depth knowledge about the patient as a result of this experience.

Students identified good communication skills (e.g., active listening, being respectful

of other viewpoints, avoiding talking down) as key to participating successfully on an interprofessional team. They also mentioned the importance of having a good understanding of medical terminology, having self-confidence and the ability to focus on the situation in order to be prepared to answer questions.

From the attending physician's perspective, this was a re-energizing experience. He reported that people were asking more questions, enabling him to get more insight into the patients' condition. When there was an adverse event, responsiveness improved because members of the team on site were able to provide the AP with first-hand information rather than reading about it on the chart. Interprofessional teamwork results in a change of attitude, going from "my stuff" and "your stuff" to "our stuff."

Students perceived a few downsides to the IPC approach. Coordinating time and schedules of the team members can be a problem if there are many patients. Another potential problem would be that a patient could get scared or overwhelmed by having so many people in their room. Another believed that students could be intimidated if

their personality was less assertive.

When asked about the things they liked best about the experience, one of the nursing students mentioned being on the same level as medical students and being treated as an equal. Others reported that they enjoyed the interaction with other professions, had a more in-depth experience than would usually be the case and additional opportunities to meet with the physicians. They also thought that getting to know the patients better was a real plus. Finally, there appeared to be a consensus that the Health Mentors Program, a two-year interprofessional experience conducted by JCIPE, helped prepare them for this experience.

The results of the project suggest that a true interprofessional collaboration can be accomplished successfully in a clinical setting. The program has been continued during the fall with the inclusion of pharmacy students. Future program initiatives will be to conduct a similar program in a rehabilitation unit and in the ambulatory care center based in Family Medicine. Medical, nursing, occupational therapy, pharmacy and physical therapy students will be involved in these programs. ■

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Note: We would like to thank the following individuals for their comments on this article and their contributions to the clinical rounding project. Mary Hanson Zalot, MS, RN, Carolyn Giordano, PhD, Julia Ward, PhD, and Karen Papastrat, RN, MSN.

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Jefferson School of Population Health invites you to join this new membership organization. Named for our longtime benefactor and champion, **Raymond C. Grandon, MD**, and his wife, **Doris**, the Grandon Society is designed for leaders throughout the healthcare sector who are dedicated to transforming the US health care system through collaboration, education and innovation.

Benefits of membership include exclusive member-only programs and events, a member e-newsletter, and early notice and special registration rates for JSPH conferences and events.

Memberships are available for individuals and for organizations, with special rates for academic, non-profit and government institutions.

For more information visit: http://www.jefferson.edu/population_health/GrandonSociety.html.

JSPH Online CME Collaboration with Johns Hopkins University

The Jefferson School of Population Health is establishing exciting new partnerships to enhance professional development and CME opportunities that are directly relevant to clinical practice in this changing healthcare landscape. A recent collaboration, **The Johns Hopkins University Practice Improvement Strategies in Cardiometabolic Disease Therapies**, presents a complimentary PI-CME activity that provides primary care physicians, endocrinologists, cardiologists, NPs and PAs with the tools to measure quality of care and to identify opportunities to improve the outcomes for their patients with cardiometabolic disease.

All practicing clinicians can earn 20 CME/CE credits without the need to attend a live or online program. After collecting some basic data on their patients, participants

will be provided with benchmarking reports that satisfy American Board of Internal Medicine (ABIM) MOC Part IV requirements. Participants will also receive detailed clinical reports analyzing care delivered to patients with cardiometabolic disease against individual peers (anonymously) and national trends. The program will also provide exclusive access to a secure and moderated “mentor program,” an online Q&A forum with nationally-recognized experts in the field.

Clinicians are invited to share the benefits of the educational grant funding that supports this program. Each participating practice is eligible to receive \$500 to support the collection of data on 25 patients with diabetes, hypertension, dyslipidemia and/or obesity. Funds are limited and will be awarded on a “first come, first served” basis.

Interested practices are encouraged to complete a brief registration online at <http://jhucardio.imedicaldecisions.com>, or to contact us by email at PIsupport@imedicaldecisions.com, or to call (610) 891-1640. ■

The Johns Hopkins University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Johns Hopkins University School of Medicine designates this PI CME activity for a maximum of **20.0 AMA PRA Category 1 Credit(s)**[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Health Care Quality Improvement and Education in Diabetes Management

Overcoming Clinical Inertia to Achieve Glycemic Goals

This 3-part CME meeting series from the American Diabetes Association and Thomas Jefferson University is intended for practicing clinicians who manage patients with diabetes and will guide attendees through a quality improvement process using actual data from Jefferson clinics. Topics will focus on improving glycemic control by identifying and addressing common barriers to optimal care.

- WORKSHOP #1 FROM DATA TO INSIGHT • JANUARY 23, 2013**
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Addressing Real-World Barriers to Achieve Optimal Diabetes Management
- WORKSHOP #3 IMPACT & IMPLICATIONS • SEPTEMBER 2013**
Addressing Improvement and Identifying Persistent Barriers in Diabetes Management

All workshops will take place at Thomas Jefferson University.

For additional information and to register visit: <http://ADAPHL2013.imedicaldecisions.com>

The Quality and Safety Leadership Series

JSPH has recently launched a live series of educational programs focused on quality and safety.

As healthcare expenditures continue to rise, stakeholders across the healthcare system are searching for ways to improve the quality of care and optimize the use of resources. Achieving these goals requires engaging and educating each participant – patient, payer, and provider – so they can better understand the issues and work together toward meaningful solutions. The Patient Protection and Affordable Care Act has led to the introduction of several new initiatives aimed at increasing accountability for outcomes and delivering a higher return on healthcare expenditures.

To help all stakeholders understand and adapt to this transition, JSPH has developed a live educational series focused on quality and safety leadership. The faculty for this program is drawn from

among some of the top experts in the field from across the country.

The Quality and Leadership Series (QSL) is a live series of customized educational programs designed to meet the unique needs of healthcare professionals, whether they have clinical or administrative responsibilities. Through the generous support of Sanofi US, JSPH developed this series to connect some of the nation's foremost experts to healthcare professionals across the country.

Programs are geared toward institutions and professional associations seeking to learn how to improve the quality and safety of healthcare delivery. Content is adapted for each program to meet the unique needs of each audience and organization that

requests a program. There is no cost to the requesting organization; JSPH simply requests that all attendees complete a post-program evaluation.

JSPH maintains a catalog of faculty and topics, available at <http://www.jefferson.edu/qsls>. QSL program staff work to identify appropriate faculty based on the information submitted, and work closely to facilitate program planning between the speakers and the requesting organization. ■

For more information or to request a QSL program, visit <http://www.jefferson.edu/qsls> for a request form that can be sent via e-mail to QSL staff at qsls@jefferson.edu. You may also contact us by phone at (877) 662-7757.

Meeting the Challenge: Technological Advances in Stroke Rehabilitation

MossRehab Symposium

June 1, 2012

MossRehab is a renowned physical and cognitive rehabilitation center. It is among *U.S. News & World Report's* top ten rehabilitation facilities in the country and is the top-ranked facility of its type in Pennsylvania. Every year MossRehab treats more than 2,400 inpatients at its six inpatient locations, including the flagship 130-bed facility in Elkins Park, and provides care for more than 140,000 outpatients at 14 locations throughout the Greater Delaware Valley.

Established in 1959, MossRehab is committed to care, to minimizing the effects of disability, and to enhancing the independence of the individuals it serves. Part of MossRehab's commitment is evidenced by its drive to educate and provide the most technologically advanced care possible.

MossRehab is a center of research and therapeutic use of rehabilitation interventions that make use of robotic and computerized technology for patients with stroke. The Moss Rehabilitation Research Institute (MRRI) sponsors interdisciplinary research aimed at improving human function and adaptation to disability. Survivors of stroke often live with significant disabilities. Through research, MRRI scientist's findings form the basis for new treatment approaches used at MossRehab and many other facilities. Patients have the opportunity to participate in various studies and have access to some of the latest findings regarding the use of these technologies in stroke rehabilitation. The growing use of robotic and computerized technology in neuro-rehabilitation promises a brighter future for patients who have residual deficits due to stroke. Progress is being made

to help patients regain speech, reacquire use of impaired extremities and relearn the basic tasks needed for everyday living.

The use of robotic and computerized technology enables individuals to make very precise repeatable movements. The intention is to increase the intensity of the intervention, which improves the effectiveness of treatment while reducing potential injuries for therapists. Robotic devices have a clear edge over manual therapy in that they enable the repetition of exact movements while avoiding variations due to fatigue, spasm or pain in the patient as well as fatigue or distraction in the therapist. It is this consistency that is the key for effective rehabilitation. Researchers at MossRehab are actively studying the efficacy and safety of these technologies

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in neuro-rehabilitation. Research findings suggest that their use in rehabilitation boosts the performance levels of those with chronic stroke, showing that patients with long-standing dysfunction can respond effectively even after long periods of time. As technology continues to progress and proliferate, robotic and computer-assisted therapy will become an integral part of the care we provide.

These advances were the driving force behind the focus of this year's stroke symposium, entitled, "Meeting the Challenge: Technological Advances in Stroke Rehabilitation." The educational objective was for participants to gain a better understanding of the technologies available and to recognize the criteria for their use and implementation in the stroke rehabilitation population. Attended by over 125 professionals, the symposium showcased the most advanced technology available in rehabilitative care and innovations created by members of MossRehab's own staff.

MossRehab is committed to offering the highest level of clinical service and dedicated to moving the field of medical rehabilitation forward through research, advocacy and education. MossRehab believes that the sharing of knowledge with other caregivers, professional and non-professional alike, is imperative if we are to provide the highest quality care for persons with stroke. For these reasons MossRehab is delighted to share its discoveries, innovations and knowledge with other professionals and the community at large. ■

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*For more information on MossRehab,
educational opportunities or
assistance with patient care you
may visit www.MossRehab.org
or 1-800-CALL-MOSS.*

Highlights of the topics covered by MossRehab staff during this year's symposium included:

Aphasia Rehabilitation: Using State-of-the-Art Technology to Enhance Treatment Outcomes and Communicate Effectiveness.

Ruth Fink, MA, CCC-SLP

The focus of this presentation was the software program developed by MossRehab researchers and clinicians called MossTalk Words®.¹

RELEAS™ To Promote Functional Integration of the Hemiparetic Hand During Activities of Daily Living

Joseph R. Padova, OTR/L

The RELEAS™ helps restore hand function for those who have lost the ability to open and close a hand due to a stroke or other neurological problems.

Interventions for Neglect: Prism and Mirror Therapy

Jaun May, MOT, OTR/L

This presentation focused on the MossRehab Research Institute and the Right Hemisphere Stroke Center's use of prism and mirror therapy to address neglect.

Technology to Extend Mental Health Treatment for Stroke Survivors

**Paul Bach, PhD and
Claire McGrath, PhD**

In response to growing need, an innovative mental health service provided through the new Neuro Mental Health Outpatient Clinic, a collaborative effort between Belmont Behavioral Health and MossRehab, was developed.

The G-EO Evolution System: New Body Weight Support Device For Gait and Stair Climbing Training in Stroke

**Michael Parlatore, PT, DPT, and
Theresa Toczylowski, MPT**
The G-EO Evolution System, a new body weight supported robotic device, designed to simulate both gait and stair performance of the neurologic population, is effective in the rehabilitation of stroke patients.²

Use of Tibion in the Acute Rehab Setting

Sarah Godlewski, MSPT

The Tibion is a non-invasive battery powered dynamic device which supplements muscle strength, provides sensory input, assists mobility, and provides force transfer in response to limb loading and knee movement.²

Using Fiberoptic Endoscopic Evaluation of Swallowing (FEES) for Management of Dysphagia in the Stroke Population

Stephanie Dunn, MS, CCC-SLP

FEES allows the evaluation of the structures and function of the upper aero-digestive tract, making it a perfect diagnostic tool for use in the evaluation of dysphagia in stroke patients.

Neuromuscular Electrical Stimulation: VITALSTIM® as an Adjunct to Dysphagia Therapy

Jody Goldsborough, MA, CCC-SLP

VitalStim®, a neuromuscular electrical stimulation modality, is an FDA-approved device specifically designed for use with patients with dysphagia.

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Population Health Forums

Formerly Health Policy Forums

Empathy in Patient Care – Myth or Reality?

Mohammadreza Hojat, PhD

*Research Professor of Psychiatry
and Human Behavior*

*Director, Jefferson Longitudinal Study,
Jefferson Medical College*

October 10, 2012

This informative Forum began with definitions of *empathy* and *sympathy*, and the distinctions between the two. Factors that influence and enhance physician empathy were discussed. The Jefferson Scale of Empathy (JSE) was presented as an internationally recognized valid tool to measure the phenomenon. Research utilizing the scale was presented, and future areas of research were outlined.

Dr. Hojat, who has authored over 180 publications on the use of psychometric testing and medical education, began the Forum program by explaining that empathy is a phenomenon that can be defined operationally (as described by psychologist Carl Rogers) and measured quantitatively. The JSE is a

Daniel Z. Louis, MS

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20-item Likert-scale questionnaire. Due to its proven validity and reliability to measure empathy in medical care, it has been used in 60 countries and 42 languages to answer numerous psychological and education questions as well as to evaluate the impact of empathy on clinical outcomes. Empathy tends to be higher in women and in physicians who select patient-oriented rather than technology- or procedure-oriented specialties. It is correlated with clinical competence, classmate perception of professional attributes, patient compliance and patient satisfaction.

Mr. Louis presented data from studies conducted at Jefferson and in Italy correlating physician empathy and clinical outcomes for

Vittorio Maio, PharmD, MS, MSPH

*Associate Professor
Jefferson School of Population Health*

patients with diabetes. Both published studies displayed robust data with large sample sizes. At Jefferson, higher physician empathy scores were associated with improved outpatient control of blood glucose and lipids. In Parma, Italy, higher physician empathy scores were correlated with fewer metabolic complications in hospitalized diabetic patients. ■

*For more information on this research
contact: Mohammadreza.Hojat@jefferson.edu*

*To read the latest publication on this
research visit: [http://journals.lww.com/
academicmedicine/Fulltext/2012/09000/The
Relationship_Between_Physician_Empathy
and_26.aspx](http://journals.lww.com/academicmedicine/Fulltext/2012/09000/The_Relationship_Between_Physician_Empathy_and_26.aspx)*

Grandon Workshop

A special additional session of the Population Health Forum for Grandon Society Members

Stefano Del Canale, MD, PhD

*Research Coordinator and Primary Care Physician
Coordinator of the Primary Care Team, Local Health Authority, Parma, Emilia-Romagna, Italy*

Dr. Del Canale joined the session live via Skype from Parma, Italy to discuss the role and cultural implications of empathy in the Italian Universal Health System.

Dr. Stefano Del Canale, research coordinator of the Parma, Italy primary care team and Dr. Vittorio Maio, Associate Professor of the Jefferson School of Population Health, relayed to the attendees the cultural expectations associated with empathy. In Italy's universal health care system, longstanding relationships are established between patients and their assigned primary care providers. Physician empathy for patients who are socially distressed, isolated or who are dying is viewed as a demonstration of the validity and effectiveness of the Italian health system.

This unique session concluded with a discussion of factors that teach empathy to medical students. Chief among these are service projects and an empathic physician role model.

In summary, the presenters provided an engaging discussion concerning the role of empathy in health care, its influences, cultural expectations and impact on clinical outcomes in diabetes. Further research ideas include identifying approaches to sustain empathy in health care providers and utilizing the JSE to identify a cutoff level at which empathy training is indicated.

Would you like to learn more about the Grandon Society? Visit: http://www.jefferson.edu/population_health/GrandonSociety.html

Population Health: Integrating Medicine and Public Health

Marc N. Gourevitch, MD, MPH

*Professor and Chair, Department of Population Health
NYU School of Medicine*

November 14, 2012

Dr. Gourevitch is Professor and founding Chair of the Department of Population Health at the NYU School of Medicine. Dr. Gourevitch leads initiatives to improve population health through interventions in health care delivery, bridging multiple departments and several of NYU's schools. He is also Co-Director of the Community Engagement and Population Health Research Core of the Clinical and Translational Science Institute that bridges NYU with New York City's municipal hospital system, the Health and Hospitals Corporation.

On the heels of Hurricane Sandy, Dr. Gourevitch opened this Forum by sharing a glimpse of the current situation and how medical facilities, including NYU, were impacted by the storm. He described the massive organizational challenge involved in transferring patients, and reassigning medical personnel and students. It was certainly impressive that this occurred safely and seamlessly.

The term "population health" is often used interchangeably with "public health" yet nuances exist within these terms and Gourevitch helped the audience to understand the differences and similarities. He first gave a historical

overview of the relationship between medicine and public health. For example, after initial alignment in the early 1900s, the fields diverged by the middle of the century as separate educational paths evolved. In recent years there has been a movement toward greater alignment.

Gourevitch defines public health as what we do as a society to assure conditions in which people can be healthy. Traditionally this included a set of functions advanced by health departments and governmental agencies. He describes population health as the science of understanding and optimizing the health of populations of persons. In the population health framework, determinants of health include medical care and health systems.

To further hone in on the theme of population health, Gourevitch analyzed how population health is viewed by academic medical centers (AMCs) and their associated healthcare delivery systems. The focus of AMCs' clinical systems is increasingly aligned with the Triple Aim (improving care, improving health of populations, and reducing costs). To fully understand population health, determinants of health beyond health care

delivery, and a focus on all patients in a geographic area, need to be considered, Gourevitch explained.

The separation between population health strategies and clinical strategies can be bridged by many fields and areas of expertise including: community health; health economics; health policy; comparative effectiveness; behavior change; biostatistics; epidemiology; health disparities; and health delivery science. Gourevitch identified ways in which AMCs house these themes in the current academic landscape.

Gourevitch summarized this Forum presentation by outlining some of the major challenges and opportunities. Incentivizing investments that bridge the divide between clinical and population-oriented strategies will continue to be a significant challenge. Additionally, the economic case for investments in population health must be strengthened. The ACA focus on system accountability creates opportunities for health. AMCs are becoming more in sync with a population health focus. Gourevitch emphasized that tremendous possibilities exist that will help to align clinical delivery systems with public health goals. ■

Less Talk, More Action: Accelerating Innovative Strategies to Eliminate Health Disparities

Stephen B. Thomas, PhD

*Professor, Health Services Administration
Director, Maryland Center for Health Equity
School of Public Health, University of Maryland*

December 19, 2012

Dr. Thomas highlighted the activities of the Maryland Center for Health Equity, a designated Research Center of Excellence Minority Health Disparities, by the NIH National Institute on Minority Health and Disparities. The Center identifies the social

context of health disparities in order to better address them. Breaking the poverty cycle, improving access to quality health care, fixing environmental hazards in homes and neighborhoods, and implementing effective programming in preventative

medicine tailored to the specific needs of the community, were all called out as necessary steps outside the 'biomedical model.'

Healthy People 2020 defines health disparity as 'a particular type of health

Continued on page 12

difference that is closely linked with social, economic, and/or environmental disadvantage.’ Using his own family history as an example, Thomas explained the generational framework of racially-derived health disparities. Breast cancer incidence and mortality, infant mortality rates, and AIDS cases among adults and adolescents were all examples given by Dr. Thomas of such racially-based health disparities.

In his 2011 paper ‘Toward a Fourth Generation of Disparities Research to Achieve Health Equity’, Thomas looks at three generations of health disparities research, and proposes public health focused interventions addressing racism, structural inequalities, and frequently occurring research biases.

The innovative methods implemented to tackle these overwhelming health disparities have a foundation in previous efforts, but have been updated to take a ‘4th Generation’ approach. The Healthy Black Family Project, an NIH-funded endeavor conducted from 2004-20012, was a community-based project focused on promoting disease prevention through engaging its participants in physical activity, nutrition counseling, stress management programs, smoking cessation classes, and self-management of chronic disease. The Health Advocates In-Research and Research (HAIR) Network brought healthcare providers to African American barber shops and beauty salons in order to reach their clientele, precisely the individuals who seemed to be slipping through the cracks in

the healthcare system. Thomas exalted the success of these programs in reaching their target audiences where they live and work.

The final message of the presentation was one of caution; Thomas warned that many health disparities are inappropriately explained away as cultural norms or lifestyle choices. He also noted that it is dangerous for policy makers and providers to assume that addressing racism is not germane to the pursuit of solutions to eliminate health disparities. Dr. Thomas implored his listeners to consider health disparities an issue of justice based on the United States’ history of racial discrimination and the denial of basic benefits to African American citizens. ■

SAVE THE DATE!

22nd Annual Dr. Raymond C. Grandon Lecture

Featuring

Glenn D. Steele Jr., MD, PhD

President and Chief Executive Officer, Geisinger Health System

Thursday, May 2, 2013

12:00pm – 2:00pm

Connelly Auditorium
Dorrance H. Hamilton Building
1001 Locust Street
Philadelphia, PA 19107

For more information call: 215-955-6969

The Business Of Medicine Summit

February 23-24, 2013

Thomas Jefferson University

*Dorrance H. Hamilton Building, Connelly Auditorium
1001 Locust Street, Philadelphia, PA 19107*

The Jefferson School of Population Health (JSPH) and the Institute for Continuing Healthcare Education (ICHE) are partnering to sponsor the 2nd Annual **Business of Medicine Summit: *Healthy Practice, Healthy Patients***. This CME-Certified program focused on the practical aspects of running a successful practice will feature nationally recognized experts.

In collaboration with *Medical Economics* and in consultation with the American College of Physicians, the weekend meeting will cover timely and important topics such as health policy issues, practice efficiencies, meaningful use and risk management.

Featured presenters include

David B. Nash, MD, MBA,
Dean of JSPH

and

Stephen D. Schoenbaum, MD, MPH,
Special Advisor to the President, The Josiah Macy Jr. Foundation

Michael Barr, MD, MBA, FACP,
*ACP's senior vice president of the Medical Practice,
Professionalism and Quality Division,
will also serve as emcee for the program.*

For more information regarding the program and to register, visit the conference website at: <http://bizmedicine.org/register-now.asp>.

To access special registration pricing for Friends of Jefferson, use Discount Code **JEFF**

\$400 (full 2-day program) – a savings of \$150

\$200 (1 day pass) – a savings of \$100

JSPH Publications

Behnke LM, Solis A, Shulman SA, Skoufalos A. A targeted approach to reducing overutilization: use of percutaneous coronary intervention in stable coronary artery disease. *Popul Health Manag.* 2012; Volume 00, Number 00, 2012. DOI: 10.1089/pop.2012.0019. <http://online.liebertpub.com/doi/pdfplus/10.1089/pop.2012.0019>

Clarke J. Proceedings of the Christiana Care Health System Value Institute. *Value Symposium. AJMQ.* 2012; 27:3S-20S.

Hojat M, Louis DZ, Maio V, Gonnella JS. Empathy and health care quality. *AJMQ.* 2013; 28(1):6-7.

Lopatto J, Pelegano JF. Literature review. *Am J Med Qual.* 2012; Published

online before print. November 6, 2012, doi: 10.1177/1062860612464732 <http://ajm.sagepub.com/content/early/2012/11/06/1062860612464732.full.pdf+html>

Nash DB. The use of medicines in the United States: A detailed review. *Amer Hlth & Drug Benefits.* 2012;5(7):423.

Nash DB. How LEAN is your practice? *Medpage Today.* October 31, 2012.

Nash DB. Public health no match for Sandy. *Medpage Today.* November 30, 2012.

Nash DB. Sandy revisited: Up close and personal. *Medpage Today.* December 26, 2012.

Nash DB. WANTED: ‘EMR 3.0’ for dummies. *Medpage Today.* January 23, 2013.

Rosenman MB, Simon TA, Teal E, McGuire P, Nisi D, Jackson JD. Perceived or actual barriers to warfarin use in atrial fibrillation based on electronic medical records. *Am J Ther.* 2012; 19:330-337.

Scott KW, Maio V, Dudash K, Templin M, Del Canale S. A physician-focused intervention to reduce inappropriate medications prescribing to older people. *Drugs and Aging.* 2012; Published online before print. December 12, 2012, doi: 10.1007/s40266-012-0043-y. <http://link.springer.com/content/pdf/10.1007%2Fs40266-012-0043-y>

JSPH Presentations

Berman B. Quality indicators-Why you should care. Presented at: The Association of Otolaryngology Administrators Annual Education Conference, September 7, 2012, Washington DC.

Berman B. Patient safety in ambulatory care. A REAL challenge. Presented at: UHC 2012 Annual Conference, September 12, 2012, Orlando, FL.

Jackson JD. The design of pivotal trails for PRO claims. Presented at: Generating Valid Patient-Reported Outcome Data for Medical Product Claims Conference, November 15, 2012, Philadelphia, PA.

Lieberthal R. Workplace wellness initiatives: return on investment?

Podium presentation at: 1st International Conference on Occupational Health and Safety Summit, September 5, 2012, Philadelphia, PA.

Lopatto J, Lupattelli M, Aristei C, Showalter TN, McAna JF, Clancy Z, Maio V. Comparing Italian and American radiation oncologist use of androgen deprivation therapy in the treatment of prostate cancer post-prostatectomy. Poster presented at: 2012 ASHP Midyear Meeting and Exhibition, December 4, 2012, Las Vegas, NV.

Pracilio VP, Goldsmith A. Activating Healthcare Advocates: A collaboration between NPA and the IHI Open School. Poster presented at: National Physicians

Alliance National Conference Leading the Way: The Next Chapter in America’s Health, November 10-11, 2012, Alexandria, VA.

Pracilio VP, Goldsmith A. Activating Healthcare Advocates: A collaboration between NPA and the IHI Open School. Poster presented at: Institute for Healthcare Improvement 24th Annual National Forum on Quality Improvement in Health Care, December 9-12, 2012, Orlando, FL.

Simmons R. Enhancing global health in a graduate public health program. Fullbright Scholars Program. Presented at: Society for Public Health Education (SOPHE) Annual Meeting, October 29, 2012, San Francisco, CA.

Upcoming Jefferson School of Population Health Forums

February 13, 2013

New Therapeutic Options for Stroke Prevention in Atrial Fibrillation

Joseph D. Jackson, PhD

Program Director, Applied Economics and Outcomes Research (MS-AHEOR)

Jefferson School of Population Health

Location: Bluemle Life Sciences Building, Room 101

March 20, 2013

Moving the Needle: Challenges and Opportunities in Communicating Patient-Centered Outcome Research

William Silberg

Director of Communications

Patient Centered Outcomes Research Institute

Location: The Curtis Building, Room 218

April 17, 2013*

Applying Comparative Effectiveness Research (CER) and Evidence-Based Medicine (EBM) in Everyday Practice

Robert W. Dubois, MD, PhD

Chief Scientific Officer

National Pharmaceutical Council

Location: Bluemle Life Sciences Building, Room 101

May 8, 2013

Challenges in Building a Knowledge-Based Technology Infrastructure for Population Health

Jonathan M. Niloff, MD

Chief Medical Officer

MedVentive

Location: Bluemle Life Sciences Building, Room 101

June 12, 2013

Managing Population Health in Low to Moderate Income Medicare Eligibles

Craig Tanio, MD

Chief Medical Officer

JenCare

Location: The Curtis Building, Room 218

*The April 17th Forum program will be followed by a special Grandon Society Member-only workshop from 9:45 am – 10:45 am. There will be an opportunity for members to interact directly with the presenters for an in-depth discussion of new findings in this area. To join the newly formed Grandon Society, please visit: http://www.jefferson.edu/population_health/GrandonSociety.html.

**All Forums take place from 8:30 am – 9:30 am
For more information call: (215) 955-6969**

Population Health *Matters*

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