Health Policy NEWSLETTER

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From the Editor

Medicare's Roadmap

Recently, the Centers for Medicare and Medicaid Services (also known as CMS) has very publicly declared its vision regarding improving the quality of medical care in our country. I was so intrigued by the so-called "CMS Roadmap for Quality" that I decided to devote this editorial entirely to a review of the CMS plan.[1] I will first lay the groundwork for the CMS Roadmap, then outline the five major system strategies, as they call them, for improving care. Then, we will focus on three emerging trends that have coalesced to stimulate CMS and its engagement in quality. Finally, we will outline the five specific strategies included in this Roadmap.

Since the publication of the breakthrough Institute of Medicine study, namely *Crossing the Quality Chasm*, CMS has decided to closely align its future vision with the key goals of the IOM, which are of course, to make health care safe, effective, efficient, patient-centered, timely, and equitable.[2] By now, most readers ought to be familiar with those six key-aims as articulated by the IOM and virtually every other major healthcare policy making organization in the last five years. CMS recognizes that it really is a "public health agency" with an opportunity to have a tremendous impact on the entire healthcare system and the care that it delivers.

CMS, in the Quality Improvement Roadmap, notes that recent developments have created in their words, "an unprecedented opportunity to substantially achieve most all of the aims of the Institute of Medicine." These recent developments include the following:

(1) A growing body of evidence showing that there are major opportunities to improve care with potential benefits for patients, providers, and payers.

(2) A growing complexity of medical knowledge and the number of participants, technologies, and specialties that create enormous rewards for better care and enormous challenges in continuing on the current path.

(3) Leading providers are innovating to improve systems of care and stakeholders are showing a new willingness to come together in partnerships to achieve new levels of improvement. I certainly would concur with these important environmental observations by the leadership at CMS.

What emerges then, from these unprecedented recent developments is a notion within the Roadmap called "Five System Strategies for Improving Care." Let me summarize those System Strategies as articulated by CMS. They include:

(1) Working through partnerships, including within CMS and with other federal and state agencies and nongovernmental partners including health professionals;

(2) Publish quality measurements and information including measures directed toward both the beneficiary audience and the professional, provider, purchaser audience;

(3) Pay for health care in a way that expresses our commitment to supporting providers and practitioners for doing the right thing – improving quality and avoiding unnecessary costs – rather than directing more resources to less effective care;

(4) Assist practitioners and providers in taking advantage of CMS quality initiatives, and make medical care more effective and less costly, in particular, greater use of effective electronic health records; and finally,

(5) CMS wishes to become an active partner in driving the creation and use of information about the effectiveness of healthcare technologies to bring effective innovations to patients more rapidly and to help doctors and patients use the treatments we pay for more effectively.

This is truly a remarkable list of so-called "system strategies" for improving care and it is worth a collective time-out to review these strategies and recognize the watershed event that is occurring by the announcement from CMS regarding the importance of these strategies. In a word, so goes CMS, so goes America's healthcare system!

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Thomas Jefferson University | Jefferson Medical College

Now that we understand the unprecedented opportunities and we have articulated the system strategies for improving care, there are three other emerging trends that may provide a critical new opportunity to improve the quality of medical care. These three emerging trends are:

(1) Much better evidence on opportunities to improve quality and save money from an expanding research basis and accompanying fund of knowledge. I would like to think that our department here at Jefferson has, in a small way, added to this body of evidence.

(2) Clear opportunities for major improvements in the way we support the health professionals who provide care that involves more treatment options and more complexity. In translation, I believe CMS means that they recognize the power of chronic disease management and other population-based care technologies.

(3) An unprecedented new willingness of many different stakeholders to come together in partnership to achieve improvement. I think CMS here explicitly recognizes that more people and more organizations understand that high quality care is the only kind of care we can actually afford. Many aspects of these emerging trends have been covered in this space previously.[3]

Let's conclude the CMS Quality Improvement Roadmap with an overview of the five strategies they believe are essential to achieving the goal of high quality care. Strategy one calls for working through partnerships to improve performance. Examples of these collaborations both within and outside of the government include partnering with the Institute for Healthcare Improvement's campaign to save 100,000 lives and partnering with the Surgical Care Improvement Partnership, a public-private group led by the American College of Surgeons.[4] Another key example is the partnership to implement performance measurement through stakeholder alliances such as the Hospital Quality Alliance, or HQA. Jefferson, like most hospitals, has been an inaugural member of the HQA.

The second strategy calls for the development and application of useful measures of quality of care including outcomes and consumer experience and cost of care, and to use them collaboratively to improve quality. I believe CMS understands how important it is to derive specific measures of hospital quality, and that these measures have emerged from some of the alliances mentioned above. We are particularly interested in measures of ambulatory care quality and efficiency developed by the Ambulatory Care Quality Alliance (AQA). The AQA recently endorsed a so-called starter set of 28 quality measures including several measures related to the efficiency of care. These measure focus on preventive care and care for common chronic conditions so relevant to CMS.

The third strategy called for paying more for patient-focused high quality care. This was the focus of a previous editorial as well.[5] I will not review the entire pay-for-performance field except to say that the Medicare Modernization Act of 2003 gave CMS the authority to implement additional demonstration projects that include payments focused on the quality of patient care, not simply on the services received. A series of demonstration projects are already well underway across the country and the results of these projects will be critically important to the future of the pay-for-performance field.

The fourth strategy calls for assisting practitioners and providers in making care more effective, particularly including the use of effective electronic health information systems. Again, our department has been in the forefront of activity in this arena, helping to create the Pennsylvania-wide summit on the electronic medical record in the summer of 2005 and then publishing these results in the *American Journal of Medical Quality*.[6] We continue to work with the Medicare Quality Improvement Organization, in our state known as Quality Insights, as they are charged in part with assisting hospitals to more effectively use health information technology in the support of quality improvement.

The fifth and final strategy calls for improving access to better treatments and evidence to use them effectively. CMS believes that health information technology systems, improved quality measures, and value-based payments to support better decisions can only be as effective as the treatments available and the evidence on what actually works to improve patient care. Work under this fifth strategy calls for streamlining of the somewhat arcane billing system within CMS.

In their own words, "the CMS Quality Improvement Roadmap represents a major agency wide effort to use the new Medicare law and other new opportunities to work in partnership with the rest of the healthcare system to achieve major improvements in the quality of healthcare." CMS views this as a shared mission and certainly we in the Department of Health Policy concur with this vision. Now comes the hard part! While the CMS Quality Improvement Roadmap represents a conceptual watershed event in our national discussion about measuring and improving the quality of care, operationalizing any one of the five key strategies will be a major political accomplishment. I am confident that we are actively tracking all of these key strategies and hopeful that we will be an effective partner with CMS moving forward. As usual, I am interested in your views and you can reach me at my email address, which is david.nash@jefferson.edu.

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Letters to the Editor

The summary of Dr Owen's presentation at Interclerkship Day published in the March 2006 Health Policy Newsletter points out very important myths surrounding the issue of the neurobehavioral performance of residents. However, there are other myths that need to be considered also, if we are to truly provide comprehensive and safe medical care for our patients and the best training for our residents:

Myth 1: Regardless of the stability of patients' medical status, all residents must leave the hospital immediately when they reach their time limit. Their departure will not impact patient care.

Myth 2: On-call residents will have the same vested interest in the care of patients as the daytime residents who know the medical history of their patients.

Myth 3: Residents leaving their duty can always anticipate and sign out all possible patient issues, such that the transfer of care will be seamless.

Myth 4: Residents can leave their patients at times of medical crises and their learning experience will be just as good as if they stayed during the crisis and continuously monitored the effects of their interventions.

Myth 5: Teaching residents a "9 to 5" mentality will produce a generation of physicians dedicated to providing responsible care to all their patients, all the time.

William Tester, MD, FACP
Albert Einstein Cancer Center

I enjoyed reading "TAP Your Feet" in the March 2006 issue of the Health Policy newsletter. I was particularly grateful to see some reference to the practical challenges in the closing paragraphs.

As a participant in the Integrated Healthcare Association's California Pay-for-Performance initiative, I can tell you that such challenges can be formidable indeed. For us quality junkies, it is tempting to recommend immediate implementation of an effective intervention for a prevalent serious disease. Unfortunately, the result could be a tidal wave of recommendations that completely overwhelm good faith attempts to implement and measure. Guidance here might be found in Toynbee's optimum challenges -- set achievable goals that require best efforts.

In closing, I would add that, as the list of interventions, guidelines and recommendations grow, some thought needs to be given to the limits of human mental capacity. It is pretty much agreed that the knowledge-problem couple required to produce evidence-based interventions at six-sigma frequencies exceeds human capability. I hope there is a TAP somewhere developing the decision support our frontline colleagues will require to deliver sage, timely, beneficial, patient-centered, equitable and efficient care to their patients. I wish you and them every success.

Dennis P. Flynn, MD, MBA
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I too have served as a TAP member, for obesity. I enjoyed the article and would like to point out my dissatisfaction with the NQF process. I read the report from NQF's Steering Committee that disagreed with some of my TAP's recommendations. The next step in the process is then to allow the "equal voices" to comment on the Steering Committee's recommendations. I have found that as the AQA has contributed to several of these in the past, the NQF "consensus" seems to be more determined by CMS's influence. Several similar groups now seem to be utilizing their association with AQA in a "rebellion" of CMS's overbearing grip on NQF. (Personal observation)

I believe that your statement about using the National Voluntary Consensus Standards for Hospital Care allow CMS to pay a small "additional" percentage on key diagnoses is misleading. If hospitals do not report the outcomes, CMS withholds that small amount.

I appreciate your work on behalf of practicing physicians everywhere.

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I enjoyed your most recent issue, particularly Dan Louis's article on Part D – Experiencing that first hand. I had some concerns about "TAP your Feet" as I did not see any issue discussed regarding the "patient." I have to assume that along with guidelines, there will be a strong component of how to get the patient involved in their disease. The clinical aspects of population management are certainly the primary aim, but without the economic and humanistic perspectives, the process is incomplete, and I am sure your TAP is paying attention to those other areas.

Otto Wolke, RPh

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

CMS Rehabilitation Policy: Expediency vs. Rationality

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There is little doubt as to the pressure from Washington to control health care costs through the Centers for Medicare and Medicaid Services (CMS). Inpatient rehabilitation facilities (IRFs) have been targets of this mission through legislation known as the 75% Rule (the Rule). Published originally in 1983, its purpose was to define eligibility for IRF payment reimbursement by mandating that 75 percent of admissions have one of ten diagnoses. Upon revisiting the Rule in the late 90s, CMS concluded that it was applied inconsistently among IRFs, suggesting the need for clearer criteria to avoid what it deemed to be abuse of the guidelines. CMS expanded the list of diagnoses to thirteen and mandated strict adherence to avoid overpayment for unneeded services. This article explores two recent briefs, from CMS and from the American Hospital Association (AHA), that demonstrate the perspectives of stakeholders regarding the Rule and its effects on the field of rehabilitation.

A quote by Peter Drucker may aid in approaching the difference in outlook of CMS and AHA. Drucker writes, "Efficiency is doing things right; effectiveness is doing the right things." CMS is attempting to be "efficient" in this matter by juggling admission criteria in the updated Rule to save money quickly. In an interesting shift from previous communications, the CMS news brief, *Inpatient Rehabilitation Facility PPS*, addresses Wall Street directly. Understandably, the financial community is monitoring events closely to ensure that changes in the Rule do not turn the rehabilitation industry topsy-turvy. In an effort to quell any dissatisfaction, CMS emphasizes the financial strength of IRFs, citing as an example their profit margins that range near 15 percent, and their compound annual growth rates that border on five percent.[1] In addition, it identifies the heterogeneity of IRF distribution and patient populations requiring their services, calling into question the need for so many facilities. Skilled Nursing Facilities (SNF) and home health agencies (HHC), it argues, can act as suitable alternatives. Finally, CMS demonstrates how "inappropriate" admissions decreased in the years 2003-2005 when it enforced the Rule more strictly, with a compensatory increase in "suitable" admissions assumed to require a greater level of care. In essence, CMS wields data to convince Wall Street that changing IRF behavior would lead only to positive results.

AHA's position, as stated in its brief, *The Current Reality of the 75% Rule*, is that the CMS argument fails to acknowledge the "effectiveness" of IRFs. Using Moran Company data, the AHA asserts that application of the Rule has resulted in denial of IRF admission to over 40,000 patients, well above the CMS estimate.[2,3] This number will likely increase to over 64,000 in year two, and continue to mount thereafter. Additional anticipated effects of the Rule include a reduction of staff in 45% of IRFs, a decrease in total beds at 38% of IRFs, and complete closure for 14% of IRFs.[2,4] Studies have already shown that care will be compromised in an environment where patients are admitted based strictly on diagnosis, without consideration for functional ability.[5,6] The AHA report also reveals that only seven percent of post-acute care dollars go to IRFs, while HHC and SNFs receive 11.3 and 13.2 percent, respectively. Furthermore, only four percent of all acute care hospital discharges are admitted to IRFs. The AHA questions whether significant financial savings will result from changes related to the revised Rule. It projects that enforcement of the Rule will hamper patient access to required services, threaten proper patient care, and eliminate multiple jobs, causing economic disruption.

After revision, CMS initiated the Rule as the 50% Rule, to be later increased to the planned 75%. Legislation to extend implementation at 50% for two additional years was spearheaded by Senators Specter and Santorum, and Representative LoBiondo, among others. Their bills also proposed the creation of a Rehabilitation Advisory Council to develop admission criteria consistent with the focus of IRFs on improving function.

The result of this effort, after Conference Committee action on these bills, was a one year continuation of the requirement that 60% of the IRF admissions be patients with one of the designated diagnoses, after which there will be a stepwise return to 75%. The legislation did not call for an advisory committee.

The American Medical Rehabilitation Providers Association (AMRPA) is tracking admissions to IRFs to document reductions in access. Studies are ongoing to determine if care is hampered when patients requiring inpatient care are instead triaged to alternative facilities. It also is tracking savings to CMS. Although CMS projected that the Rule will have modest impacts on IRFs, early data distributed by the AMRPA show that both access and economics far exceed the CMS projections. Neither stakeholder, the CMS nor the AHA, has sufficient evidence to support their respective preferred models of service delivery. Providers with strong views on the effectiveness of their services need to develop supportive evidence that includes reviewing the use of alternative models.

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The Einstein-La Salle Nursing Careers Partnership Program

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The importance of a strong nursing workforce to quality of care has been demonstrated in a number of studies.[1,2] In a multi-institutional analysis of patient, nurse, and institutional characteristics, Aiken and her colleagues found that a high patient to nurse ratio was associated with increased mortality in surgical patients, as well as with increased likelihood of nurse burnout and job dissatisfaction.[3] Needleman also reported an association between nurse staffing levels and poor outcomes in both medical and surgical patients.[4]

An inadequate supply of nurses continues to be one of the key issues facing nursing, and indeed our healthcare system in the 21st century. The factors contributing to the shortage are well documented and include increasing age of registered nurses; alternative career choices in pharmaceutical firms and managed care companies; a continued trend of declining enrollments; and increasing patient demand for nursing services as the "baby boomers" age. Statewide, Pennsylvania healthcare providers continue to struggle with a nursing vacancy rate hovering around 9 percent. Federal health officials have projected that the rate could climb to 30 percent in Pennsylvania by 2020, which would translate into more than 40,000 nurse vacancies at hospitals.

In addition to a general shortage, the recruitment and training of nurses prepared to work with an increasingly diverse population continues to be a major challenge. As the demographics change in the United States, the need for diversity in nursing intensifies. The 2000 report from the National Advisory Council on Nurse Education and Practice (NACNEP) emphasized the importance of a culturally diverse nursing workforce as a way to reduce health disparities and to increase effectiveness in community outreach initiatives. Nursing schools have accelerated efforts to increase numbers of minority students, but retention of many of these students – especially those with multiple responsibilities and/or substantial financial stress – remains a significant issue.

In 2005, Albert Einstein Healthcare Network and La Salle University announced the initiation of a collaborative partnership to provide high-achieving students from the communities served by Einstein with nursing education, employment, and financial support.[5] Each year, Einstein will select 10 students on the basis of an interview process designed to evaluate their current performance in school, their interest in a nursing career and their reasons for wanting to work at Einstein. Our goal is to recruit students who express interest in working in an urban hospital, who are stimulated by the challenges of nursing, and who we believe can help build a strong and diverse nursing workforce at our institution. Albert Einstein Healthcare will provide selected students with stipends, paid externships, and nursing positions upon graduation – as well as assistance with school loans. Students will also be assigned a mentor – an Einstein nurse who will help the student balance the competing demands of school, hospital work, and home. The Einstein Center for Urban Health Policy and Research will work with Einstein and La Salle Nursing to coordinate the partnership, assist in the implementation of the program, and evaluate outcomes.

Nationwide, employment-based benefits are being used to address the nursing shortage in both recruitment and retention of nurses. Most hospitals offer nurses a range of benefits beyond those offered to non-nursing employees. However, Spetz and Adams report that nurses often consider these benefits to be less important than the work environment.[6] In addition to providing financial support to nursing students, the Einstein-La Salle partnership was designed to strengthen the inter-relationships among an urban healthcare delivery system, an academic institution and the surrounding community. In the future, we plan to broaden the program to include educational outreach initiatives with area high schools and to promote the pursuit of nursing and allied health careers for students in our communities.

Although five students have begun the program, it is too early to assess the effects of this relatively new collaborative program. Over time, the plan is to track individual students in their career development and to evaluate the impact of the program on nursing retention and recruitment.

For additional information about the Einstein La Salle Nursing Careers Partnership, contact Mary Beth Kingston at KingstonM@einstein.edu . For more information about the Einstein Center for Urban Health Policy and Research, contact Etienne Phipps at PhippsT@einstein.edu.

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WHYY Seeks Guidance from Healthcare and Community Leaders

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On February 24, 2006, WHYY held a Community Leadership Summit as part of its effort to expand the programmatic focus of its Caring Community Coalition to include healthcare. At the Summit, leaders from health, insurance, industry, government and patient advocacy organizations shared concerns about healthcare in greater Philadelphia, and identified solutions through institutional collaboration and partnership with WHYY.

Representing diverse stakeholders in the health of the community, including David B. Nash, MD, MBA, Chair of the Department of Health Policy at Jefferson Medical College, participants prioritized health and healthcare issues according to the amount of control and influence they felt their organizations had over the issues and by indicating which issues resonated with their personal passions.

Issues reached beyond basic health and healthcare to address interdependence of related factors such as poverty. The group acknowledged the dichotomy between problems of the healthcare system, which relate to leadership and infrastructure, and problems of community health, which range from economic development, obesity and violence to lack of awareness of preventive health measures.

Three primary challenges emerged through discussions:

Large Cultural Rift – Exemplifying the gap that exists between interest in the latest technology and research and the less glamorous promotion of preventive public health measures. Environmental factors such as public awareness, messaging in commercial media, reimbursement policies and current domains of healthcare practice all create a diminished position for messages of preventive health.

Lack of a Common Vision – There is a need to continue dialogue to find and adopt a common language regarding health and healthcare issues. In the Philadelphia region there is an added complexity in that healthcare is both a service and a significant factor in the local economy. The industry has not come together to develop a shared vision, which could direct political leadership, especially if it focused on economic issues related to healthcare.

Limited Community Focus – To improve health and healthcare in Philadelphia, there must be a shift in focus from the problems imbedded in the healthcare system to those plaguing the community's health. A focus on the community would include issues across the broad health and healthcare continuum, as well as the voices of diverse populations.

To address these challenges the leaders recognized related issues for the Philadelphia area:

Barriers to access to care;
- Language barriers;
- Lack of political will at local, state and national levels to address healthcare systemic challenges;
- Healthcare leadership skills development;
- Improving public understanding of quality healthcare; and
- Promote informed decisions in consumer-directed care.

The participants agreed that there is great potential in collaboration with public broadcasting, and identified the role for WHYY:

- Engaging other media including commercial and print to inform the community and inspire more positive messages, possibly creating a "Broadcasters' Coalition for a Healthy Region."
- Serving as a neutral convener of stakeholders to talk about information and its quality and the best way to disseminate it.
- Finding ways to convey content that resonates with multiple populations including those not in the traditional demographic of public broadcasting viewers or listeners.
- Provide video programming for television systems in hospitals, waiting rooms and other venues to reach non-traditional public television viewers.
- Partner with healthcare providers who have existing content.

Building on momentum from the national "Cover the Uninsured Week" held in early May 2006, the group suggested working collaboratively around the issue of uninsured persons. The leaders felt that this could be the first in a series of healthcare topics and could serve as a model. Each person indicated what their organization could bring to a collaborative effort, including government relations and public affairs staff, access to chapters of professional organizations, providing subject matter, experts/key informants, data, stories, initiatives providing care to the uninsured, funding and access to different perspectives.

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AHRQ ACTION

The Department of Health Policy was selected to join an elite pool of healthcare organizations that are permitted to bid on a series of rapid-cycle research contracts under the auspices of the Agency for Healthcare Research and Quality (AHRQ). Under this program, called AHRQ ACTION (Accelerating Change and Transformation in Organizations and Networks), fifteen coalitions of researchers, providers and insurers have been granted exclusive access to future task orders aimed at translating quality improvement research into better care in the hospital and ambulatory care settings. Jefferson's coalition partners include the CNA Corporation, Sentara Healthcare, the Virginia Health Quality Center, the Center for Excellence in Aging and Geriatric Health, and Ivan Walks and Associates. Other coalitions include the Rand Corporation, NCQA, JCAHO, Cigna, WellPoint, the Mayo Clinic, Geisinger Health System, and others.

Considering "Faculty Priorities Reconsidered"

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What constitutes *scholarship* and how can academic medical centers, such as Jefferson Medical College, promote more of it? Traditionally, academic faculty have been responsible for conducting research, teaching, and service. In the 1980s, concerns were raised that universities placed excessive emphasis on research and gave insufficient recognition for teaching and other scholarly achievements. This spurred a movement among top U.S. universities in the 1990s to find ways to align the priorities of the professoriate by redefining faculty roles and restructuring reward systems to promote scholarship.

Jefferson Medical College is an active proponent of this movement, Dr. Karen Novielli, associate dean in the Office of Faculty Affairs at Jefferson, sparked an internal discussion of a new scholarship paradigm by distributing the book, *Faculty Priorities Reconsidered: Rewarding Multiple Forms of Scholarship* by KerryAnn O'Meara and R. Eugene Rice to department chairs and members of the Appointments and Promotions Committee. The goal was to improve their understanding and ability to evaluate non-traditional forms of scholarship. As in other academic facilities, Jefferson has integrated these non-traditional forms of scholarship into new guidelines for the faculty appointment and promotion process, effective July 1, 2006, so that faculty can be rewarded for all aspects of their scholarly activities—not just research.

Faculty Priorities Reconsidered discusses the events leading up to and the response to *Scholarship Reconsidered: Priorities for the Professoriate*, the best-selling report published by the Carnegie Foundation for the Advancement of Teaching in 1990. Written by Ernest L. Boyer, the seventh president of the Foundation, the report spurred a number of universities, including Jefferson, to modify their appointment and promotion policies so that faculty can be better rewarded for what they do best – scholarship in all its manifestations

Faculty Priorities Reconsidered continues the Boyer legacy by outlining four forms of scholarship that serve to expand upon the traditional teaching, service, and research paradigm. These include the scholarship of 1) teaching and learning, 2) engagement, 3) discovery, and 4) integration. Redefining scholarship in terms of these four dimensions inspires faculty to rethink their roles as academicians. Indeed, a major priority in *Faculty Priorities Reconsidered* is to challenge America's professoriate to be "scholars" first and foremost, and to realign reward structures to forms of scholarship that support universities' missions.

The first form, the **Scholarship of Teaching and Learning**, emphasizes an interactive rather than didactic student-instructor educational format wherein teachers continually adapt to students' varying abilities and backgrounds, and continually evaluate whether their pedagogical methods are carefully planned, continuously examined, and related directly to the subject taught. Moreover, the scholarship of teaching and learning emphasizes the development, testing, and dissemination of advances in pedagogy. For example a professor may develop a new way to teach statistics, testing its effectiveness by comparing the exam scores of students taught using the new method with the exam scores of students taught using the traditional mode. Results and lessons learned could be published in a peer-reviewed journal. Like the traditional results of research, scholarship in teaching and learning should be widely disseminated for the benefit of the field and society.

Similarly, **Scholarship of Engagement** goes beyond the traditional concept of service to emphasize genuine collaboration with the community. It incorporates what is often called the "Scholarship of Application," which aims to increase awareness, as well as practical application, or translation, of new information and methods learned through scholarly work. Scholarship of engagement includes the dissemination of new research discoveries within the community. This form of scholarship goes well beyond publication of results in peer reviewed journals; rather, it implies an active engagement with the local community, such as the patients seen at Jefferson University Hospital. Research on quality of care, ways to improve physician-patient communication, and other research findings await the budding scholar of engagement to disseminate to the local community.

Under *Faculty Priorities Reconsidered*, traditional research has evolved into the **Scholarship of Discovery**. Whereas in many realms of academia, research continues to be the main focus of the American professoriate, *Faculty Priorities Reconsidered* emphasizes the importance of rewarding scholars for teaching and learning and engagement in addition to research. At the same time, Faculty Priorities Reconsidered highlights the importance of multidisciplinary teams for enhancing the discovery process.

Recognizing the power of interdisciplinary teams, the **Scholarship of Integration** was added as a new dimension. Scholars of integration build connections within and between disciplines and place their own activities in multiple contexts. Rewards for integration are based on a faculty's success at creating teams and expanding and sharing knowledge across disciplines to create a comprehensive approach to research and its applications. For example efforts to improve healthcare quality could benefit from looking beyond clinician involvement to incorporate the novel, but essential, knowledge and experience of organizational psychologists, engineers, information technology specialists, economists, and business experts.

The evolving and expanding definition of scholarship promises to enable academia to attract and reward faculty with diverse interests, backgrounds, and skills. Recognizing that Boyer's efforts began in 1990, this transition in recruitment and promotion is long overdue and welcomed by current and future faculty.

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Boyer EL. *Scholarship Reconsidered: Priorities for the Professoriate*. Carnegie Foundation for the Advancement of Teaching. New York, NY, 1990.

Save the Date: The 8th Annual International Conference on Terrorism and Disaster Preparedness Thursday, October 26, 2006

THE CONFERENCE: This 8th annual conference is presented by the Center for Bioterrorism and Disaster Preparedness of Thomas Jefferson University Hospital and will be held at the Pennsylvania Convention Center, Philadelphia PA.

FEATURED SPEAKERS: Presenters have real-life experience with the response efforts to or management of major incidents of terrorism or natural disaster.

CONTINUING EDUCATION: Thomas Jefferson University Hospital is an approved provider of continuing nursing education by the PA State Nurses Association, an accredited approver by the American Nurses' Credentialing Center's Commission on Accreditation. Jefferson Medical College of Thomas Jefferson University is accredited by the ACCME to provide continuing medical education for physicians. The Department of Health Policy of Jefferson Medical College provides CPEs for pharmacists. Information and applications for EMS continuing education will be available at conference registration.

WHO SHOULD ATTEND: Physicians, nurses, pharmacists, paramedics, EMTs, public health professionals, emergency response and public safety personnel, emergency managers, fire, police, security personnel, and others responsible for terrorism and disaster preparedness and planning.

The 15th Annual Grandon Lecture: Improving Ambulatory Care Quality

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The results of a March 28, 2006 Gallup poll indicate that the availability and affordability of health care is the number one concern in the United States, ahead of other weighty issues such as Social Security, future terrorist attacks, the economy, and illegal immigration. The National Committee for Quality Assurance (NCQA), often thought of as the "watchdog" of the managed care industry, strives to improve the quality of health care. NCQA, a private, non-profit health care quality oversight organization, is best known, perhaps, for its accreditation of health plans using performance data. NCQA is committed to measurement, transparency, and accountability in health care, and coordinates a number of quality improvement programs including the Health Employer Data Information Set (HEDIS), the Consumer Assessment of Health Plans Survey (CAHPS), measurement of quality in provider groups, and physician recognition programs for a variety of conditions.

Improving ambulatory care quality is essential and, in addition to NCQA, organizations such as the National Quality Forum and the Ambulatory Care Quality Alliance also take part in the endeavors. On a local front, the Jefferson University Physicians (JUP) Clinical Care Committee (CCC) dedicates its efforts to measuring and improving the quality of care delivered through JUP practices. In its brief existence, the CCC has made significant advances in improving the quality of care for Jefferson patients. This work helped to make the 2006 Grandon Lecture so pivital.

The Department of Health Policy felt honored to host Margaret E. O'Kane as the speaker for the 15th Annual Dr. Raymond C. Grandon Lecture. Ms. O'Kane, President and Founder of NCQA, is nationally recognized as one of the most prominent leaders in health care as evidenced by numerous awards. Most notably, Ms. O'Kane was named one of Modern Healthcare's "Top 25 Women in Health Care in 2005," and she has previously been voted one of the nation's "100 Most Powerful People in Health Care."

In what proved to be a highly informative and stimulating talk, titled "Improving Ambulatory Quality and an Integrated Value Strategy," Ms. O'Kane addressed critical issues such as expanding measurement, transparency, and accountability in health care and offered a seven-item value agenda for the future of health care. Ms. O'Kane affirmed that "we can't improve what we don't measure," "quality data must be translated into understandable, actionable reports for consumers and purchasers," and "once we can measure we can hold everyone accountable for improvement."

In the seven-item value agenda, Ms. O'Kane urged us to:

1. Engage and activate patients with information about care options;
2. Push prevention;
3. Get serious about patient safety;
4. Focus on chronic care;
5. Renew the emphasis on primary care;
6. Stop paying for overuse of care; and
7. Reduce geographic disparities in health spending.

Ms. O'Kane speculated that if we don't implement a value strategy, the number of uninsured and underinsured will continue to rise, doctors and hospitals will come under enormous pressure to cut costs or face draconian limits, and we will see further restrictions on capital spending for new devices and services. In other words, if we do not take charge our health insurance system might fall to pieces.

In addition to the Ms. O'Kane's keynote speech, a reactor panel including Jefferson's Judith Bachman, Abigail Wolf, MD, and Pauline Park, MD, as well as Etienne Phipps, PhD, of the Einstein Center for Urban Health Policy and Research, provided a broad range of perspectives on the topic of ambulatory care quality. Ms. Bachman, Senior Vice President of TJU, asserted that providers generally do not get reimbursed on preventive medicine, such as weight management, creating a challenge in fulfilling item two of the value agenda. Dr. Wolf, Director of Medical Student Education in JMC's Department of OB/GYN, raised concerns about potentially adverse effects of quality improvement initiatives. She stated that focusing on indicators and measures of quality that health insurance companies deem important may cause providers to neglect other important services that may not be sufficiently reimbursed. Dr. Park, Assistant Professor in the Department of Surgery, stressed that addressing issues important to patients, such as discussing the value of mammograms or engaging in conversations about having a new child, may be deemphasized in the quality improvement world since these types of activities are not included in measurement sets, nor are they billable by providers. Dr. Phipps reinforced that we need to come to a consensus about what is in the best interest of the patients and we need to consider what we are not doing and why we are not doing it, rather than emphasizing solely on what were are currently doing.

To view Margaret O'Kane's lecture slides please visit The Department of Health Policy's homepage: www.jefferson.edu/dhp. Additional information about NCQA can be found at: www.ncqa.org.

New Publications from the Department of Health Policy

Blackstone EA, Fuhr JP Jr. Unintended Consequences: Generic Competition in the Prescription Drug Market. *Medicare Patient Management*. 2006;1(2):25-43.

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Nash DB. Hooray for BCMA. *P&T*. 2006;31(3):130.

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Pizzi LT, Weston CM, Goldfarb NI, Moretti D, Cobb N, Howell JB, Infantolino A, Dimarino AJ, Cohen S. Impact of chronic conditions on quality of life in patients with inflammatory bowel disease. *Inflamm Bowel Dis*. 2006;12(1):47-52.

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Presentations from the Department of Health Policy

Lofland JH, Rupnow M, Gagne JJ, Smith KD, Poston S, Pizzi LT, Papadopoulos G. Impact of Topiramate for Migraine Prophylaxis on Workplace Productivity:Results from a U.S. Randomized, Double-Blind, Placebo-Controlled, Multicenter Trial. Poster presentation at the American Academy of Neurology (AAN) Annual Meeting. San Diego, CA, April 2006.

Pizzi LT, Gagne JJ, Lofland JH, Rupnow M, Smith KD, Poston S. Effect of Topiramate Migraine Prophylaxis on Workplace Productivity: Results from Two U.S. Randomized, Double-Blind, Placebo-Controlled, Multicenter Trials. Poster presentation at the 48th Annual Scientific Meeting of the American Headache Society. Los Angeles, California, June, 2006.

Hartmann CW, Sciamanna CN, Mui S, Blanch DC. Qualitative analysis of patient experiences with asthma care website. Qualitative Health Research Conference. Edmonton, Alberta, Canada, April, 2006.

From the 11th Annual Meeting of the International Society for Pharmacoeconomics and Outcomes Research. Philadelphia, PA, May 2006:

Gagne JJ, Smith KD, Pizzi LT. Collecting and Using Productivity Data Alongside Clinical Trials.

Gagne JJ, Smith KD, Pizzi LT.Collecting and Using Productivity Data Alongside Clinical Trials.

Singh M, Pizzi LT, Lofland JL, Higashi M, Patel N. Economic Burden of Work Loss Among Sufferers of Lymphatic Filariasis: An Eradicable Global Health Problem.

Talati AR, Pizzi LT, Dahl N, Gemmen E. Validation of the Work Productivity Questionnaire: Results of the MATRIX Study.

HEALTH POLICY FORUM

The Forum meets on the second Wednesday of each month (September-June) from 8:30 a.m. to 9:30 a.m. in Conference Room 218, Curtis Building, 1015 Walnut Street, Philadelphia, PA. A light breakfast will be served.

September 13, 2006
The Role of Healthcare Quality Ratings in Marketing
Tom DeSanto
Executive Vice President
Aloysius Butler & Clark

October 11, 2006
Improving Health and Lives of Community Members
James O'Hara
Director, Policy Initiatives and the Health and Human Services Program
Pew Charitable Trusts

November 8, 2006
Eliminating Racial Disparities in Treatment
David Smith, PhD
Professor of Risk, Insurance and Healthcare Management
Temple University (ACPE No: 079-999-06-011-L04)

December 13, 2006
Managing the Leadership Capital Portfolio: Lessons from Real Life in Academic Centers
Warren Ross, MD
Senior Client Partner
Academic Health Care Practice, Korn/Ferry International

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