

Population Health *Matters*

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EDITORIAL

The Geisinger Mystique

I recently had the pleasure of hosting Dr. Glenn Steele, President and CEO of the Geisinger Health System, as the featured speaker at the 22nd Annual Raymond C. Grandon Lecture on the Jefferson campus in Philadelphia, PA. Geisinger has often been cited in the national media as a role model for implementation of the Affordable Care Act. I'd like to share some of my impressions of Dr. Steele's presentation and the Geisinger "mystique."

Let's begin with a little background about Geisinger, a self-described integrated health services organization that includes provider facilities, a physician practice group, and several different managed care companies. The provider facilities include Geisinger Medical Center, the main hospital, and several affiliated community hospitals (Geisinger Wyoming Valley Medical Center and others). The physician practice group has over 1000 employed physicians across 73 primary care and specialty clinic sites. They also have more than 450 residents and fellows as part of their teaching program. The managed care companies include a 322,000-member plan that includes 68,000 Medicare Advantage members. They also hope to add 100,000 Medicaid Managed Care members in the next year. No doubt this is a large and complex organization.

Few appreciate the importance of Geisinger's \$180 million dollar investment in cutting-edge healthcare technology. They've built a fully integrated electronic health record across all 43 community practice sites, 3 hospitals, 3 emergency departments, 4 surgical centers and 12 CareWorks retail-based and worksite clinics. Geisinger has been celebrated for several years running as one of the "100 Most Wired Hospitals and Health Systems" by Hospital and Health Networks Magazine.¹

Given the size, scope and connectivity of the system, Steele outlines three strategic priorities for Geisinger, which include, most importantly, quality and innovation, followed by market leadership and a sense of the Geisinger family. They are very clear about where they want to be. The strategic goals include affordable coverage for all, payment for value, coordinated care, continuous improvement, total patient empowerment and national leadership in public accountability.

I thought Dr. Steele was quite self-reflective when he noted that the Geisinger advantage rested on several pillars. These pillars include the large number of employed physicians, their insulated marketplace in central Pennsylvania, a solid vision for the future and deep operational and professional integration across their entire enterprise. He added that the fact that they own their

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own insurance company just gives them an additional “sweet spot.”

Astute readers recognize that there is no cost/quality “correlation” -- in other words, a greater amount spent for healthcare never has predicated a better outcome. Dr. Steele went through an assessment of the accumulated decade’s worth of evidence that described this lack of a correlation. He also noted that the only way to really improve the outcome of care is through a focused reduction on waste and a focus on value re-engineering. Probably the most well-known aspect of the Geisinger re-engineering is their ProvenCare acute program. ProvenCare means that with certain high-volume diagnosis related groups (DRG’s), they have been able to determine, essentially, the best practice techniques. The system’s commitment to best practice and delivery of evidence-based care is demonstrated by the willingness to forego additional payment for any complications that might arise. Since they have distilled the best practices and are so deeply linked electronically, they are confident in their ability to deliver the best care at the best possible price.

I was skeptical about the portfolio of ProvenCare’s chronic disease program until I saw Dr. Steele’s presentation. The accumulating evidence in various journals across multiple disease entities has made me a believer. Deeply embedded within the ProvenCare experiment are ProvenHealth Navigators, nurses and others with a laser-beamed focus on the transitions of care and the length of stay. They are utilizing information technology at the bedside, targeting patients in nursing homes and other skilled nursing

facilities. While space precludes a detailed description of the ProvenHealth Navigator model, there is now no question in my mind that these represent the “boots on the ground” who help make the ProvenCare model work.

I was also intrigued to learn about Geisinger’s expanding telehealth presence. Geisinger has an experiment that capitalizes on their information technology called primary care e-Visits. They use MyGeisinger, an online system, for initiating health advice, which helps their health plan to avoid costly emergency room visits. Tightly related to this telehealth experiment is the Geisinger patient activation platform called “Open Notes.” This program engaged 24 primary care providers and over 8,700 Geisinger primary care patients. The reviews of this program, as presented by Dr. Steele, were uniformly very positive.

So what’s left for an integrated, nationally prominent system like Geisinger? They want to expand the Geisinger brand and Dr. Steele is supremely confident that the innovation engine they have created is definitely scalable and generalizable to the rest of the country. He appreciates the unique nature of the Geisinger culture, but believes that the reduction in unexplained variation, the commitment to integration using technology and the culture of the employed physician are some of the critical aspects necessary for ongoing success.

Dr. Steele concluded with an upbeat prediction regarding their for-profit subsidiary, XG Health Solutions, which will provide consulting services, population health data analytics, case management,



Glenn Steele, Jr., MD, PhD, President and CEO of Geisinger Health System featured at 22nd Annual Dr. Raymond C. Grandon Lecture

third party administration and other unique EHR applications. This subsidiary, now headquartered in Columbia, MD, will be a force to be reckoned with.

So, is the Geisinger mystique justified? After spending a day with Dr. Steele and listening carefully to both his prepared remarks and private conversation spent with our faculty at the School of Population Health, I am convinced that the reputation is well deserved. I am also convinced that we ought to pay more careful attention to Geisinger and other comparable models around the country, as we all seek to learn the ingredients to the “secret sauce” of surviving and thriving under the Affordable Care Act. ■

David B. Nash, MD, MBA
Dean, Jefferson School of Population Health
David.Nash@jefferson.edu

To view slides and listen to the podcast of the 22nd Annual Dr. Raymond C. Grandon Lecture visit: <http://jdc.jefferson.edu/hplectures/27/>

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Moving Ahead With MOOCs

JSPH will pilot its first MOOC later this year. We asked Juan Leon, PhD, JSPH Director of Online Learning, to provide an overview of what MOOCs are all about.

What is a MOOC?

MOOCs are “Massive Open Online Courses” usually offered free of charge and available to a global audience. Various forms of recognition, certification, or academic credit may be offered by some MOOC providers, though most MOOC participants today are not driven primarily by desire to earn a degree through MOOC-based study.

How do MOOCs work?

MOOCs did not emerge from the introduction of a novel, enabling technology. Rather, they’ve emerged through a reconceptualization and redeployment of existing online learning technologies driven by contemporary trends in higher education, society, politics, and culture. These trends promote greater sharing of knowledge (an aspect of “openness”) and lowering barriers to high quality, life-long learning.

MOOCs work by making digitized content accessible to very large numbers of learners in the structured online environment provided by a course management system. It’s the “massiveness” of the MOOCs more than any other single characteristic – course enrollments sometimes number in the tens of thousands – that most profoundly influences the kind of learning experience they offer. Due to the large class sizes, designing MOOCs for productive peer interactions and other contributions from students become especially important, and the role of the instructor changes significantly.

What is the focus of the JSPH MOOC?

We aim to pilot two to three MOOCs in 2013-2014. One course will introduce *Population Health*, a second will focus on *Prevention and Wellness*, and a third may take an international perspective, addressing comparative health systems.

Initial MOOCs have often been from disciplines that lend themselves to quantitative assessment, such as engineering, computer science and math. How are MOOCs becoming more applicable to disciplines such as population health?

Subjects lending themselves to objective, quantitative assessments that can be automatically graded reduce some of the logistical problems inherent in the MOOC’s very large class sizes. For an interdisciplinary subject such as Population Health, however, the appeal of MOOCs is less about the mechanics of testing than about the opportunities offered by the online learning experience.

Representativeness: A large, diverse group of students drawn from around the country and around the world can more fully represent the needs and interests of all the stakeholders that are part of the “universe” of population health. The abstract systems perspectives promoted in population health studies come to life the more classmates can authentically voice the views of players located throughout those systems.

Embeddedness: Because online learners typically participate in courses from where they live and work, these students can make excellent “field reporters.” Whether analyzing the outcomes a local healthcare quality improvement effort, polling neighborhood sentiment regarding a proposed public health policy, or designing a pharmaco-economic simulation that address a county-wide health concern, these embedded observers can prove invaluable to class efforts better understanding reality on the ground.

Effectiveness: These online learners – broadly representative, fully embedded, and highly motivated – are likely to prove effective change agents for population health.

What will the JSPH MOOC look like? Will there be video lectures/quizzes?

In general, MOOCs are online courses and they do not look terribly different from other online courses available today. That said,

some MOOCs will tailor their look to their audience demographics. They may design the course to look more like Facebook if their audience finds that style easy to use.

MOOCs designed for healthcare professionals and those with similar interests are typically more conservative, and I expect our own design will stay close to our current design for our other online programs. The emphasis is on instructional integrity.

Video lectures and quizzes are part of that design, as appropriate. In the MOOCs a greater variety of briefer presentations will be favored, and quizzes will be more formative (allowing students to check their own work and self-correct) and more adaptive (directing student to additional questions and/or material based on their responses to questions posed).

What E-learning technologies will be utilized with the JSPH MOOC?

We are working with the MOOC platform provided by Blackboard, the university’s course management system.

Will the JSPH MOOC be offered for credit?

There are no plans to offer MOOC courses at JSPH for credit at this time.

How can MOOCs help extend the JSPH brand?

Through their special attributes of representativeness, embeddedness, and effectiveness, our MOOCs can directly further JSPH’s mission. Because the term Population Health remains new to many, and our School’s existence is still a novelty to most parts of the country, offering free mini-courses, potentially to large numbers of participants, will answer questions about the meaning of population health and raise awareness of what we’re doing at JSPH. We expect to promote that awareness further by showcasing a number of JSPH and TJU experts in each of the MOOCs. ■

For more information about JSPH Online Learning Programs contact: Juan.Leon@jefferson.edu

Health Reform Update: The Road to Implementing State-Run, Partnered, and Federally Facilitated Exchanges

The Patient Protection and Affordable Care Act (ACA) was signed into federal law on March 23, 2010 with the intent of overhauling the health care system and expanding health insurance coverage. One of the major provisions under the ACA is the establishment of state health insurance exchanges that will function as centralized marketplaces to assist individuals and small businesses in obtaining appropriate health insurance coverage. Navigator programs created through grants will raise awareness about the exchanges, provide impartial information about insurance options, and assist consumers with enrollment.¹ The structure aims to increase enrollment in health insurance and ensure compliance with regulated health plan standards set by the federal and state governments. These health insurance exchanges will be implemented in each state on October 1, 2013, with coverage to begin on January 1, 2014.

Under the ACA, each state has chosen whether its health insurance exchange will be run by the state, the federal government, or a partnership between the two. As a partner, the state may assume responsibility for plan management functions, consumer assistance functions, or both, with the remainder of functions being federally run. States that did not opt to participate defaulted to the federally-facilitated option to be established and operated by the Department of Health and Human Services. These states will have the option of developing into a state-run exchange in the future.²

States that have chosen to run their own health insurance exchange or partner with the federal government have the advantage of being able to tailor the program to their population by determining how the exchange will be structured and governed, what standardized plans will be offered within it and what premiums are appropriate. They will also create insurance rating rules and compliance standards by which plans within the exchange will have to abide.³ While state-run and partnered health insurance exchanges provide states with increased flexibility and autonomy, they also come with increased administrative and financial responsibility. Currently, federal

funding for state-run exchanges expires at the end of 2015; after that, states must figure out how to manage and fund their exchanges.⁴

According to the National Conference of State Legislatures, 17 states and the District of Columbia have been approved for state-run health insurance exchanges, seven states are partnering with the federal government to run their health insurance exchanges, and 26 states will default to federally facilitated exchange (Table 1).⁵ The majority of states that have either opted or defaulted into federally facilitated exchanges have Republican administrations, a contrast to the traditional Republican stance of limited federal government. Many of these states delayed administrative discussion and preparations regarding health insurance exchanges with the hope that the ACA would be overturned by either the Supreme Court or the 2012 Presidential election.⁶ Other states have cited ideological opposition to the ACA as a reason for their hands-off approach.³

In Pennsylvania, Governor Tom Corbett announced in December 2012 that our state's exchange will be run by the federal government. In a press release, he stated that his administration became discouraged with a state-run option after seeking guidance from the Department of Health and Human Services and receiving "little acknowledgement."⁷ As a federally-facilitated exchange, Pennsylvania's exchange will operate according to the guidelines released in April 2013 by the Centers for Medicare & Medicaid Services in a "Letter to Issuers on Federally Facilitated and State Partnership Exchanges." It states that roles that would otherwise be undertaken by state officials, such as designating health plans as Qualified Health Plans in the exchange and operating call centers for customer support will instead be executed by the federal government.⁸ It remains to be seen whether this will affect the ease of enrollment, quality of health plans, or consumer satisfaction.

With the creation of health insurance exchanges comes an influx of previously uninsured or underinsured patients into the healthcare system. The expected expansion

State Run	Partnership	Federally Facilitated
CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA	AR, DE, IL, IO, MI, NH, WV	AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

of the patient population is likely to make the shortage of primary care physicians more severe, as already experienced by Massachusetts, which developed its own exchange prior to ACA. It is important, therefore, that states evaluate the availability of primary and preventative care and with the goal of developing and restructuring services to meet these demands.

As medical students in a community with a large underinsured population, we have seen firsthand both the struggle of patients without access to health care and the financial burden that the healthcare system suffers when medical problems are not addressed promptly. As future internal medicine physicians, we look forward to working in a system in which more patients can go to the doctor rather than the emergency department and can follow up in the office rather than returning to the hospital. As health care providers we must continue to monitor the progress of health insurance exchanges and ensure that the system meets its goal of providing health care for more Americans. ■

Anne Mainardi, MD
Internal Medicine Resident
Yale School of Medicine

Shira Yun, MD
Internal Medicine Resident
Icahn School of Medicine at Mount Sinai

Dr. Mainardi and Dr. Yun are recent graduates of Jefferson Medicine College.

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Health Workers Working Healthy: A Labor-Management Collaboration

When the scalding fluid from a spent Sterno container splashed into Dietary Aide Sharon Chestnut's eye, she knew precisely what to do to avert a tragedy. Chestnut had just taken part in the District 1199C Training & Upgrading Fund's first annual safety conference for frontline healthcare workers. "They taught us what to do in an emergency. I stayed calm, I didn't panic. I was giving out orders – I even remembered what we learned about taking the actual chemical with you to the hospital."

District 1199C Training & Upgrading Fund, a 40-year-old non-profit, is the training arm of District 1199C of the National Union of Hospital and Health Care Employees - the city's healthcare union that represents thousands of direct care workers. These frontline healthcare workers face a laundry list of physical, chemical, and infectious occupational hazards ranging from needlesticks to violence. According to Dr. David Michaels, Assistant Secretary of Labor for Occupational Safety and Health (OSHA), "In hospitals and healthcare facilities, workers are hurt at rates even higher than in construction and manufacturing and, in some cases, at more than double the average for all private industry. Nursing aides, orderlies, and attendants have an incidence rate of musculoskeletal injuries more than six times the average for all industries."¹

Since the publication of the Institute of Medicine's *To Err is Human: Building A Safer Health System*,² patient safety has become the clarion call of the healthcare industry. District 1199C places a high priority on safety and quality and believes that worker safety and patient safety go hand in hand. The union is concerned about ensuring the frontline workforce not only understands its critical role in creating a culture of safety but also how taking a systems approach to safety creates a high-value care system.

The Training & Upgrading Fund was established as a labor-management partnership in 1974 through a trust agreement with nine founding employer partners. The employers contribute into a pooled education trust fund 1.5% of gross payroll for covered District 1199C members. The

Training Fund's board of trustees consists of an equal number of employer and labor representatives, with co-chairs representing each group. Currently, the Training Fund partners with 50 regional healthcare and human services employers and nearly 5,000 employees utilize the training benefit annually. The partnership, which has also been awarded federal and state grants to serve community members, has been recognized as a national model for its innovative programs in healthcare career advancement.

In 2011, the Training Fund was awarded its first OSHA Susan Harwood Training Grant to provide healthcare worker safety training, with a special focus on healthcare-acquired infections. The Susan Harwood Training Grant Program is designed to fund the development and delivery of culturally competent training materials and educational opportunities for workers in high-risk occupations. Funds are awarded annually to nonprofit organizations on a competitive basis.

"The grant gave us the means to start our Health Workers Working Healthy (HWWH) initiative and to present our frontline workers - nurse aides, housekeepers, laundry workers and dietary aides - with a coherent but easily understood account of evidence-based best practices in safety precautions and infection control," said Cheryl Feldman, executive director of the District 1199C Training & Upgrading Fund. "Our curriculum is designed for a diverse group of workers, some with lower technical literacy levels, so it has to be engaging as well as informative. A lecture, an online course or a video would not be nearly as effective as the role-playing and hands-on activities we provide. We cover the most up to date information regarding hand hygiene, personal protective equipment, hazards communication, blood-borne pathogens, workers' rights under OSHA and, of course, infection control. But to keep patients as well as workers safe, we help our members turn this information into actionable knowledge."

After receiving a second round of funding in 2012, Cheryl Feldman was invited to present the HWWH program to the 72 Susan

Harwood Training Grant program recipients from across the country. This past March, in recognition of the Training Fund's innovative teaching practices, OSHA again invited the HWWH team to Washington, DC to present *Crafting Successful Participatory Exercises* to Harwood grantees.

The urgency for enhanced safety training for the frontline healthcare workforce is further underscored by the upsurge in *Clostridium difficile* infection (CDI). A recent issue of *Vital Signs* (Centers for Disease Control and Prevention) reported that deaths related to CDI rose 400 percent between 2000 and 2007, and added at least \$1 billion a year to healthcare costs. The report concluded that hospitals and other healthcare facilities need to do even more to reduce rates of CDI, including strengthening prevention efforts.³ The day-to-day efforts to reduce a facility's CDI rate will depend heavily upon the quality of the work of its environmental services workforce.

"I am teaching our workers in practical job-embedded ways that resonate with them and supplement the training being done at the worksite. I explain, for example that *Clostridium difficile* is a spore that can survive in the environment for months and the important role that they play as housekeepers in preventing the transmission of CDI," said Ellie Barbarash, coordinator of HWWH. Barbarash works with the Training Fund's healthcare partners, including Thomas Jefferson University and Hospitals (TJUH). Jolene Shaw, TJUH's manager of Environmental Safety and Health, serves on the HWWH's Technical Advisory committee and has helped shape the direction of the program. At TJUH, Barbarash has conducted trainings on hazards communication for over 100 housekeepers. She has also spoken to TJUH's departmental managers about workers' concerns regarding infection control and personal protective equipment. "Our shared goal is to train a high-reliability team to reduce errors and to prevent both worker and patient harm," said Barbarash.

For this second year as a Harwood recipient, the Training Fund is working to develop peer trainers at each worksite and helping them to think critically about how to break the link in

the chain of events that could cause recurring health care-related adverse events and close calls. “Our goal is to provide extensive train-the-trainer professional development for selected workers who will, in turn, conduct short, targeted peer safety trainings at their worksites,” explained Feldman. “It is critical that frontline workers understand the vital

role they play in reducing healthcare acquired infections and ensuring patient safety.” Feldman added that the Fund’s long-range vision is to have each member grow into a well-informed safety champion for their worksite and that the direct care workforce is represented on healthcare facilities’ patient safety committees. ■

Lynette Hazelton, MPH
Manager of Communications
District 1199C Training & Upgrading Fund
lhazelton@1199ctraining.org

For more information about the Susan Harwood Training Grant Program visit:
<https://www.osha.gov/dte/sharwood/>

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Jefferson Hosts American Public Health Association Student Assembly’s Strategic Planning Meeting

June 15-16, 2013

Jefferson recently hosted the student board of the American Public Health Association (APHA) during their biannual strategic planning retreat. Over 30 students from across the country were in attendance, representing the 18 committees and sub-committees of the nation’s largest student-run public health group. Students ranged from undergraduates to doctoral candidates in fields across a spectrum of healthcare disciplines. This year, APHA is revisiting their overall strategic plan, making the meeting at Jefferson an important time for the Student Assembly to ensure they remained aligned with the overall mission of APHA while continuing to be the premier organization for students interested in public health.

After some brief opening remarks, the meeting began with a presentation by Drew Harris, DPM, MPH, Program Director for JSPH’s Masters of Health Policy program and a member of APHA’s Executive Board. Dr. Harris’ presentation gave attendees insight into how to craft a vision, mission statement, and objectives which would ensure that the organization is guided by relevant, measurable outcomes and a sound strategic

foundation. For the next day and a half, the board worked on Student Assembly’s strategy, making sure that every facet was up to date and reflected the needs of the thousands of student members who will soon be entering the public health workforce.

Among the issues addressed were: the availability of leadership opportunities for students, student engagement in public health advocacy, and encouraging a diverse student body in public health. The student board also began preliminary planning for this year’s APHA Annual Meeting in Boston, MA. The program, which will be held November 2-6, will feature the National Student Meeting, numerous student poster sessions, and many other student-centered programs.

Overall, the meeting was very successful, offering students a unique opportunity to shape their own national member group while learning how to create a comprehensive strategic plan. The ideas discussed at the meeting will guide the Student Assembly for the next two years, as it continues to offer leadership, educational, and career development opportunities for stu-



Left to Right: Alex Bryn, Chair Elect; Liesl Nydegger, Chair; and Brittany Marshall, Immediate Past Chair.

dents across the country who are interested in public health. ■

Alex Bryn
MD, MPH, Class of 2016
Thomas Jefferson University
Chair-Elect, Student Assembly
American Public Health Association
Alexander.Bryn@jefferson.edu

JSPH Class Night 2013

May 29, 2013

Every year prior to commencement, JSPH celebrates Class Night to acknowledge and celebrate the achievements of students who earn a Master's degree and graduate in the current academic year. Open to family, friends, and colleagues, class night also honors outstanding students and faculty.

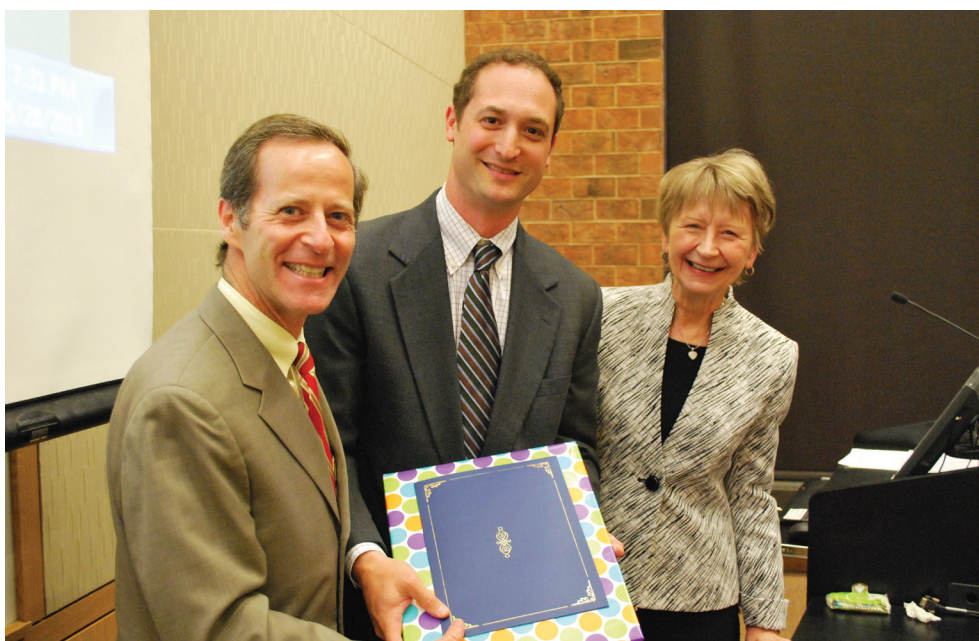
This year the *Outstanding Student Award* was presented to **Tiffany “Tk” Rodgers** a graduate of the MPH program and a Schweitzer Fellow for Life. Tk has a wealth of experience with community service activities, and is particularly interested in addressing the needs of underserved populations. In 2012 she also received an Outstanding Student Award from the College of Physicians, which recognizes the contributions of Philadelphia area students, leaders, colleges, and institutions in public health. Tk is a true leader in public health and will continue to forge ahead in her commitment to serving populations in need.

Although she was unable to attend Class Night, **Danielle Casher, MD, MSHQS**, received the *Outstanding Online Student Award* as a graduate of the Master's program in Healthcare Quality and Safety program. Dr. Casher is a pediatrician at St. Christopher's Hospital for Children, where she provides emergency medicine and is actively involved in quality improvement, and utilization management. Dr. Casher believes the academic training she received at JSPH has provided her with the tools to continue her work and commitment to improving the value of care.

For the first time, JSPH presented a *Special Recognition Award* to show appreciation to someone who has made considerable contributions – above and beyond the call of duty – to the learning needs of students and to the success of JSPH. There was no one more deserving of this award than **Dan Kipnis, MIS**, Senior Education Services Librarian, in Education Services Department of Academic and Instructional Support and Resources (AISR). Dan is responsible for course-based and distance learning instruction in the use of library resources. He has been an invaluable



Left to Right: Rob Simmons, DrPH, MPH, MCHES, CPH; Tiffany “Tk” Rodgers, MPH; and David B. Nash, MD, MBA.



Left to right: David B. Nash, MD, MBA; Dan Kipnis, MIS; and Caroline Golab, PhD.

resource and mentor to students and faculty, showing extraordinary support and commitment to JSPH.

The *Award for Excellence in Teaching* was presented to **Sandford (“Sandy”) M. Barth, PhD**. Sandy is a health economist who has taught for the Jefferson School of Population Health since the first day JSPH opened its doors in September 2009. Sandy has also served as interim

Director of the Health Policy program and supervised numerous Capstone projects in Health Policy. He taught similar courses for Jefferson's Bachelor of Science degree programs in health services management and health services management information systems from 2002 to 2009. ■

To read the complete of presentation of Dr. Barth's Award for Excellence in Teaching, refer to page 9.

Award for Excellence in Teaching Presented to Sandy Barth, PhD

May 28, 2013

It is truly an honor and a pleasure to present the Award for Excellence in Teaching to Sandford (“Sandy”) M. Barth, PhD.

Sandy is a health economist who has taught for the Jefferson School of Population Health programs in public health and health policy since the first day we opened our doors in September 2009. To date, he has taught *US Healthcare Organization and Delivery* and *Advanced Health Policy* a total of 15 times to public health and health policy students, including three cohorts of experienced executives at Johnson & Johnson in Titusville, NJ.

Sandy has also served as interim Director of the Health Policy program and supervised numerous capstone projects in Health Policy. No stranger to Jefferson, he taught similar courses for Jefferson’s Bachelor of Science degree programs in health services management and health services management information systems from 2002 to 2009, when we summoned him from retirement to teach for us in Jefferson’s new School of Population Health.

Sandy’s BS degree, in economics, is from Rider University, his MA is in Health Care Administration from George Washington University, and his PhD in Health Economic Policy is from Century University in Albuquerque, NM.

Sandy’s experiences in the field of health care are truly exceptional. He has more than 40 years of experience in economic analysis of health care delivery and financing. His analysis of employer, provider and payer markets in the 1970s and ‘80s led to publication of a predictive model on health market changes that now defines today’s healthcare market. Shortly before he retired, he served as consultant to Aetna, Inc. on issues of strategic assessment of the Medicare population, provider pay-for-performance modeling and programmatic outcomes evaluation. Before that, he served as the Supervisor of the Pennsylvania Public School Employees’ Retirement System Health Options Program. He is the founder and managing director of SMB



Sandy Barth, PhD (center) receives the Award for Excellence in Teaching from Carolyn Golab, PhD, and David B. Nash, MD, MBA.

Strategic Solutions, a private educational and research initiative.

He has served as a consultant to Johns Hopkins University Health System; the Hispanic Physicians Network, Independence Blue Cross/Keystone Health Plan East/AmeriHealth; the Northern Virginia Health Care Purchasing Alliance; Sara Lee Corporation; Parker-Hannifin; PECO Energy, and the Chattanooga and Memphis Business Coalitions on Health, among others. He has served on the Advisory Board of the National Managed Health Care Congress and the American Society of Quality Control; he has been an appointed member of the Pennsylvania Economy League Task Force on Health. He is widely published and a frequent speaker, here and abroad, on current healthcare issues, especially health system process improvement, assessment of health care financing and delivery, and medical plan benefit trends and longitudinal changes in the health status of 50-65 year olds.

One of the electives offered in the MPH program is Qualitative Research Methods which introduces students to techniques and ways to “quantify” qualitative information with the use of special NVivo

software. An NVivo analysis of student responses revealed that “excellent,” “favorite,” “enjoyable,” “challenging,” “knowledgeable,” and “great discussions” were the words most frequently used to describe Sandy’s courses and his teaching.

Let’s let the students speak for themselves:

Very elegant approach to a very complex task – well organized, well prepared, very informative. Encouraged critical analysis, not just memorization. Favorite class.

Sandy was amazing. He has so much passion, it was contagious. His ability to make information tangible was so valuable.

Excellent instructor, really motivated students and encouraged fruitful and relevant discussion...

He really knows his subject matter. I really enjoyed learning about the US healthcare system from his expertise.

This is one of the best courses I’ve ever taken. Dr. Barth clearly has a huge knowledge base on the subject and encouraged questions

Continued on page 10

and discussions in class This was by far my favorite class of the MPH curriculum.

But this student probably summed it up the best, speaking directly to his instructor:

I appreciate the style of your learning. You foster a stress-free and comfortable environment for learning so we can concentrate on the information. You are very welcoming for discussion and questions. I appreciate that. It helps to keep me engaged and interested. You clearly have a wealth of information from the lifetime of career experience and it certainly shined through as an asset to your teaching abilities. You are also a terrific and engaging storyteller.

On the more personal side, Sandy Barth is a native of Hartford, Connecticut. Before embarking on his career in health policy and economics, and during the Vietnam War era, he was a Captain and a medic in the US Army Medical Services Corp, directing a MASH unit in Korea during the capture

of the US Pueblo and its 80 sailors by the North Koreans in January 1968. He is very proud of his military service and considered making the military a permanent career, but left in order to pursue graduate studies in health policy and economics.

Sandy is an avid golfer who dreams of golfing in Hawaii, is a dedicated gardener who grows his own tomatoes, peppers, cucumbers and eggplants, and he is king of the outdoor barbecue. He and his wife, also named Sandy, met on a blind date and were intrigued that they both had the same name; Sandy and Sandy will be married 41 years this August. They have two children, Pamela and David, and two very adorable granddaughters, Samantha, 5, and Jeanine (“Nina”), 3, who are definitely spoiled by their grandparents. When not golfing, cooking, traveling to exotic places like the Far East, the Middle East or Eastern Europe, cruising the German *Autobahn* at 100 miles per hour, or preparing for a month-long trip to Australia and New Zealand this fall, Grandpa Sandy can be

found explaining the intricacies of managed care to Samantha and Nina, who nod in appreciation and fortunately concur with all of his explanations.

The success of our programs depends greatly on the quality and dedication of its faculty. It depends on individuals like Sandy Barth who teach because they love to do it and for the contribution they can make to helping others achieve their goals. Sandy, it is with great pleasure that we present you with the 2013 JSPH Award for Excellence in Teaching. You have done so much to enlighten the world, including our students, about the mysteries and intricacies of the US healthcare system. As your students said so accurately, you are “awesome” and “amazing.” ■

Presentation of the Award for Excellence in Teaching written by Caroline Golab, PhD, Associate Dean for Academic and Student Affairs, Jefferson School of Population Health.

Orthopaedics and iPads: The Future of Resident Education?

The Orthopaedic Surgery Residency Program of the Einstein Medical Center is located in Philadelphia. It is a dynamic, community-based training program to provide residents aspiring to become orthopaedic surgeons with an excellent foundation. With two residents per graduating class, Einstein Orthopaedics provides early operative exposure in conjunction with protected daily didactic conferences. An important aspect of their training includes a component dedicated to using new technology to improve patient care and access information. The modern tablet computer is a very powerful and versatile tool that is rapidly changing the way physicians learn and practice medicine. The Einstein Orthopaedic Surgery Residency Program introduced the use of iPads in 2010; since that time, it has become an integral part of the residency training. Although it originally was designed to supplement resident education, use of the iPad will soon become part of routine patient care.

The goal for iPad program was to improve efficiency in patient care, improve

academic accessibility and environmental sustainability of the educational curriculum. This project was funded by a grant from the Albert Einstein Society Innovative Grants Program. Creating this curriculum required cooperation with other disciplines (computer services and academic affairs) within the Einstein Healthcare Network. iPads with 16 GB memory and wireless internet access were distributed to each resident. To date, there have been no problems registering or operating the devices. Proper safeguards were implemented in accordance with HIPAA requirements safeguarding the privacy of protected health information. The users agreed not to enter, locally store, or access patient information in the iPad. In addition, each iPad is equipped with a passcode, automatic security updates and a security application (Find My iPhone). In the case of a misplaced device, this security app will locate and remotely erase all iPad contents. In addition to the patient privacy agreement, each user agreed to a special iPad insurance policy in the event of a stolen or lost tablet.

Some of the highlights of the program include:

- 1. Patient care:** As hospital systems across the country continue to embrace electronic medical records (EMR), the iPad provides an efficient and portable method for immediate access to these programs. At Einstein Medical Center, the EMR system (ACEIS) has just recently become available for use on the iPad. The latest patient vital signs, blood work, medications, etc. will be readily accessible through the iPad. This helps facilitate patient rounding and will allow for orders to be immediately placed or discontinued. In hospital settings where patient medications and information are constantly changing, the iPad provides physicians with the unique opportunity to stay up to date with the dynamic healthcare system. The Einstein Orthopaedic Department has planned to initiate the ACEIS system to our iPad program by the summer of 2013.

2. Improved information access: With the entire body of orthopedic literature at a resident's fingertips, information is rapidly accessed during daily didactic conferences or journal club meetings. This instant availability of information also facilitates fracture management, preoperative planning and surgical techniques. Residents have several orthopaedic iPad programs (apps) which provide specific information about fractures, management and splinting techniques. For training physicians, these apps provide immediate information about specific injuries and their management. This provides a resident the ability to begin planning a definitive management strategy from the initial patient encounter.

3. Orthopaedic In-Training Exam (OITE): The portable iPad gives residents immediate access to question banks and OITE preparation websites in any wireless internet location. In the first two full years of the iPad program, Einstein Orthopaedics achieved an OITE score in the top 2% and 5% of the country. Our orthopaedic residents report that the iPad portability provides them with a convenient study tool they can use at any time while they fulfill their daily operative and clinical responsibilities. These in-training exam results provide an objective measure that affirms

the positive effect the iPad has on a resident's knowledge base.

4. Use of mobile applications (apps): Each resident is required to install the mandatory apps including Find my iPad, iAnnotate, iBooks, Keynote, etc. These applications facilitate teaching, learning, and research. Applications also exist that allow residents to log duty hours and to keep notes on procedures performed in the operating and emergency room in real time. Emphasis for residents to record their procedures and duty hours has greatly increased over the past several years. This trend will undoubtedly continue to be stressed by the ACGME in order to properly evaluate the training programs of orthopaedic residencies across the country. The iPad provides an immediate and convenient method for residents to stay up to date with these demands.

5. Environmental responsibility: Before the implementation of the iPads, the residency program printed an estimated 25,000 pages of reading material every year. This practice has been almost eliminated as each daily reading is now accessible on the resident's tablet.

6. Easy access to scheduling: Utilizing the iPads, each resident has access to the on call and reading schedule through an online calendar system. The previous

schedule was only available in the resident orthopaedic office and was time-consuming to access. These schedules are now easily viewed with the use of iPads.

Modern technology has provided the orthopaedic resident with many options to enhance their training experience. At Einstein Medical Center, the Orthopaedic iPad Program has positively affected education, surgical planning, and research capabilities of each resident. The next frontier for the iPad includes integration into routine patient care through the use of electronic medical records. We firmly believe the iPad will improve and expedite patient management in a hospital setting. The portability of the iPad has many advantages but does require an effective protocol to protect sensitive patient information in case of a misplaced or stolen device. As medicine and technology continue to develop at a rapid speed, it is important for physicians to embrace these advancements and utilize new innovations. The iPad Program is a testament to how technology and medicine can continue to develop together for a better educational and patient experience. ■

Nathan Tiedeken, MD

John A. Handal, MD

Solomon P. Samuel, D.Eng.

Department of Orthopaedic Surgery, Einstein Medical Center

For more information contact Dr. Tiedeken at nathan.tiedeken@gmail.com.

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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 QSLS staff at qsls@jefferson.edu. You may also contact Amanda Solis by phone at (877) 662-7757.

Jefferson and Japan: Working Together to Advance Best Practices in Healthcare Education and Research

Thomas Jefferson University has had a history of medical exchange with Japanese institutions for more than 25 years. Under the direction and support of Joseph Gonnella, MD, Dean Emeritus of Jefferson Medical College, and other key administrative leaders, the University has accepted more than 300 Japanese medical students, physicians and nurses for short-term and long-term training. The initial Japanese supporter of the program has been the Noguchi Medical Research Institute (NMRI). Recently the Japanese Association for Development of Community Medicine, the largest hospital network in Japan (JADECOM), joined the NMRI in sending faculty and staff to Jefferson for short-term training. Because this involved a significant expansion in the number of health professional exchange visitors, a more organized system was required to coordinate their training needs on campus. As a result JADECOM and NMRI have collaborated with Jefferson to create the Japan Center for Health Professions Education and Research at Jefferson (Japan Center). The purpose of the Center is to coordinate the exchange of health personnel between Jefferson and JADECOM-NMRI. The initial approach is to conduct a two-year pilot project in 2012 and 2013 to test the mutual satisfaction of all parties with this new arrangement.

The goals of the Japan Center are to:

- Supplement the development of health professionals from participating Japanese institutions with educational experiences at Jefferson
- Promote the exchange between participating institutions and Jefferson of research ideas and personnel based on the availability of funds; and
- Conduct research on these exchanges.

During 2012, 63 health professionals participated in the program; in 2013, 58 health professionals attended. The program attendees consisted of physicians, residents, medical students, nurses, dietitians, medical clerks, administrative staff and a clinical engineer. The visitors come from a number of different hospitals and universities across Japan, and are

sponsored by JADECOM and NMRI, along with Chiba and Osaka Universities and Kariya Toyota hospital. They spend anywhere from one week to a month visiting clinical sites and academic offices in the hospital and university. They have presentations from Jefferson faculty and administration about US health care including such topics as interprofessional education and practice, risk management, patient safety, nutrition and health information management. They also have opportunities to visit Methodist and Magee hospitals, various clinical sites and cultural attractions off campus.

Participants in this program have consistently reported a high level of satisfaction with the

Japan Center program attendee evaluation comments

"I was very impressed to see TJUH advanced facilities. Especially, simulation center in TJUH has a lot of productive equipment for nurses, doctors, co-medical staffs, and medical students. In addition, I was interested in simulation programs which are elaborately customized for each classification."

"I would like to say thank you for TJUH staff that they kindly supported us for one week. It would be good if TJUH nurses come to Japan, know the Japanese medical situation, and receive training in JADECOM hospitals in return."

"I was very impressed with the educational attitude of the residents."

"I have visited three facilities, TJU, Rehabilitation Center and Methodist Hospital and learned a lot about nutritional management in each hospital. Also, one dietitian gave us samples of nutrient and supplement, and then we exchanged the information of each country's situation of dietitians. Staff in the Rehabilitation Center were interested in nutrient or supplement in Japan, so I will send it to him/her. Through this training, new relationships have been made between JADECOM and TJU dietitian. It was very good for each other I think."

various activities in which they participated. Evaluation responses on rating scales revealed good to excellent rating on each of the presentations in the program. The evaluations also revealed that they either agreed or strongly agreed that they had improved their clinical skills and the training was useful. They expressed that they would encourage others to attend this program at Jefferson and some of the participants' comments suggested that they had a better understanding of the US health system and a desire to share the Japanese approaches to care.

The evaluations and comments made by the participants make it clear that the Center has carried on and expanded upon the 25-year successful and productive partnership between Jefferson and its partner Japanese health systems. This cooperative arrangement provides a unique sharing of ideas between the two health systems and paves the way for using the best practices from each to improve patient care and effective health services delivery. ■

Yumiko Radi

*Director of Operations
Jefferson Japan Center for Health Professions Education and Research
Yumiko.Radi@jefferson.edu*

The Center is under the direction of James Erdmann, PhD with Charles Pohl, MD as Associate Director. Ms. Janice Bogen serves as Administrative Officer and Ms. Yumiko Radi is the Director of Operations. They are supported by an advisory committee consisting of Joseph Gonnella, MD, Clara Callahan, MD, Takami Sato, MD, PhD and Michiyasu Yoshiara, MD, Chairman of the Board of Directors, Japan Association for Development of Community Medicine and Yoshihisa Asano, PhD, DPH, Founder; Chairman Emeritus, Noguchi Medical Research Institute.

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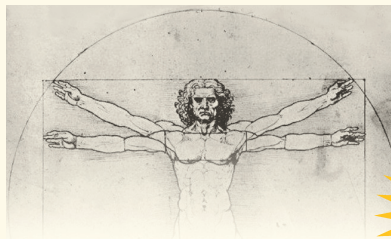
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Adverse Childhood Experiences, Disability and Health-Risk Behaviors

Adverse childhood experiences (ACEs), including exposure to abuse and family dysfunction, impact over half the US population.¹ The original ACE study, performed in over 17,000 members of a California health maintenance organization, found that ACEs are highly interrelated and that there is a strong graded relationship between ACE exposure and health-risk behaviors such as smoking and substance abuse.^{1,2} In addition to the social and behavioral impact of ACEs, adverse childhood environments are increasingly recognized to have potential biological effects on later life health, through environment-gene interactions which can result in changes in gene expression and alterations.^{2,3} These changes can result in altered physiological responses to future stresses. Recognizing the importance of ACEs, the American Academy of Pediatrics has called for all physicians to incorporate an “ecobiodevelopmental” framework as a way of understanding the social, behavioral and economic determinants of physical and mental health disparities.⁴ In this article I will discuss my work examining the relationship between ACEs, disability and health-risk behaviors.^{5,6}

My interest is in how ACEs impact the development of disability after neurological trauma. Most studies on childhood adversity have focused on psychological disability; less is known about the impact on those with disabling physical injuries. My ongoing work examines the relationship between childhood adversity and disability. An exploratory study, described below, found that rates of self-reported disability were increased in those reporting adverse childhood experiences, even after controlling for health conditions. One possible mediator of the relationship between ACEs and increased rates of disability are health-risk behaviors.

I used data from the Behavioral Risk Factor Surveillance System (BRFSS), an annual state population-based random-digit-dialed telephone survey that is a joint effort of the Centers for Disease Control and Prevention and state health

departments.⁷ Starting in 2009, the BRFSS implemented an ACE module containing questions that were adapted from the original ACE study.⁸ Fourteen states and the District of Columbia used the ACE module in 2009 and/or 2010. The ACE module asks participants about abuse (sexual, physical and verbal) and family dysfunction (witnessing domestic violence, having a caregiver with substance abuse problems, mental illness, or absence of a parent because of incarceration or divorce/separation) occurring before age 18.⁸ The BRFSS also asks about disability (defined as activity limitation from a mental or physical health problem and/or use of an assistive device) and health-risk behaviors (smoking, heavy drinking, binge drinking and HIV risk behaviors (under age 65 only). Age adjustment was performed using direct standardization and the US Census 2000 population standard. Multivariate logistic regression was used to control for age, sex, race, marital status, education and income.

Preliminary results showed that respondents reporting disability had a higher age-adjusted prevalence of experiencing any ACE (70.2% vs. 54.2%) and four or more ACEs (27.4% vs. 12.1%) compared to respondents not reporting disability. Those reporting disability had a higher age-adjusted prevalence of smoking (27.4% vs. 17.1%) and HIV-risk behaviors, but not heavy or binge drinking. However, among persons reporting disability, those who reported one or more ACEs had higher age-adjusted rates of each type of health-risk behavior compared to those with no ACEs, including more than twice the prevalence of smoking (31.5% vs. 15.3%) and greater than three times the prevalence of HIV risk behaviors (6.6% vs. 1.4%). This increase remained significant even after adjusting for other demographic factors.

The results are consistent with those of the original ACE study, but have the advantage of having been performed in a population-based sample. ACEs appeared to affect those reporting disability similarly to those not reporting disability with respect to increases in health-risk

behavior prevalence. However, because those reporting disability already had an increased prevalence of certain health-risk behaviors (current smoking and HIV risk behaviors), those reporting disabilities and ACEs had the highest prevalence of these behaviors. Future research will investigate the role of health-risk behaviors as a mediator in the relationship between ACEs and associated increased rates of self-reported disability.

Clinicians working with patients to change health-risk behaviors should inquire about ACEs. Although further research is needed, to the extent that health-risk behaviors may represent a way of coping with the effects of ACEs, addressing the underlying experiences may be necessary to enable effective change in behavior.⁹ The strong association of ACEs with health-risk behaviors suggests that policy interventions aimed at preventing ACEs or ameliorating their effects early on is an important strategy in public health efforts to decrease the prevalence of health-risk behaviors. Policies include supporting early childhood programs that provide services to vulnerable children and families;¹⁰ working with Medicaid and other insurers to increase access to needed services; and enabling coverage of services aimed at both parents and child.¹¹ States that participated in the BRFSS ACE module, such as Wisconsin, have begun using the ACE Study data to raise awareness, foster collaboration and identify successful existing programs aimed at ACE prevention and fostering resilience.¹¹ ■

Sophia Miryam Schüssler-Fiorenza Rose, MD, PhD
Smrose11@stanford.edu

Dr. Schüssler-Fiorenza Rose recently completed a residency program in the Department of Rehabilitation Medicine at Thomas Jefferson University. She is currently in the Spinal Cord Injury Medicine Fellowship program, Stanford University School of Medicine and Veterans Affairs Palo Alto Health Care System.

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Working Together to Address Obesity: Philadelphia Health Initiative

In healthcare, when you talk about equipping providers, it’s rare that you’re talking about parents. Yet, when it comes to addressing childhood obesity, parents may be the most important provider of all.

A child’s weight is increasingly becoming a primary concern for parents. A survey from the University of Michigan found insufficient exercise and childhood obesity as the two most important concerns parents have regarding their child’s health – ranked higher than smoking, drugs and bullying.¹

But, perhaps even more troubling to parents is what to say about it. According to a WebMD/Sanford Health survey, parents of teens find it more difficult to talk about weight with their children than talking about sex, drugs, alcohol or smoking.²

Find that hard to believe? Well, if you are a parent reading this article, how would you answer this question from your child: “Mom and Dad, am I fat?”

Not so easy, is it? While helpful resources

on this topic have been in short supply – if available at all – a new tool is available. The **STOP Obesity Alliance**, in collaboration with the **Alliance for a Healthier Generation**, released a guide to help parents respond to challenging and unanticipated questions about weight from their kids.^{3,4,5} “*Weigh In: Talking to Your Children About Weight and Health*” is a free conversation guide that offers parents “real-world” situations and plain language responses to questions about weight issues, including understanding BMI, body image, bullying, weight bias and family obesity.⁶ This research-based guide, reviewed by experts from a cross-section of fields including pediatrics, obesity research, and psychology, provides a framework to better equip parents and caregivers to talk about weight and health in ways that are factual, meaningful and helpful.

There is no question that this is a step – a huge leap, actually – in the right direction. At the same time, I also know it is not enough. As director of the STOP Obesity Alliance, I examine issues regarding weight and health from a three-pronged perspective involving

personal, policy and public health concerns. We need to take each into consideration when crafting approaches to address and prevent obesity. That’s why I was greatly encouraged when a new, local health initiative in Philadelphia wanted to build upon our national efforts and create a meeting discussion toolkit for local community leaders based on the *Weigh In* guide.⁷ The toolkit provides everything a community leader might need to host a small group discussion with parents to help them talk to their kids about weight and health. And, for Philadelphia families, the kit includes a local resource list that identifies places to purchase healthy foods (including dining-out options) and activities for families to enjoy together in the city.

The Philadelphia Health Initiative (PHI), a newly-created and diverse group of stakeholders, is working to create integrated and measurable efforts in community, workplace and healthcare settings, all designed to prevent and treat obesity and diabetes. Designed to amplify and

Continued on page 16

accelerate valuable work already underway in Philadelphia, ultimately PHI hopes to achieve not only better health locally, but to be a model for how other communities can mobilize and coordinate their unique assets to improve health.

PHI held its first public discussion in May, in which I joined a diverse group of experts including: David B. Nash, MD, MBA, Dean of the Jefferson School of Population Health;

Barbara Connors, DO, MPH, Chief Medical Officer of Center for Medicare & Medicaid Services, Region 3; Neil Goldfarb, Executive Director of the Greater Philadelphia Business Coalition on Health; and Giridhar Mallya, MD, MSHP, the Director of Policy and Planning for the Philadelphia Department of Public Health. The panel talked about some of the great work already underway in Philadelphia and how that work has begun to move the needle on childhood obesity.

I look forward to seeing the change that the PHI will help bring about in Philadelphia – and having the STOP Obesity Alliance take part of this local-area work. ■

Scott Kahan, MD, MPH

Director, STOP Obesity Alliance

To learn more about the PHI or the Weigh In discussion toolkit, email weighinphilly@jefferson.edu.

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Dr. Gerald Meyer Emphasizes “Courage” at the American Society of Health System Pharmacists

The following is an excerpt of an inaugural address given by Gerald E. Meyer, PharmD, MBA, FASHP, new President of the American Society of Health System Pharmacists (ASHP), at the Opening Session of ASHP’s Summer Meeting in Minneapolis, MN, June 4, 2013. Included in this excerpt are highlights from questions submitted from ASHP members. Dr. Meyer is Director of Experiential Education at the Jefferson School of Pharmacy.

I would like to begin by acknowledging you—our members. I want to personally thank all of the members who have participated in ASHP’s state societies. ASHP could not fulfill its mission without the support and inspired leadership of our affiliates. Yes, being president of ASHP involves a lot of time and travel. But it also comes with a large support staff.

The volunteer leaders in our affiliates, on the other hand, *do it all*. You are the membership committee, the program committee, the finance committee, the professional advocacy committee, the strategic planning committee, and so much more. So, to all of you, a great big thanks!

A Rich Pharmacy History

Many of you may know that I am from Philadelphia. And I am *proud* of it.

Philadelphia has a very rich pharmacy history. We have the first hospital in the United States—Pennsylvania Hospital — founded by Benjamin Franklin in 1751. We have the first college of pharmacy in the United States—the Philadelphia College of Pharmacy, which opened in 1821. And we had the first hospital pharmacist in the United States. His name was Jonathan Roberts.

We also lay claim to the first Hospital Pharmacy Residency Program to be surveyed for ASHP accreditation and the first accredited Pharmacy Technician Training Program, both at Thomas Jefferson University Hospital.

We have four past-presidents of ASHP currently working in Philadelphia and a fifth in retirement nearby. I have been truly fortunate to have had access to so many health-system pharmacy leaders.

I am most appreciative for the inspiration, support, and encouragement that I have received from numerous professional colleagues – including more than 230 pharmacy residents – at Thomas Jefferson University Hospital and Thomas Jefferson University with whom I have had the privilege to work. And, most importantly, I am thankful for the wonderful personal support

from my wife, Cheryl, my sons Kevin and David, and many family members and friends.

Top Priorities

In writing this speech, I definitely had a lot of people to call upon. Yet, as much as I value their wisdom, I did not ask a single one of them for guidance on what I should talk about today. Rather, I asked you, the members. ASHP is a membership organization. It is owned by you, its members. So I felt it was appropriate to focus our discussion today on those issues that are of greatest importance to you.

We sent out a survey to a random sample of ASHP members and asked: “What question would you like to ask Gerry Meyer?” Well, you did not disappoint. We received 130 questions, many of which spoke to the concept of courage.

“What will be your top priorities as incoming president of ASHP?”

I have a list of priorities to share with you. But *my* priorities are of little value unless they become *our* priorities. My top priority, therefore, is to be the best leader I can possibly be. And you can’t lead without a vision.

What makes a good leader?

- The ability to articulate a vision,
- The ability to motivate others toward that vision, and
- The ability to remove obstacles to promote achievement of the vision.

Now, who among you can recite ASHP’s vision? ASHP’s vision is that medication use will be optimal, safe and effective for all people, all of the time. There’s no mention of “hospitals” or “health systems.” There’s not even mention of “patients.” It says “all people, all of the time.”

Here is my list of priorities for the year. I would suggest that we view most of the individual items on this list as obstacles confronting us in our efforts to accomplish ASHP’s vision:

- Build coalitions
- Implement the recommendations of the Pharmacy Practice Model Initiative
- Pursue provider status

- Promote interprofessional education and practice
- Expand training and certification for pharmacists and pharmacy technicians
- Position ASHP to be as nimble as possible in a rapidly changing environment, and...
- World peace!

There’s a reason for the last item on the list. Creating an environment in which medication use will be optimal, safe and effective for all people, all of the time is a bold and expansive vision. And just because it is hard to conceptualize, we cannot be deterred from putting our energies towards its achievement. (So, in that respect, our vision is a bit like world peace.)

Antagonism vs. Synergism

“We see a push to work collaboratively with other health care providers but seem to have a difficult time putting this into practice. Are there ways to accelerate this interprofessional practice? Perhaps through pharmacy education and post-graduate residency programs?”

By definition, interprofessional activities clearly cannot be accomplished by one profession. Each profession must be willing to participate.

The good news is that in May 2011, a group called the Interprofessional Education Collaborative—consisting of educators representing pharmacy, medicine, nursing, dentistry, and public health—released a report that summarized the core competencies needed for interprofessional collaborative practice. Those core competencies fell within four domains:

1. Values and ethics
2. Roles and responsibilities
3. Interprofessional communication
4. Teams and teamwork

What this report says is that to build an efficient and effective health care system, health care providers need to:

- Have a common understanding of health care ethics and values

- Understand one another’s roles and responsibilities
- Learn how to communicate with one another, and
- Learn how to be part of effective teams and how to play well together in the sandbox.

For two years, we have had this guidance document that delineates the curricular components that should be taught to health care students, interprofessionally. Our profession needs to take a leadership position in incorporating interprofessional competencies into our formal education and training standards. These changes cannot occur fast enough. Furthermore, to develop this set of skills and knowledge within *practicing* pharmacists, ASHP must incorporate this critical content within our continuing professional development offerings.

It’s important to consider what this report does *not* say. Nowhere does it say that interprofessional education should encompass getting health care students into the same classroom to teach them pathophysiology, pharmacology, diagnosis, or treatment. So, if those are not our commonalities, then those must be our differences. *Exactly.*

Let’s look at this in pharmacologic terms. Sometimes, we administer two very effective drugs that may compete for the same receptor, and the result is that they become less effective. We call that phenomenon “antagonism.” On the other hand, sometimes we prescribe two drugs and the positive effect is greater than the anticipated sum of their individual effects. We call that “synergism.”

Let’s move past interprofessional antagonism. Let’s have the courage to promote an efficient and effective health care system comprised of *interdependent, synergistic* health care providers.

The Future of Residency Training

Among the questions I received, more related to residencies than to any other topic. Two members asked: *“How does ASHP plan to help grow the number of residency programs and the number of available positions? And, how can the accreditation process be simplified?”*

Continued on page 18

Although it sometimes may *feel* like we are making little progress in this area, the numbers tell a different story. From 1995 to 2006 (a 12-year period), the number of available accredited residency programs and the number of available positions in those programs doubled. From 2006 to 2012 (a subsequent 6-year period), the number of accredited residency programs and number of positions doubled again.

Part of the reason for this rapid growth is that the value proposition for residencies is easily developed for residents, employers, patients, and the profession. The ASHP website contains a number of documents that can assist practitioners in justifying, designing, and conducting residency training programs.

However, one of the greatest barriers to increasing the number of residency training programs cannot be overcome with guidance documents alone. A good training program requires a *solid infrastructure*.

Pharmacy services must meet contemporary standards of practice. Preceptors must have the ability to impart knowledge and develop critical reasoning skills. Residency program directors must be able to mentor and inspire those entering the profession. And an organization's culture must be supportive of the training mission. We cannot, and we should not, compromise on these foundational pillars.

While ASHP's residency policy is aspirational in nature and the decision about whether to pursue a residency is a career decision and you do not need a residency to obtain a pharmacist license; you *do* need a residency to pursue and advance along certain career paths and the number of those career paths continues to grow every year.

There are four stages to the education and continued training of a pharmacist: pre-pharmacy undergraduate education, professional doctorate education, formalized training, and continuing professional development. *Coordinating the outcomes* of each of these four stages is a professional imperative. Yes; the requirements for the pre-pharmacy and pharmacy curricula will continue to evolve; but, we must recognize that there is only so much that we can accomplish in the classroom because (1) contact time is limited, and (2) students do not have pharmacist licenses.

At some point in time, the profession will need to address the question: Should residency training be *required* for pharmacists to meet their obligation to their patients? At some point, that answer will be "yes." Whether this happens by 2020 or not, it is far better for the profession to prepare for that future than to be unprepared when that future arrives.

Gaining Provider Status

"When are pharmacists finally going to be recognized as providers, and what will it change?"

Many of you may have attended the Provider Status Town Hall at this Summer Meeting where this very issue was discussed. Much of what we heard, we already knew:

- The health care environment is changing.
- Emerging practice models are focused on integrated health care delivery systems.
- Policymakers are seeking ways to make health care more affordable for more people.
- Payment will be focused on quality, not quantity, of care.
- Consumers will demand transparency in the cost of their care.

So, what will happen when pharmacists are recognized as health care providers?

- Pharmacists' patient care services will *improve access*.
- Pharmacists' patient care services will *improve quality*.
- Pharmacists' patient care services will *help control costs*. Access—quality—cost. There is substantial documentation to support the positive impact of pharmacists on access, quality and cost of care. We know it. Now we have to sell it. We must have the courage of our convictions.

The first step towards achieving provider status is to ensure that the profession moves forward with this *common message* by solidifying these basic principles within the existing coalition of pharmacy organizations. Then, we need to expand the coalition to include other critical stakeholders, including health care provider groups, payers, and patient advocates. We need to draft legislation

and seek support by educating legislators, both on a state and national level.

ASHP will serve as your collective voice in formulating the message. ASHP will develop the materials needed to deliver that message. ASHP will tailor those materials for different audiences. And ASHP will train you. But, *we need you to deliver the message* to your legislators, to your C-suite, to your health-system's lobbyists, to your health care colleagues, to your complacent pharmacist colleagues, to your local media, and to your patients. Access—quality—cost. The message is clear. The message is focused. The message meets society's needs.

Gaining provider status will ensure that pharmacy is at the table when regulators and other policymakers invite *health care providers* to help construct new delivery models. And that is why ASHP, the American Pharmacists Association (APhA), the American College of Clinical Pharmacy (ACCP), and other health care organizations have committed significant resources to achieving provider status for pharmacists.

While no one can predict when we will finally succeed, I am confident that we *will* succeed if we have the courage to stand strong and united on this issue and if our members get personally involved.

I call upon all pharmacists who believe they are health care providers, on all student pharmacists who believe they are training to become health care providers, on all people who want their medication use to be optimal, safe and effective all of the time. I call on everyone to send the message: "*Pharmacists are medication-use experts. Pharmacists improve access, improve quality, and control the cost of health care. Pharmacists are health care providers.*"

In closing, I want to thank everyone who took the time to submit questions. I invite you to continue to send me your comments and suggestions over the next year. Send your emails to: prez@ashp.org.

Finally, I want to thank you for the courage you show every day toward advancing ASHP's vision: that medication use will be optimal, safe and effective for all people, all of the time. ■

Population Health Forums

Applying Comparative Effectiveness Research and Evidence-Based Medicine to Everyday Decisions

Robert W. Dubois, MD, PhD

Chief Science Officer

National Pharmaceutical Council

April 17, 2013

Comparative Effectiveness Research (CER) and Evidence-Based Medicine (EBM) is at the heart of many transformative changes in health care, driven in part by the Affordable Care Act (ACA). Robert W. Dubois, MD, PhD, Chief Science Officer at the National Pharmaceutical Council, offered a compelling and succinct overview of CER and EBM at a Forum this past spring.

The National Pharmaceutical Council (NPC) is a health policy research organization focused on the advancement of good evidence and science, and fostering medical innovation within the United States. Dr. Dubois oversees NPC's research on policies related to CER and health outcomes. Throughout his career, Dr. Dubois' primary interest has centered on defining "what works" in health care and finding ways for that evidence to inform health care decision making. He is a recognized expert in defining best practices, disease management and appropriateness of care.

Dr. Dubois began his presentation by explaining that CER is not exactly new, but that it is related to EBM and decision making; in other words, it is important that

it is used to examine and improve clinical practice. He refers to Eddy's model of thought process that describes evidence, scientific judgments and value judgments, and how these influence decisions.¹

Dubois described EBM as a general concept of using evidence to apply to a clinical decision, whereas CER is a more patient-focused strategy that compares alternative approaches to management. Dubois provides an easy approach to the thought process around CER by using these questions: *What works when? For whom? And Under what circumstances?* Adding to this, he outlines characteristics that are critical to CER and decision making: delivery of the right care, to the right patient, at the right time, in the most appropriate setting. He states that we have to make this easy to do and embedded in how we make health choices.

Although there is overlap between CER, EBM and Health Technology Assessment (HTA), Dubois identified differences: CER is primarily a research activity to answer certain questions; EBM is focused on the application; and HTA is centered on

assessment and cost-effectiveness.

Dubois discussed two major motivators illustrating the need for CER. First, patients face many alternative therapeutic options to manage their conditions, and comparative evidence is often not available. Second, the complex and chronic conditions characteristic of the baby boomer population demand different and effective health strategies, especially as we face concerns about rising health care costs.

Dubois went on to discuss the relationship between CER and medications. He described the challenges of population vs. individual results. For example, efficacy data on certain medications may not apply to individuals. Posing the question, "Will access to medications be constrained?" Dubois states that this could vary in different states. This is an example of how difficult it can be to translate CER into policy choices. ■

For more information on the National Pharmaceutical Council visit:
<http://www.npcnow.org/>

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

Jonathan M. Niloff, MBA, MD

Chief Medical Officer, MedVentive

Vice President, Executive Medical Director, Population Health, McKesson

May 8, 2013

Dr. Niloff is vice president and executive medical director of population health for McKesson Provider Technologies' Health Systems Performance Management organization. He is also Founder and Chief Medical officer for MedVentive,

which is now a part of McKesson. Dr. Niloff is responsible for the strategic development of population health analytics and solutions. His core areas of expertise include: accountable care; population health; improving the quality and

efficiency of healthcare delivery; helping organizations become clinically integrated; and improving cost of care among at-risk populations and networks.

Continued on page 20

At the May Forum, Dr. Niloff's presentation focused on ways to achieve organizational alignment and manage successfully through health care transformation. He first described the groundwork required to adapt to the challenges and opportunities within the changing healthcare environment. Niloff points out that most CFOs are anticipating the reality of impending reductions in commercial reimbursements, and there is a clear shift toward models of Medicaid managed care, which Niloff refers to as "back to the future." The adoption of this model is accelerating, and this changing environment also means that risk is transitioning to providers.

Niloff described transition challenges, including conflicting contract models and

conflicting incentives, particularly between physicians and hospitals. He emphasized the importance of alignment and buy-in among all constituents.

Healthcare systems must be concerned with aligning physicians and coordinating care. Niloff identified a shift from transactional care to population management. This new model of care is a more proactive approach in looking at populations, identifying patients who are most at risk, and managing populations across the care continuum.

Niloff went on to explain that success requires interrelated strategies: data strategy; IT strategy; and adoption and communication. Integrating these strategies into the clinical work flow can be one of

the most problematic challenges. New programs and technology are needed for success and must include a continuous integration program focused on guideline compliance, and coordination of care.

Ideally, health care systems should have all patients being cared for in a system using a single platform or database that is shared across all caregivers and networks, regardless of specialty or geography. Data must be processed in a way that each clinician and their team are able to access a user friendly view of that patient, relevant to that specialty. Niloff concluded his talk by emphasizing the need to have patient information embedded into the work flow...this is key for the future of care coordination. ■

Managing Population Health in Low to Moderate Income Medicare Eligibles

Craig Tanio, MD

*Chief Medical Officer
ChenMed*

June 12, 2013

The Spring Forum season closed with an interesting and forward-thinking presentation by Craig Tanio, MD, Chief Medical Officer for ChenMed, a company that oversees Chen Neighborhood Medical Centers, serving Florida seniors, and JenCare, a joint venture with Humana, serving other regions within the US. Dr. Tanio specializes in internal medicine, with an emphasis on complex cases, preventive medicine, health care disparities and quality improvement.

Dr. Tanio first addressed the overarching issues affecting his concerns about health care. He explained that primary care and integrated care are major unmet needs in the US and it is very challenging, if not impossible, to make health care affordable without them. As providers look to strengthen their primary care base (i.e. medical home), the majority of organized efforts are in the context of hospital-based systems or larger integrated delivery systems. There is however, a minority of efforts focused on building primary care through bottom-up innovation; these efforts tend to drive more rapid innovation than existing entities.

The ChenMed vision is based on positively changing American health care through primary care innovation for the neediest populations. Inspired by his own life threatening illness, founder Dr. Jenling James Chen, designed the company to meet the needs of seniors by offering quality, well-coordinated care in an accountable and compassionate physician-led culture.

At the core of ChenMed's approach is a business strategy that focuses on: low to moderate income seniors with 5 or more chronic conditions; urban areas with health system competition; HMO Medicare Advantage; and full capitation risk-adjusted capitation through hierarchical condition categories. ChenMed is not trying to optimize around fee-for-service medicine. Along with this focus, Dr. Tanio described a one-stop shopping approach that enhances coordination, collaboration, convenience, and compliance. He further explains that this model essentially resembles an ambulatory ICU and has the capacity to keep patients out of the hospital. Primary care doctors lead the care team and do not have private offices; door-

to-door transportation improves patient access to care.

The ChenMed model consists of many other core elements, including a physician culture built on leadership, physician value proposition, and accountability and peer review. Information technology is another core element and Tanio emphasized the importance of using the technology for all stakeholders (i.e. clinicians, patients, pharmacy, care managers), and examining technology beyond the electronic medical records. Other core elements include leveraging effectively in integrated care; understanding the key drivers of success; and bringing in ideas outside of healthcare.

Tanio summarized his presentation by stating that increased investment in primary care on the front end helps to reduce overall costs in the future and improve care. ■

To listen to Forum podcasts and access presentations visit: <http://jdc.jefferson.edu/hpforum/>

Grandon Workshop

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

April 17, 2013

In this workshop, Dr. Dubois continued to discuss CER through a stimulating discussion of heterogeneity and the importance of finding a balance between CER results at the population level and when that may be applied appropriately to the individual.

Dubois identified key factors to be taken into account when considering variation in individual treatment response as: likelihood of response to similar treatments; clinical consequences of delaying optimal treatment; underlying patient diversity; and patient preferences. These factors influence and affect the higher risk and clinical impact of heterogeneity. Dubois used the example of treatments for depression and multiple sclerosis to show how difficult it is to provide a population-based framework for treatment. Individual differences and patient preferences are significant factors in treatment strategies.

The audience had the opportunity to ask a number of questions, and the interactive session also addressed issues of payments for tests, companion diagnostics, and value-based purchasing. Dr. Dubois concluded by discussing some of the new payment changes to providers, where they will be accountable for both the economics of care, and quality performance.



Grandon
Society



Jefferson School of Population Health invites you to join the **Grandon Society**, a membership organization comprised of individuals and organizations focused on advancing population health. 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

Questions?

Contact Amanda Solis at (215) 503-6871

Upcoming Jefferson School of Population Health Forums

September 11, 2013

Pathways for Successful Accountable Care Organizations: Physician Engagement

James E. Barr, MD

Medical Director

Optimus Healthcare Partners and Atlantic Health Systems Accountable Care Organizations

Location: Bluemle Life Sciences Building, Room 101

October 9, 2013

Population Health as a Corporate Strategy: The Value of Investing in Wellness

Dixon Thayer

Chief Executive Officer

HealthNEXT

(Please note: This Forum will be followed by a special Grandon Society member only workshop.)

Location: Bluemle Life Sciences Building, Room 105/107

November 13, 2013

The Role of Employers and Business Coalitions in Improving Health Care

Neil Goldfarb

Executive Director

Greater Philadelphia Business Coalition on Health (GPBCH)

Location: Bluemle Life Sciences Building, Room 105/107

December 11, 2013

A Continuous Quality Improvement Approach to Organizational Cultural Competence

Cheri Wilson, MA, MHS, CPHQ

Program Director, Culture-Quality-Collaborative

Faculty Research Associate, Department of Health Policy and Management

Johns Hopkins Bloomberg School of Public Health

Hopkins Center for Health Disparities Solutions

Location: Bluemle Life Sciences Building, Room 101

All Forums take place from 8:30 am – 9:30 am

For more information call: (215) 955-6969



October 12-13, 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 3rd **Business of Medicine Summit: Healthy Practice, Healthy Patients**. This CME-Certified program focuses on the practical aspects of running a successful practice will feature nationally recognized experts.

At the event, educational sessions and presentations in **Stark Law, Health IT, Meaningful Use 1-3, PQRS, Value-based reimbursements, New MOC Reimbursement, Physician Compensation Models, Survival Strategies, Practice Efficiencies, Coding**, and many other topics focused on supporting today's and tomorrow's physicians and medical practices.

Featured presenters include **Christine A Sinsky, MD**, a medical home practice expert, and a director, American Board of Internal Medicine.

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

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

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

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Comer DM, Couto J, Aguiar R, Kolm P, Elliott D. Identifying medication discrepancies through linked administrative pharmacy claims. Poster presented at: AcademyHealth Annual Research Meeting, June 2013, Baltimore, MD.

Comer DM, Couto J, Aguiar R, Ratledge E, Elliott D. Characterizing medication fills through linked administrative pharmacy claims. Poster presented at:

ISPOR International Annual Meeting, May 2013, New Orleans, LA.

Comer DM, Couto J, Aguiar R, Kolm P, Elliott D. Identifying medication discrepancies through linked administrative pharmacy claims. Poster presented at: SGIM Annual Meeting, April 2013, Denver, CO.

Harris D. Strategic planning. Presented at: American Public Health Association Student Assembly's Strategic Planning Meeting, June 15, 2013, Philadelphia, PA.

Harris D. Population health panel. Caucus NJ. Show 2442. <http://www.caucusnj.org/videos/caucusnj.aspx>

Lieberthal RD, Comer DM. Pridit Method to access hospital quality. Webinar presented at: Society of Actuaries Webinar Series, April 24, 2013.

Lieberthal RD. Hospital quality: motivation and metrics. Podium presentation at: Society of Actuaries Spring Health Meeting, June 10, 2013, Baltimore, MD.

Lieberthal RD. Economics of HIX—past, current, and future. Podium presentation at: Society of Actuaries Spring Health Meeting, June 11, 2013, Baltimore, MD.

JSPH OPEN HOUSE INFORMATION SESSIONS

Learn More About Our Academic Programs

This fall JSPH is hosting a series of convenient online and onsite information sessions that will introduce you to a number of our degree and certificate programs including: Applied Health Economics and Outcomes Research; Population Health; Public Health; Healthcare Quality and Safety; and Healthcare Quality and Safety Management.

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Jefferson School of Pharmacy

Joel Port, MHSA, CHE, CMPE
Chief Operating Officer
Accountable Care Organization of Pennsylvania
Jefferson Health System

Rob Simmons, DrPH, MPH, MCHES, CPH
Associate Professor
Program Director, Public Health
Jefferson School of Population Health

Alexis Skoufalos, EdD
Associate Dean
Professional Development
Assistant Professor
Jefferson School of Population Health

Rachel Sorokin, MD
Chief Patient Safety and Quality Officer
Thomas Jefferson University Hospital

**Elizabeth Speakman, EdD, RN,
CDE, ANEF**
Co-Director
Jefferson Center for
Interprofessional Education
Associate Professor
Jefferson School of Nursing

**Richard G. Stefanacci, DO, MGH,
MBA, AGSF, CMD**
Associate Professor, Health Policy
University of the Sciences
Chief Medical Officer, The Access Group

Michael Vergare, MD
Senior Vice President, Academic Affairs
Thomas Jefferson University