

Health Policy NEWSLETTER

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FROM THE EDITORS

The Hospital Bed of the Future

In its seminal publication *Crossing the Quality Chasm*, the Institute of Medicine (IOM) laid the groundwork for conceptualizing, measuring, and analyzing quality along six domains: patient-centeredness, safety, timeliness, efficiency, effectiveness, and equity. For the last two years, the Department of Health Policy has had the privilege of working with a company called GetWellNetwork® to advance quality in the domains of patient-centeredness and safety in the hospital setting in a novel fashion.

GetWellNetwork® is a privately held firm founded in 1999 whose services are utilized in nearly 40 hospitals throughout the United States. The basis of the company is an innovative package of hardware and software elements designed to be used primarily by hospitalized patients, their families, and healthcare providers. The services provided by the GetWellNetwork® have a very personal connection to Michael B. O'Neil, Jr., the founder and CEO of the company. O'Neil developed the idea for the company while he was hospitalized; he was dissatisfied with his access to the type of information and connectivity that he was used to having in the "outside" world. Elsewhere, one of us (DBN) initially described GetWellNetwork®.² In this space, we will look at how the company has evolved.

Patients actively engage the system and their care as they interact with the GetWellNetwork® using a bedside touch screen monitor or other handheld devices to access educational, communication, and entertainment tools. This innovative technology is called Interactive Patient Care (IPC). A byproduct of this interactivity is that it enables healthcare organizations to deliver true patient-centered care.

Patient-centered care is defined by the IOM as "care that is respectful of and responsive to individual patient preferences, needs, and values."¹ "Patient needs" includes the responsibility for educating patients about their condition and expectations for their hospital course.

GetWellNetwork® calls its interactive patient care platform the **PatientLife:~)System 2.0™**. This consists of 3 software packages: the Patient Care Suite™, the Patient Communication Suite™, and the Patient Resource Suite™. Each works in conjunction with another program called Patient Pathways™.

Should they choose to, physicians and other healthcare providers can customize the **PatientCare:~)Suite™** to inform and care for specific needs of individual patients during their hospital stay. This suite offers on-demand access to patient education modules in the realms of safety; education about their condition; a tool to assess the amount of pain they are experiencing, with an eye toward pain management; information about the medicines they are taking; and diet. Many of the patient education programs are in the form of videos that address highly specific conditions. Over 600 videos are available which cover topics of general health and medical specialties. General topics include such things as CAT scans, X-rays, MRIs, diabetes, and depression. Within the specialty area of cardiac disease, for example, are videos describing such detailed subjects as angiograms, atrial fibrillation, and ventricular tachycardia. For those about to be discharged from the hospital, patient education continues with videos that have titles such as "Getting Well Again," "Living Beyond Cancer," and "Sleep Soundly."

The PatientCommunication:~)Suite™, as the name implies, allows for two-way communication between the hospital and its staff and patients. This innovative process is initiated when a "Patient Admission Pathway" is triggered as soon as a patient enters his/her room. This Pathway helps orient the patient to the room, hospital services, information about their physician(s), and other details, helping to diminish the anxiety of the many unknowns associated with a hospital stay.

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The suite lets patients provide feedback to their care staff via instant feedback tools, surveys, and electronic comment cards. For example, an assistance menu provides a list of possible complaints a patient might have during their stay such as: “my room is too hot; my room is too cold; my sink is leaking; my room hasn’t been cleaned,” etc. The patient selects the appropriate option, and sends an instant message to the e-mail or pager of the person whose responsibility it is to handle the complaint, such as the maintenance staff or cleaning personnel—not the nurse on duty! This frees up valuable nurse time which can be spent more appropriately on direct patient care.

The PatientResource:Suite™ is predominantly an entertainment package offering patients access to the Internet, a hospital-based email account, Hollywood movies, television, games and music. It also contains a template for patients to maintain a journal/log of their stay as well as general hospital and visitor information, such as visiting hours, cafeteria hours, special events, etc.

In addition to its contributions in the domain of patient centeredness, the GetWellNetwork® system is readily adapted and utilized to make contributions in the realm of safety. Our Department has been working with the GetWellNetwork® on a project in the domain of safety, directed toward prompting patients to ask questions of their care team by encouraging physicians, nurses, and other caregivers in hospitals to wash their hands before and after contact with them. This is being conducted in the spirit of the Joint Commission (until 2007, the Joint Commission on Accreditation of Healthcare Organizations –JCAHO) initiative called Speak-Up³ wherein patients are encouraged to question their physicians and other providers on safety-related issues.

Unfortunately, compliance with handwashing standards among hospital personnel is still low. It is estimated that handwashing occurs in less than half of the circumstances in which it is indicated, and for a shorter period of time than recommended. Of interest, self-reporting of handwashing by hospital staff has not been proven to be reliable, as staff have been found to routinely overestimate the frequency and quality of their handwashing.⁴ The full CDC recommendations for hand hygiene can be found in their publication “Guideline for Hand Hygiene in Health-Care Settings.”⁵ While their comments confirming that hands of healthcare workers in hospitals are regularly contaminated with pathogenic microorganisms and are the major source of nosocomial infections were not new, their recommendation that alcohol-based hand rubs (ABHRs) should be used for routinely decontaminating hands was new. The Guideline notes that ABHRs require less time and are easier to use than soap and water, are more effective at killing pathogenic microorganisms, and are less irritating to skin, encouraging adherence by healthcare workers.

In an effort to empower patients to become more involved with their care, we will customize GetWellNetwork® to deliver an interactive, tailored, hand hygiene message designed to educate patients and encourage them to remind their caregivers to clean their hands before coming into contact with them. Due

to the nature of the portal, we will be able to capture survey data and customize text and/or video in accordance with their responses. When we collate the data from our study, we believe that this intervention will show an increase in healthcare workers' compliance with appropriate hand hygiene methods, improve patient satisfaction with the care they receive, as well as decrease the number of hospital-acquired infections.

The interactive tools of the GetWellNetwork® can be utilized far beyond encouraging hospital caregivers to wash their hands. Additional uses in the arenas of quality and safety include, in the proper clinical settings, such diverse functions as: encouraging patients to closely observe nurses to make sure they do a proper identification check before giving medications; making patients aware of appropriate discharge medications included in performance measures, such as aspirin and beta-blockers for patients hospitalized due to myocardial infarction; prompting post-surgical patients to get out of bed and use incentive spirometers; delivering and documenting smoking cessation counseling; and encouraging patients to ask for pneumovax.

Hospitals today are driven by powerful market dynamics. While all need to survive financially, those that will be at the forefront focus on adding value in the realms of quality improvement, safety, and service excellence. We believe these GetWellNetwork® tools offer hospitals and patients a competitive advantage. As always, we are interested in your views and you can reach me at david.nash@jefferson.edu.

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Health Care for Homebound Geriatric Patients: Perspective from the Front-Line

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The Problem: A minority of our elderly patients, those with the greatest burden of chronic disease (i.e. our homebound geriatric population), in their last six months of life, use a disproportionately large share of the health care budget compared to other segments of the population. There is little prospect of restoring them to independent living and to less intensive health care maintenance.

This situation is often exacerbated because these persons, due to their “invisibility” from ambulatory society and even the medical profession, do not receive timely medical care to head off developing medical problems. They are often isolated and disenfranchised, and their physicians may not have seen them for years because they are unable to leave their homes and their physicians can’t or won’t come to them. By the time their health has deteriorated to an advanced stage (the condition in which hospital emergency rooms usually find them), these patients are often on a downward slope from which they may be only partially or not at all extricated. They often wind up consigned to a nursing home or return to the unforgiving home environment that allowed their terminal disease and/or disabilities to progress to the point of no return. Alternatively, they may be admitted to a hospital for well-meaning but misguided “care,” giving the patient, their families, and even their physicians the mistaken expectation of some beneficial result. Unless the patient has a fixable acute complication of his/her chronic illness, this expectation will rarely be achieved.

As a physician approaching retirement, I have had the opportunity and privilege of providing care to the homebound elderly. The patients whom I treat – the urban poor – are usually insured by Medicare directly or by Medicare or Medicaid HMOs. They often live in senior apartment housing or, occasionally, individual houses. Their homes are often in substandard conditions, despite their efforts to keep their homes and themselves meticulously clean. My patients often live alone, or have family caregivers either living with them or frequently visiting them. They may be malnourished if they lack sufficient funds to afford food or are unable to get to a market. Some who can obtain food may be unable to prepare it themselves due to physical or cognitive disability.

The homebound elderly, unlike their ambulatory brethren, are dependent and lonely. Although they may previously have been independent and gregarious, they have retreated into their homes because they are physically disabled (due to stroke, amputation, chronic lung or heart disease, arthritis, etc), cognitively or emotionally disabled (due to dementia or depression), afraid or ashamed to socialize (due to incontinence, falls, deafness or blindness), or unable to use public transportation.

Home visits to the homebound elderly involve a very different approach from hospital-based medicine, which today deals largely with acute medical problems. Home visits by mature clinicians, nurse practitioners, and social workers experienced in dealing with chronic disease, can identify early medical problems which can be treated before they fester and become irreparable. The home visit clinician can perform a careful and complete history and physical examination, an environmental assessment (i.e. determine the patient’s financial resources, food

availability, presence or absence of alcohol, relations with and effectiveness of caregivers, if any) and, most importantly, develop a feeling of intimacy and trust with the patient and caregivers. The clinician

can also ascertain possible elder abuse or neglect and can marshal community or other support services to insure that caregivers have the backing to continue their role. Finally, using their knowledge of home care and community organizations, they can obtain laboratory tests, EKGs, a variety of X-rays and ultrasound imaging studies, and can also provide a variety of professional services (i.e. charitable food delivery organizations, physical and occupational therapy, podiatry, psychiatry, audiology, and eye exams) that can be performed in the patient’s home. This type of physician-patient relationship can be fostered more quickly and strongly, and the patients’ problems grasped more readily in their home environment where they evolved.

A Solution: Retired physicians are in a unique position to affect the quality of care for aging populations. It is not unusual for retired physicians to state that they miss patient contact and have little opportunity to use their skills and experiences. I propose that we take advantage of our retired colleagues’ often non-verbalized needs and create a win-win situation by asking them to provide home care for our needy, homebound geriatric population. These clinicians, trained in an era when high-tech diagnostic tools were not yet commonplace, relied for their effectiveness primarily through understanding the course of clinical disease and by spending time with patients, and getting to know their histories well, and providing a thorough examination. Such assets would be particularly valuable in the care of our elderly, homebound population, people who fondly recall when physicians, unimpaired or influenced by financial demands or restrictions imposed, were able and willing to spend precious time with their patients.

Implementation of such a plan would require: 1) identifying and reaching out to retired physicians, 2) providing physicians with adequate social service, nursing, clerical support and community linkages, 3) giving the physician a brief, but intensive course in the medical and social problems of the elderly homebound (which are often different from those of the ambulatory elderly) and, 4) giving these physicians verbal praise and some financial incentives.

Benefits of this plan would include: 1) gratitude of a well-deserving but neglected segment of our population, 2) restoration of the ideals and goals so well expressed in the Hippocratic Oath, and 3) enormous cost savings by instituting efficient home visits and hospice care rather than transferring patients to emergency rooms, subjecting them to hospitalization that will have little beneficial effect on their medical, social or psychological welfare, or consigning them to nursing homes which the elderly almost universally despise and fear. Community-based solutions are consistent with the principles of programs such as Rx for Pennsylvania. Through collaborations with existing medical and geriatric organizations and support from national and community-based agencies, this type of program has the capacity to revolutionize the quality of care for the homebound elderly.

Hospital Inpatient Capacity: Making Room for the Next Patient

Hospital crowding is one of the top issues facing America's healthcare industry. Crowding can be defined as exceeding the carrying capacity. According to a recent report by the American Hospital Association, almost half of U.S. hospitals are at or over capacity.¹ A report published by the Institute of Medicine (IOM) indicates that the past decade has seen an increase in the number of patients being treated in Emergency Departments (EDs), while the number of hospitals reporting ED visits is declining. The IOM also states that each year over half a million ambulances with emergency patients will be diverted to a treatment center that is farther away.² Communities are unable to access the appropriate medical care in the appropriate setting by the appropriate clinicians, compromised by the disparate system of medical records across hospital systems.

Furthermore, this capacity issue is making it difficult for healthcare systems to achieve the six aims of healthcare—care that is safe, effective, patient-centered, timely, equitable, and efficient—that are recommended by the IOM.³ All of these aims are at risk when there are inadequate resources to provide care or resources are allocated inefficiently, which can lead to negative outcomes, long wait times, and poor patient satisfaction.

Although the most visible impact of crowding is on EDs, crowding is an issue facing the whole house and capacity management must be tackled by the entire organization. The federal government has started to take notice. Congress has introduced a bill to create a commission dedicated to examining factors driving effective ED care in addition to improving payments to certain ED physicians.

The capacity issues in the region were the main focus this past spring, when the Hospital and Healthsystem Association of Pennsylvania (HAP) held its 1st annual conference on Patient Capacity Management. Attendees felt a sense of urgency to do something about the capacity issues facing our systems. Main Line Health (MLH) had several attendees who brought discussions to the larger Jefferson Health System (JHS) level, specifically to the Chief Medical Officer, Dr. Stanton Smullens and the process improvement guru from Premier, Anthony Veese. What developed was the first JHS Patient Flow Summit held on July 17th, 2007 at the American College in Bryn Mawr. Sponsors included JHS, MLH, and Premier, Inc.

Mutual interest in the issue of capacity management and open communication helped bring together the fragmented pieces of the capacity puzzle. The system recognized the critical need of a common vision for change and used the Patient Flow Summit as an opportunity to define that vision. Objectives included providing the skills, incentives, and resources to member organizations to work towards mitigating the impact of capacity problems.⁴

The Summit included presentations by member organizations showcasing specific capacity or throughput initiatives and projects implemented at various JHS facilities. Main Line Health-Bryn Mawr Hospital outlined how to improve the

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efficiency and effectiveness of patient flow within the hospital through interdisciplinary collaboration with a focused team approach. Bryn Mawr implemented solutions such as: dedicated fast care of non-urgent patients; fast track

of lab testing; utilization of a patient flow coordinator; instant bed status alert; rapid admit nurse; and day-before-discharge program.

Frankford Hospital used rapid cycle teams to establish baseline metrics including improved patient satisfaction, decreased number of shifts holding patients, decreased amount of patients leaving prior to treatment, increased physician and staff satisfaction, and improved throughput times. Frankford identified clear goals such as: decreasing patient delays and access problems; improving the ability to rapidly identify the sickest patients and move them to the most appropriate level of care; and delivering patient care rapidly and moving patients to the appropriate part of the hospital seamlessly.

Albert Einstein Healthcare Network utilized integrated hospital-wide efforts to redesign ED processes and functions, including: establishing criteria for divert status; initiating ED care management program; utilizing criteria for admitting patients; and enhancing notification systems for ED crowding. Care Management was redesigned to include multi-disciplinary rounds, education and competency training, and the establishment of a resource center. A single point of accountability was established through a patient flow coordinator, while care and bed management software were utilized.

Thomas Jefferson University Hospital and JHS employed the use of a Bed Management Center (BMC) to improve patient flow. The BMC was led by a team of individuals from patient registration and logistics in addition to a bed officer. This team directed a bed board, admissions and discharges, and a bed management team (patient flow coordinator, housekeeping, and transport). Key performance indicators included: time the room is assigned; external transfers accepted; patient satisfaction; total hours a patient is in pre-admission testing; and average number of patients boarded in the ED, in addition to others.

The purpose of the Summit was to spark discussions about what worked and what didn't work, and to solicit suggestions for improvement. Furthermore, participants had the opportunity to see the latest technology in the area of capacity management and ask questions of vendors who provide solutions which included bed management, resource tracking, and decision support. Evaluation of the Summit revealed the majority of attendees were able to achieve their objectives and found presenters to be effective. These evaluations will be reviewed to improve future JHS Summits.

The collaborative nature of this event fostered a candid dialog about where we are in the region with capacity issues, and more specifically, how JHS is dealing with the problem. Leaders throughout JHS are working to answer this question and discover, more importantly, how JHS *should* deal with the

capacity issues in our region. Stanton Smullens, MD (Chief Medical Officer of JHS) and Nancy Valentine, PhD (Chief Nursing Officer of MLH) have organized a workgroup to ensure that the momentum of the Patient Flow Summit will not be lost. The leaders will engage the Senior Leadership at the member hospitals to look for areas of best practice and share the across all the organizations in JHS. With a specific and detailed action plan in place, JHS can move towards change and be successful in alleviating the stress that overcapacity has caused its member organizations.

Please address questions and comments to hansont@mlhs.org.

For more information about capacity issues in Pennsylvania visit the Hospital and Healthsystem Association of Pennsylvania's website on the Pennsylvania Hospital Capacity Enhancement Initiative at <http://haponline.org/quality/capacity/>.

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Department of Health Policy Hosts CMS Presentation on Value-Based Purchasing

On October 15, 2007, the Department of Health Policy hosted a three-hour presentation and policy discussion with representatives from the Centers for Medicare and Medicaid Services (CMS) on the topic of Value-Based Purchasing.

Leading the discussion on behalf of CMS was Thomas Valuck, MD, JD. Dr. Valuck is the Director of the Special Program Office for Value-Based Purchasing. He was accompanied by the chief medical officers from the Philadelphia, New York, and Chicago CMS offices. Attending on behalf of Jefferson were representatives of leadership from Thomas Jefferson University Hospital, Jefferson University Physicians, the Jefferson Clinical Care Committee, and the Department of Health Policy.

The meeting was initiated by an invitation from David Nash, MD, MBA, Chairman of the Department of Health Policy at Jefferson, to Dr. Valuck. Dr. Nash thought the meeting would provide a useful forum for Jefferson leadership and the CMS team to interact and discuss proposed changes in the reimbursement models for health care services.

The presentations and discussions were organized around three main themes: "Value-Based Purchasing Initiatives," "Hospital Acquired Conditions-Not Paying for not Performing," and "Measuring Physician Resource Use: The Next Frontier."

The message of the "Value-Based Purchasing" portion of the presentation was that it is the goal of CMS to transform Medicare from a passive payer to an active purchaser of high quality, efficient health care. The tools that will be utilized to

achieve that include pay for reporting (the current Physician's Quality Reporting Initiative-PQRI), pay for performance, and gain-sharing. All of these are part of the roadmap as Medicare transitions its approach to paying for provider services. Another key take-away message was that quality must be improved, unnecessary costs must be avoided, and all of this must be documented.

In the "Hospital Acquired Conditions-Not Paying for not Performing" portion, the discussion centered around the conditions selected for non-reimbursement from Medicare and the rationale for the initiative. Jefferson physicians provided feedback regarding some of the conditions chosen that had the potential to be controversial; this feedback was taken under advisement by the CMS team.

The last presentation, "Physician Resource Use: The Next Frontier," centered on a methodology called "episode groupers." This is a technique to evaluate and compare the cost implications of clinical decision making patterns of physicians, to determine which physicians use resources most efficiently. While the methodology is complicated, CMS believes it holds promise for reining in costs and improving quality in the future.

In conclusion, it was clear from the meeting that we are in the early stages of what will turn out to be no less than a revolutionary change in how Medicare pays for provider services, and that CMS was seeking input from as many stakeholders in healthcare as possible.

Pennsylvania Academy of Family Physicians Lecture Series “21 Strategies to Survive in the 21st Century”

Over the course of the past several months, I have had the privilege of addressing family physicians in the eastern part of Pennsylvania in a series of dinner CME presentations entitled “21 Strategies to Survive in the 21st Century.” These presentations have been made on behalf of the Pennsylvania Academy of Family Physicians (PAFP).

Each year, the PAFP sponsors a series of regional meetings throughout the state designed to inform its members on topical areas of importance. During the previous two years, the lecture series addressed “Pay for Performance” and “Electronic Medical Records. While “21 Strategies to *Survive* in the 21st Century”¹ may seem at first a dramatic assessment of the current state of family physicians, it captures the essence of the state of affairs for many family physicians given decreasing reimbursement and the many changes currently taking place in healthcare throughout the state and the country. I would like to share with you additional background of the presentations and some of my observations gleaned from dialogue with attendees.

The theme and title for the lecture were developed by Patricia Bricker, the Director of Practice Advocacy for the Pennsylvania Academy of Family Physicians and Foundation. The book “Practicing Medicine in the 21st Century,” recently published by the American College of Physician Executives and edited by David Nash, MD, Chairman of our Department of Health Policy at Jefferson served as the basis of the content of the presentation. Given the topical, educational and practical perspectives of the book, Pat concluded that this was the perfect vehicle for communicating a variety of important updates and messages to family physicians throughout the state. With that, a presentation was developed which outlined in the introduction our impression of the societal factors coalescing in a “perfect storm” to drive the current rapid pace of change in healthcare, followed by twenty-one specific strategies to adapt to those changes.

The strategies were organized around the themes used in the five section headings of the book, namely: Clinical Management (Quality, Safety, Pay for Performance), Information Management (Electronic Medical Records, E-Prescribing), the Practice Environment (Risk Management, Managed Care, Medicare and Medicaid, Disease Management), Practice Management (Open Access Scheduling, Operational Organization, Workflow Process Re-engineering), and Financial Management (Documentation, Coding, Billing, Accounting Tools). Our goal in developing the presentation was not only to provide updates on policy related initiatives, but to provide concrete suggestions relating to quality, safety, and practice organization that could enhance the practitioners’ financial bottom line through enhanced revenue opportunities and savings on office expenses through more efficient practice processes. The presentation was delivered in such a fashion as to facilitate questions, comments, and interaction between and among the presenter and the audience.

I must confess that I was surprised to learn of the lack of awareness, preparedness, or implementation on behalf of the family physicians of many of the major policy initiatives underway. For example, when questioned concerning their awareness of the existence of the Physician Quality Reporting

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Initiative (PQRI-Medicare’s voluntary Pay for Performance program), approximately 50% responded affirmatively. And while half of the physicians had heard of PQRI, only approximately 5% indicated they

planned to report on any of the quality measures. In other areas, approximately 10% of the attendees were using electronic medical records, with the remainder showing little inclination toward adopting this technology. Electronic prescribing was being utilized by less than 5% of the attendees. There was little knowledge of the general theme of consumer directed health plans. The role of the Institute of Medicine in transforming public awareness of quality and safety issues through its two seminal publications “Crossing the Quality Chasm”² and “To Err is Human”³ was essentially unknown to the attendees. And while many of the physicians were aware of and felt threatened by the emerging trend toward “Convenient Care Clinics,” they generally had little or no insight as to their role in fostering the development of this movement by virtue of their office practice patterns, and had even less insight as to strategies concerning what to do about it. As to increasing office efficiency through process re-engineering, the general reaction was that physicians did not have time for such activities, were not trained to manage them and could not afford to bring in outside consultants to carry them out.

I would like to focus especially on the feedback concerning the PQRI. This is a major policy initiative in this country which I believe has merit on many levels. If the PQRI initiative follows the path of the Hospital Quality Reporting Initiative, it will be first voluntary and then mandatory, and likely tied to Medicare reimbursement rate increases. If the PAFP physicians’ participation in this program is indicative of participation nationwide, when the program is reviewed after this trial, it will not be considered a success.

I feel that this program may have been implemented too rapidly to address the details that will maximize its opportunity for success. Indeed, there are currently two bills before Congress, the Voluntary Medicare Quality Reporting Act introduced in the Senate by Sen. Ben Cardin, D-Md. and Sen. Arlen Specter R-Pa., and companion legislation introduced in the House by Reps. Bart Gordon D-Tenn. and John Shadegg R-Ariz., that would give Medicare officials more time to figure out how best to run a voluntary quality reporting program and prevent the program from becoming mandatory in 2008. In a statement released when the bill was introduced in May 2007, sponsor Sen. Cardin said, “Current law does not provide sufficient time to assess the appropriateness and effectiveness of this new system. Nor [does it] take into account the fact that most physicians and other health professionals have no experience in quality reporting and do not have in place the necessary health information technology and administrative infrastructures to participate in a reporting system.”⁴ In addition, Sen. Cardin noted the difficulties some medical practices would face if a reporting program became mandatory in 2008. “Across America, there are practices that would face tremendous obstacles in meeting such standards: they lack the information technology necessary to document and report standards in a timely manner; they see patients with economic and language barriers that will result in higher noncompliance rates; they treat a patient

population for whom ethnic and racial differences require different clinical interventions than for other patients,” Sen. Cardin said. “Ignoring these considerations will not only fail to dramatically improve quality, it will significantly penalize providers who treat the traditionally underserved populations.”

Clearly, in this regard, Sen. Cardin has his finger on the pulse of what I have observed in my PAFP lectures throughout Pennsylvania.

If you have comments on this article, please contact me at richard.jacoby@jefferson.edu.

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Getting Boards On Board October 19, 2007

The Department of Health Policy worked with Premier | Care Science to develop a leadership conference specifically for those involved in hospital governance. “Getting Boards on Board: Leadership Strategies for Quality and Performance Improvement,” was held in Philadelphia on October 19th and attracted 105 attendees from throughout the US. Presentations by seven noted authorities and a discussion moderated by David B. Nash stimulated the audience to consider new approaches to the challenges regarding quality.

Stephanie Alexander, MBA, Senior Vice President and General Manager of Healthcare Informatics at Premier Inc., delivered the welcome address and provided insights from the CMS / Premier Pay-for-Performance (P4P) demonstration and extension and the National Leadership Survey regarding “top quality performers” and characteristics of boards, medical staffs, and senior executives which drive such performance.

David B. Nash, MD, MBA, Chair of the Department of Health Policy at Jefferson Medical College, provided an engaging presentation on “Leadership for Quality and Safety: The Role of the Board,” reviewing statistics, his professional and personal experiences, and other case studies to show trends and challenges in hospital quality and safety; also highlighting board-level structure and process changes needed for boards to succeed in overseeing quality.

Blair L. Sadler, JD, Senior Fellow at the Institute for Healthcare Improvement and Vice Chair of the Center for Health Design, discussed “Why Building Better Hospitals Will Reduce Harm, Increase Joy in Work, and Save Money,” presenting research evidence and case examples on improved clinical outcomes, patient satisfaction, and staff recruitment and retention and thus making a strong business case for using evidence-based design to “build better hospitals.”

John R. Combes, MD, President and Chief Operating Officer of the Center for Healthcare Governance, presented “A Critical Accountability: The Board’s Role in Quality” and reviewed calls

to action by the National Quality Forum, Moody’s and Fitch’s, and the Institute for Healthcare Improvement and findings from the DELMARVA survey and presented a typology of board accountabilities.

During lunch Richard A. Bankowitz, MD, MBA, FACP, Vice President and Medical Director for Healthcare Informatics, and Eugene Kroch, PhD, Vice President and Chief Scientist, both at Premier, presented the Premier | Care Science Select Practice Awards to the top 49 hospitals selected for superior clinical outcomes and exceptional efficiency.

Following lunch, three speakers reviewed their experiences in quality and performance improvement:

“Cooper Health System: A Case of Change and Opportunity” was presented by Christopher Olivia, MD, its President and CEO;

“The Pursuit of Excellence: The Role of the System Board in a 20 Hospital Organization,” was reviewed by John Hensing, MD, Senior Vice President for Care Management and Quality at Banner Health; and

Marlon L. Priest, MD, Senior Vice President and Chief Medical Officer at the Bon Secours Health System, proposed “Getting Board Members to Ask: “Doctor, Why Do You Do it That Way?”

To consolidate all of the ideas and experiences presented during the day-long conference, David Nash moderated a concluding discussion, highlighting the changing risks and rewards facing healthcare organizations, the changing accountabilities of boards, and the changing competencies required to meet these challenges. The key take-home message from this conference is this: Ultimately, the board bears the financial responsibility for quality and safety—not the medical staff or hospital leadership.

Department of Health Policy Presentations

Berman B. *PQRI Implementation: A Report from a University Practice Plan.* University HealthSystem Consortium 2007 Fall Forum, October 10, 2007, Palm Springs, CA.

Berman B. *Physician Adherence to Prenatal Clinical Performance Measures Among Jefferson University Physicians.* Poster presentation at the University Health System Consortium 2007 Fall Forum, October 9-12, 2007, Palm Springs, CA.

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Reifsnyder J. *Expanding Horizons: End of Life Ethical Dilemmas in Non-Hospice Settings.* New Jersey Hospice and Palliative Care Organization Annual Conference, November 7, 2007, Eatontown, NJ.

Safarty M. *Colorectal Cancer Screening: Tools for Your Practice and the Evidence for Them.* New Jersey Academy of Family Physicians and the American Cancer Society, Train the Trainer Conference, October 20, 2007, Trenton, NJ.

Safarty M. *Response of Pennsylvania Insurers to the New HEDIS Measure on Screening for Colorectal Cancer.* American Public Health Association 135th Annual Meeting, November 3-7, 2007, Washington, DC.

Simmons R. *Tobacco Control-How It Became a National Environmental Health Issue.* Philadelphia Department of Public Health, Division of Chronic Disease Control Environmental Health Forum, August 10, 2007, Philadelphia, PA.

Simmons R. *Cardiovascular Health: Education and Motivational Methods-Applying What You've Learned.* Cardiovascular Institute of Philadelphia Annual Conference, September 26, 2007, Philadelphia, PA.

Simmons R. *Making the Most of Your Health Education Career: Finding Your Passion.* Pennsylvania Society of Public Health Education (SOPHE) Conference, October 12, 2007, Philadelphia, PA.

Simmons R. *2008 Priorities for Health Education and the Society of Public Health Education.* Pennsylvania Society of Public Health Education (SOPHE) Conference, October 12, 2007, Philadelphia, PA.

Simmons R. *Career Opportunities in Public Health Law: The Jefferson JD/MPH Combined Degree Program.* Widener University School of Law, Health Law Institute Annual Conference, October 19, 2007, Wilmington, DE.

Simmons R., Strack R. *Inspiring Students Out of Their Desks and Up to the Hill.* The National Health Education Advocacy Summit. Society of Public Health Education (SOPHE) Annual Meeting, November 2, 2007, Washington, DC.

Yuen EJ. *Shaping the Face of Grief: Understanding Culture and Diversity.* Palliative Care Team, Pennsylvania Hospital, August 28, 2007, Philadelphia, PA.

Yuen EJ. *Stress Reduction in the Workplace.* U.S. Environmental Protection Agency, Region III, September 18 and 25, 2007, Philadelphia, PA.

Yuen EJ. *Cultural Diversity and Health Policy Research.* Symposium on Health Care Access: Ethical and Cultural Issues, Widener University, November 8, 2007, Chester, PA.

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New Publications from the Department of Health Policy

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Department of Health Policy Forums

Household Survey and Consumer Driven Health Care

Cindy Fillman

Consumer Liaison

Pennsylvania Insurance Department

September 12, 2007

According to a 2004 survey conducted by the Pennsylvania Insurance Department, the majority of Pennsylvanians tend to have some type of health coverage. This is directly due to the fact that Pennsylvania is an industrialized state with buy-in from employers in large companies. Results of this phone survey, which reached over 256 individuals, also highlighted some key concerns:

- The cost of health insurance is still a problem, mostly affecting the working poor.
- The uninsured population is younger, between the ages of 18-34. This population is less expensive to cover, and more difficult to reach.
- Those working for larger companies tend to have private health insurance.
- Many individuals are not familiar with their explanation of benefits.
- African Americans are more likely to be without healthcare coverage, compared to other racial groups.
- Many people decide not to go for check-ups if they have to pay for it out of pocket.
- Most uninsured Pennsylvanians who are employed work in the service industry.

The PA Insurance Department was created over 2 years ago as a regulatory office designed to provide education and outreach for consumers, and review legislation and policy. Cindy Fillman, Consumer Liaison for the Pennsylvania Insurance Department, explained that the cost of health insurance, particularly for small businesses, is the biggest issue complicating insurance reform. Fillman provided an overview of factors affecting health insurance costs such as: aging populations; technology; cost shifting; mandated benefits; drug costs; and open access products.

In response to these factors, Pennsylvania has explored ideas such as universal coverage and consumer-driven health care. Currently, the spotlight is on Consumer-Driven Health Plans (CDHPs), whose concept is directly rooted in an attempt to address the drawbacks of managed care. Whereas managed care limits consumer choices and decisions, consumer-driven health care is designed to provide options, and involve the consumer in the selection of services and costs. CDHPs may include such programs as Medical Savings Accounts (MSAs); Health

Reimbursement Accounts (HRAs); Flexible Spending Accounts (FSA); and Health Savings Accounts (HSAs). In a CDHP, the patient ultimately becomes the financial decision-maker, and the role of the physician shifts to a different type of responsibility,

one where he or she will primarily provide patients with accurate information about service costs, options, risks, and benefits. Although the federal government believes that CDHPs are the wave of the future, their impact and potential for success and cost savings is still in question. The PA Insurance Department will continue to assess consumer and employer insurance concerns, and the impact of insurance reform measures.

For more information about the Pennsylvania Insurance Department: www.insurance.state.pa.us.

Pharmaceutical Management Program

Kevin Caviston

Program Manager

Drexel University, LeBow College of Business

October 10, 2007

The pharmaceutical and health care industries are multi-billion dollar businesses that will continue to grow due to the aging population and increasing prevalence of chronic diseases. However, this growth is occurring in the face of numerous challenges, including:

- Increasing operating costs
- Thinning product pipelines
- Increased product development time
- Pressure to reduce prices
- Need to streamline processes
- Demands to increase health care quality and value

Pharmaceutical companies and the health care industry need professionals with industry-specific knowledge and expertise, and with the business savvy to navigate an increasingly competitive and global marketplace.

MBA programs in pharmaceutical management or health care provide a way to fill this gap by linking knowledge of benchmarking, marketing, finance, operations, and leadership to health care economics, health care outcomes, drug development processes, and industry specific regulations.

continued p.10

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Department of Health Policy Forums

Medication Therapy Management & Pharmacy Quality Measurement

Dave Domann, MS, RPh

Senior Director, Healthcare Quality Management

Ortho-McNeil Janssen Scientific Affairs

November 7, 2007

Bridging the gap between the way patients' drug therapy is currently managed to the way that it should be provided is a challenging task. In 1990, Hepler and Strand proposed a new model, "Pharmaceutical Care" (PC), to address the increase in drug-related morbidity and mortality in the U.S. Dave Domann, MS, RPh, Senior Director of Healthcare Quality Management at Ortho-McNeil Janssen Scientific Affairs, discussed PC, which is a process that essentially involves the patient, the pharmacist, and other health care professionals in:

1. identifying potential and actual drug-related problems,
2. resolving actual drug-related problems and
3. preventing potential drug-related problems where the pharmacist accepts the responsibility in producing the specified therapeutic outcomes.

The principles of PC have been referred to as standards for pharmacy practice. Numerous studies, in addition to the Asheville Project described by Mr. Domann, have demonstrated positive effects of PC in improving patients' clinical outcomes and health-related quality of life. Mr. Domann explained that

according to CMS, Medication Therapy Management (MTM) programs must be provided to Medicare Part D beneficiaries, and can be accomplished by means of a letter, phone call, or live pharmacist consultation. Core elements of MTM are medication therapy review, personal medication record, medication action plan, intervention and/or referral, documentation, and follow up.

With the implementation of MTM programs, the need arose to measure the outcomes; this partly led to the founding of the Pharmacy Quality Alliance (PQA) in April, 2006. The mission of PQA is to measure performance at the pharmacy and pharmacist levels, collect data, report information to key stakeholders to help make informed choices, improve outcomes, and stimulate the development of new payment models. PQA endorsed 34 quality indicators for development across eight categories. The development of a quality measurement approach is underway. As the practice of pharmacy undergoes a transformation from mainly drug dispensing to providing pharmaceutical care, the main challenge will be to address the structural issues related to payment models.

To learn more about MTM and PQA, please visit the following sites: <http://www.pharmacist.com>, <http://www.pqaalliance.org>

To access podcasts of Department of Health Policy Forums, please visit: http://www.jefferson.edu/dhp/education_ls.cfm#forum2

HEALTH POLICY FORUMS: SPRING 2008

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January 9, 2008

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

Jeff Brenner, MD

Robert Wood Johnson Medical School

February 14, 2008

MedMining and Electronic Health Record Data

James Peters, CEO

MedMining

March 12, 2008

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