Health Policy NEWSLETTER

In This Issue

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From the Editors

AHRQ ACTION

It can take nearly 17 years to turn a small percentage of what is reported in the medical literature into innovative patient care at the bedside.[1] This cumbersome journey often prevents the latest information from impacting medical practice in a meaningful way. We need answers now, but they are not coming fast enough. A new 5-year program from the federal Agency for Healthcare Research and Quality (AHRQ), called Accelerating Change and Transformation in Organizations and Networks (ACTION), seeks to fast track the process of both defining what works and implementing it in current healthcare settings.

First, we will discuss the evolution of AHRQ ACTION, its goals, and involved parties. We will then focus on Jefferson' Medical College's partnership with The CNA Corporation and other groups (The CNA Corporation Health ACTION Team, or CHAT), and the strengths CHAT brings to the national ACTION program. Finally, we present CHAT's expectations for the five years of the program.

ACTION is the follow-up to AHRQ's 5-year Integrated Delivery System Research Network (IDSRN) program, which ended in 2005.[2] The IDSRN program focused more on defining "what works." ACTION picks up where IDSRN left off, with a stronger emphasis on "testing the application and uptake of research knowledge."[1] The overall mission of ACTION is to "promote innovation in healthcare delivery by accelerating the development, implementation, diffusion, and uptake of demand-driven and evidence-based products, tools, strategies, and findings" over the 5-year program period.[1] It aims to accomplish this by directing projects and implementation tasks to a select group of research and delivery partnerships throughout the country.

There are 15 partnerships involved in ACTION, including Abt Associates, Inc., American Association of Homes and Services for the Aging, American Institutes for Research, Aurora Health Care, Boston University School of Public Health, CHAT (of which Jefferson is a member), Denver Health, Health Research and Educational Trust, Indiana University, RAND Corporation, RTI International, University of California: San Francisco School of Medicine, University of Iowa Center for Health Policy and Research, Weill Medical College of Cornell University, and Yale New Haven Health Services Corporation. Many of these groups were also involved in IDSRN, but CHAT is a new addition since the advent of ACTION. These groups represent all 50 states, diverse practices and populations, and multiple private and public insurers. Together they have the capacity to reach over 100 million patients.[2]

Each of the partnerships involved in ACTION has "demonstrated capacity to 'turn research into practice,'" and has the framework and methodology in place to handle projects on short notice.[1] These projects will generally take less than 18 months from bid to project completion, compared to years for traditional research. Upon project completion, results will be disseminated quickly through ACTION's nationwide network of healthcare delivery systems, leading to rapid implementation.

Although financial support for these projects comes mainly from AHRQ, other government and private groups—such as the Centers for Disease Control and Prevention, National Institutes of Health, Department of Health and Human Services, the Robert Wood Johnson Foundation, Department of Defense and the National Cancer Institute—contribute both funding and research ideas as well. This makes ACTION a clearinghouse for government health research, giving the Department of Health Policy access to projects outside our usual pool. Many projects are related to quality and biotechnology, areas in which the Department of Health Policy is already well-respected.

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Thomas Jefferson University | Jefferson Medical College

Each of the 15 participating partnerships in ACTION has a unique set of members, including varying combinations of health insurers, hospitals, nursing homes, academic medical centers, and other entities. In CHAT, The CNA Corporation—a non-profit research and analysis company based in Alexandria, VA—partners with Jefferson and Sentara Healthcare, along with the Center for Excellence in Aging and Geriatric Health (CEAGH) in Williamsburg, VA, the Virginia Quality Improvement Organization (called Virginia Health Quality Center, or VHQC) in Glen Allen, VA, and Ivan Walks and Associates in Washington, DC to create a diverse team of experts.

According to Dr. Daniel Harris, Principal Investigator, Senior Scientist at CNA, and Project Director for CHAT, "CHAT has special strength and depth in several areas of interest to the ACTION program, including cost-effectiveness of innovative approaches to delivering care, quality and patient safety, disability and long-term care, ambulatory care, and emergency preparedness."[3] Specifically, Sentara Healthcare and Jefferson are complementary, innovative delivery systems: Sentara serves the Tidewater area of Virginia as a community-based regional health system with its own insurance company. In contrast, Jefferson is an inner-city academic medical center, employing strong medical researchers and leading clinical specialists.[3] Together, proven research groups from CEAGH, CNA Corporation, and Jefferson create a diverse academic powerhouse. CHAT is a strong team of proven, well-connected groups that stands to make a considerable impact on U.S. health care.

As a newcomer to the ISDRN/ACTION scene, Dr. Harris and colleagues would like to see CHAT win two contracts in the first 18-24 months of the 5-year program. In the long-term, Dr. Harris sees CHAT "leveraging" our status as an ACTION team to successfully compete for additional funding, both through other government program contracts and private foundation grants."[3]

For Jefferson specifically, membership on an ACTION team is good news. It fosters the opportunity for the various components of Jefferson Health System (JUP, TJUH, affiliated hospitals, JMC, and others) to work together on these major research projects, helping overcome organizational barriers. It publicizes our name (through CNAC, the AHRQ website, and any ensuing publications), putting us in the minds of other research and health organizations throughout the nation. We are also afforded the opportunity to network with other major ACTION groups. Finally, our participation in AHRQ ACTION provides us with a venue to contribute our expertise toward improving health care in a way destined to yield quick results. We don't have any time to waste!

As always, we welcome your comments. Email me at david.nash@jefferson.edu.

Kathryn Walker, JMC 2009
David B Nash, MD, MBA
Editor

REFERENCES

1. Clancy C, Fraser I, Palmer C. Turning Research to ACTION through Delivery Systems: 1st Annual Meeting. Washington, DC. June 1, 2006.
2. www.ahrq.gov/RESEARCH/action.pdf
3. Harris D. Personal Communication, July 2006.

International Medical Graduates (IMGs): Building Cultural Competence into the Curriculum

Harriet P. Bernstein
Director
Volunteer and Chaplaincy Services
Language and Cultural Services
Albert Einstein Healthcare Network

The Education Commission for Foreign Medical Graduates (ECFMG) certifies the readiness of international medical graduates (IMGs) to enter accredited residency training programs in the United States. Recently, the ECFMG addressed some of the special needs of these students, stating that:

> *There continues to be obstacles and challenges for IMGs and those with whom they interact with respect to their full integration into American culture, American medical culture and the American healthcare system.*[1]

Recognizing these and other educational needs, the Department of Medicine at Albert Einstein Medical Center (AEMC) has instituted a 3-year curriculum devoted to *Communication and Cultural Competence*. Topics covered include: Improving Communication, Literacy, Informed Consent, Techniques for Negotiating Issues influenced by Culture, and the Clinician's Cultural Attitudes and their Impact on Patient Care. The curriculum also includes explanatory models for gathering patient information—including that of Arthur Kleinman, MD[2]—and guidelines, such as the *Culturally and Linguistically Appropriate Services* (CLAS) standards.[3] Similar curriculae have been introduced by other training programs across the country; for example, White Memorial Family Medicine Residency Program in Los Angeles, California and UMDNJ-Robert Wood Johnson Medical School, New Brunswick, New Jersey.

Though all AEMC medical residents participate in this curriculum, we designed a special orientation for IMGs to provide additional support and to demonstrate that the institution is sensitive to the challenges of practicing medicine in a cultural milieu inherently different from their own. The orientation includes a discussion about the diversity of AEMC's patient population, staff, and programs.

More importantly, this special session focuses on the IMGs themselves—on who they are as individuals, as representatives of their diverse cultures, and as medical residents at AEMC. The essentials—names, countries of origin, reasons for coming to America and to AEMC—are easy to determine. The discussions become richer when talk turns to whether or not the IMGs wish to be seen as representatives of their own cultures... some have sought to avoid being perceived in this role.

When conversation focuses on the IMGs' expectations of America and AEMC, most recognize that they had made assumptions about American medicine. Parsing the various opinions in the group, including those related to the culture shock experienced upon arrival, leads to the identification of issues for further discussion.

The combination of the IMG orientation session and the curriculum has fostered an understanding that there is an institutional approach to cultural issues, which assumes that they are central to the manner in which care is to be delivered. The program has allowed IMGs to feel safe both in accepting and offering help with culturally-based concerns. For example, several IMGs have been tutored in English usage or pronunciation by staff interpreters. Residents have asked for assistance in finding personal counseling provided within a specific cultural context. And some IMGs offered their services to mediate patient-staff conflicts that centered on cultural issues.

All residents at AEMC eventually work with staff interpreters, culture brokers, members of the multi-faith chaplaincy team, and residents in Clinical Pastoral Education. Many of these encounters provide insights into attitudes toward differences and approaches to decision making. These encounters also hone the resident's ability to respect his or her own personal values while offering support to a patient with a completely different value system. Some of these encounters validate that being "different"—coming from another country and having received one's medical training in another culture—can affect patient interactions positively.

Last year, the AEMC network provided interpreters for patients speaking 58 different languages. It has proved to be invaluable that the house staff includes many representatives of the same countries as the patients. The benefits can be measured in patient care and in the sharing of insights during discussions with peers. For example, talking with an IMG whose personal experience has included being a refugee adds depth to class discussion of the differences between being an immigrant and a refugee. In another instance, an IMG whose background provides direct knowledge of the cultural attitudes surrounding female circumcision adds a dimension to a case-study review that no amount of library research can match. While anecdotal changes have been shared, a formal curriculum evaluation tool is presently under development to assist in measuring attitudinal and behavioral changes.

Cultural competence is vital to the personal and professional growth of all AEMC residents and in the delivery of patient-focused care that is culturally appropriate.

REFERENCES

1. Memo from Gerald Whelan, M.D., Director, IMG Acculturation Program, Education Commission for Foreign Medical Graduates. February 3, 2006
2. Kleinman A, Eisenberg L, Good B. Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Ann Intern Med.* 1978;88:251-258.
3. U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* Washington, DC: March 2001.

The Childhood Obesity Epidemic: Rebalancing the Scales

Kristy Alvarez, BS
Research Study Coordinator
Christopher Sciamanna, MD, MPH
Associate Professor
Department of Health Policy
Jefferson Medical College

Obesity is one of the biggest challenges to the well-being of the people of the United States, and indeed all industrialized nations. The negative health impacts of obesity are numerous and can be quite serious. In 2000, obesity was related to over 100,000 deaths.[1] In adults, overweight and obesity increases the risk of heart disease, diabetes and some types of cancer, while exacerbating musculoskeletal problems and hypertension. In 1999–2002, 65% of adults were overweight, 31% were obese.[2] Between the years of 1999 to 2004 the prevalence of overweight and obesity increased most dramatically among men and children.[3] About 16% of children and adolescents are now overweight.[2]

Childhood obesity is one of the most important pieces of the epidemic. If current obesity trends among children continue, adult rates will rise considerably, as about 50%–70% of obese children become obese adults,[4] and those who are initially overweight have the highest incidence of major weight gain.[5] Furthermore, overweight in adolescence has been shown to predict a wide range of adverse health effects regardless of adult weight.[6]

One question vital to tackling the issue is what exactly is causing the obesity epidemic? The simple answer is that for many, food intake and physical activity are not in balance. The factors that mediate this relationship are considerably more complex and far-reaching, including social, environmental, and policy conditions.

While discussion about how to address obesity in our society in general commonly results in debate about regulation vs. liberty, addressing the problem in children seems to induce more public support.[7,8] Additionally, the most effective policies in the largely successful campaign against tobacco were those focusing on children.[9] For these reasons, obesity in children may be an ideal forum to tackle these issues, and avoid what looks like a very unhealthy future for America's population.

Some efforts are currently underway at the state level. As of Sept. 30, 2005, 42 states introduced approximately 200 bills that provide some level of nutritional guidance for schools, 44 states introduced legislation that would implement or enhance physical education or activity standards for school children, and 24 states introduced legislation calling for schools to educate children about nutrition and/or the benefits of physical activity.[10] However, it is important to keep in mind a bill introduced is not necessarily a bill passed, and may better yet be a bill overturned. This inconsistent pattern of legislation, marked with strong industry influence, can be seen in the poor state legislative record on soft drinks and snack food taxes.[8]

Researchers at the University of Baltimore have created a childhood obesity report card that compares legislation passed to curb childhood obesity at the state level.[11] Each state receives a grade based on their success at passing five types of legislation. These include: 1) controlling the types of foods and beverages offered during school hours, 2) limiting access to vending machines at designated times, 3) body mass index (BMI) measurement in school, state-mandated additional recess and physical education time, and 4) establishment of obesity and education programs as part of curriculum. The majority of states received a "C", and almost a quarter of them a failing grade, emphasizing the fact that not enough is being done.

One possible reason for the dearth of sufficient action may be the lack of clear evidence about which types of legislation and initiatives result in an actual change in obesity-related outcomes. Without this information, states and schools will likely find it very difficult to dedicate resources to childhood obesity when confronted with a myriad of other competing interests.

Promising progress in the quest for new evidence has taken place in the state of Arkansas. The 84th General Assembly Act 1220 of 2003 required the elimination of all vending machines in public elementary schools statewide, professional education for all cafeteria workers, public disclosure of beverage contracting, establishment of a local parent advisory committee for all schools, establishment of an Arkansas Child Health Advisory Committee, and a child health report delivered annually to parents with BMI assessments. With the help of the Arkansas Center for Health Improvement and its director, the Surgeon General of Arkansas, Dr. Joseph W. Thompson, the state was able to examine the effect of this legislation, using longitudinal BMI data available by school district, school, grade level, ethnicity and gender. This combination of action and measurement has yielded many encouraging results. Further initiatives by the Arkansas Board of Education have taken place, self-regulation by food corporations in schools has begun, and best of all, a plateau in childhood BMI has been seen in a relatively short time.[13]

The federal government is also participating in the search for effective programs and policies. This fall, HEALTHY, a new 2.5-year National Institutes of Health (NIH) funded study, begins. Forty-two schools will be randomized to the intervention or control group to determine whether increases in physical education, healthier school food service and activities to promote healthy behavior can lower risks for type 2 diabetes. Risk factors for diabetes, including blood levels of glucose, insulin and lipids, as well as fitness level, blood pressure, height, weight, and waist circumference will be measured.[13]

Several local efforts to fight childhood obesity exist. One, a collaboration between the Jefferson School of Nursing and Police Athletic League's (PAL) Positive Images Program, which aims to fostering self-esteem and ambition among girls ages 11-17. While serving on the PAL Education Committee, Dr. Mary Schaal, Dean of the Jefferson School of Nursing, learned about the concerning incidence of obesity in the girls participating in the PAL Positive Images Program. Motivated by concern, a group of nursing students, led by Associate Professor and Assistant Dean of Nursing Programs, Dr. Elizabeth Speakman, joined together with the PAL Positive Images Program teachers and participants to create a comprehensive health curriculum. The 12-week program uses exercise and nutrition information as its basis for the educational sessions. Activities were designed to be highly interactive, such as a live demonstration on food choices and the creation of a dance music video. The curriculum

incorporates the Positive Images Program primary emphasis on self-esteem, while recognizing the importance of diversity in the surrounding community, and strives to work within the bounds of local food availability. Pre- and post-surveys will be administered to the participating children to assess knowledge changes.

These recent federal, state, and local efforts are building the base of knowledge necessary to fight childhood obesity, but more research is needed. It is essential that continued exploration into the roots of the problem is followed by thoroughly evaluated programs and policies to address them. It is with this further knowledge that we can prevent childhood obesity and realize our aspirations for a nation of healthy children and ultimately adults.

REFERENCES

1. Flegal KM, Graubard BI, Williamson DF, Gail MH. Excess deaths associated with underweight, overweight, and obesity. *JAMA*. 2005;293:1861-1867.
2. National Center for Health Statistics. Health, United States, 2005 with Chartbook on Trends in the health of Americans. 2005. Available at: http://www.cdc.gov/nchs/data/hus/hus05.pdf. Accessed September 13, 2006.
3. Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. *JAMA*. 2006;295:1549-1555.
4. Reilly JJ, Methven E, McDowell ZC, et al. Health consequences of obesity. *Arch Dis Child.* 2003;88:748-752.
5. Williamson DF, Kahn HS, Remington PL, Anda RF. The 10-year incidence of overweight and major weight gain in US adults. *Arch Intern Med.* 1990;150:665-672.
6. Must A, Jacques PF, Dallal GE, Bajema CJ, Dietz WH. Long-term morbidity and mortality of overweight adolescents - A follow-up of the Harvard growth study of 1922 to 1935. *New Engl J Med.* 1992;327:1350-1355.
7. Weiss RI, Smith JA. Legislative approaches to the obesity epidemic. *J Public Health Policy.* 2004;25:379-390.
8. Caraher M, Cowburn G. Taxing food: Implications for public health nutrition. *Public Health Nutr*. 2005;8:1242-1249.
9. Stanton KR, Acs ZJ. The infrastructure of obesity and the obesity epidemic: Implications for public policy. *Appl Health Econ Health Policy.* 2005;4:139-146.
10. Health Policy Tracking Service, a Thomson West Business. State Actions to Promote Nutrition, Increase Physical Activity and Prevent Obesity: A legislative overview. Thomson West, 2005. Available at: http://www.rwjf.org/files/research/July%202005%20-%20Report.pdf. Accessed September 13, 2006.
11. Cotten A, Stanton KR, Acs ZJ. The UB Obesity Report Card™: An Overview. Available at: http://www.ubalt.edu/experts/obesity/. Accessed September 13, 2006.
12. Thompson JW. Transforming data into information to drive the agenda. *Academy Health Annual Research Meeting.* June 25, 2006. Available at: http://www.academyhealth.org/2006/thompsonj.pdf. Accessed September 13, 2006.
13. National Institutes of Diabetes and Digestive and Kidney Disorders. New study seeks to lower diabetes risk in youth. Available at: http://www.nih.gov/news/pr/aug2006/niddk-28.htm. Accessed September 13, 2006.

Delaware Valley Schweitzer Fellows Program Seeking Sponsors

SARA L. THIER, MPH
PROJECT DIRECTOR
DEPARTMENT OF HEALTH POLICY
JEFFERSON MEDICAL COLLEGE

The Albert Schweitzer Fellowship, a nationally renowned organization dedicated to developing leaders to address the health needs of underserved communities, has launched a major expansion across the United States, with generous support from The Merck Company Foundation. The September 2006 *Health Policy Newsletter* presented a brief history of the program and offered more information about its expansion to the Delaware Valley, with The Department of Health Policy at Thomas Jefferson University serving as the administrative host.

David B. Nash, MD, MBA, Chairman, Department of Health Policy at Jefferson Medical College of Thomas Jefferson, will serve as the program chair and Neil I. Goldfarb, Program Director for Research in the Department of Health Policy will serve as the program director. "As an urban, academic medical center, Jefferson has been a leader in healthcare issues involving public policy and reducing disparities in health and healthcare, which is the mission of The Albert Schweitzer Fellowship," said Dr. Nash. "We are honored to have been selected to take the lead in helping to expand the important work of Albert Schweitzer in the Delaware Valley."

Schweitzer Fellows are healthcare graduate students (medical school, nursing school, public health programs and the like), that are selected through both an application and rigorous screening process. The program consists of a stipend-supported year in which they work with a community organization on a service project which they develop and propose.

The program's funding is based solely on contributions from individuals, foundations, corporations, professional societies, schools, and hospitals. Donations serve to fund administrative costs, fellows' stipends, and the national program. Tax-deductible contributions at all levels are appreciated and will be publicly recognized. Organizations or individuals donating $5,000 or more will be designated as a Sponsor, receiving public recognition, with the contributor's name and/or logo on The Delaware Valley Schweitzer Fellows Program webpage. As a sponsor, you will enjoy the satisfaction of knowing you are fostering the intellectual and experiential growth of dedicated students, while also enhancing the overall health of local communities in Philadelphia, Southern New Jersey, and Delaware.

If you are interested in contributing, please visit http://www.schweitzerfellowship.org/features/giving/ to learn more about giving opportunities, or contact Nicole M. Cobb, MAOM, the Delaware Valley program coordinator, at (215) 955-9995 or Nicole.Cobb@Jefferson.edu.

Web 2.0 and Podcasting: Implications for Health Care

Rodney B. Murray, PhD
Director of Application & Web Services, Jefferson Information Technologies

Assistant Professor, Pharmacology & Experimental Therapeutics, Jefferson Medical College

Introduction

Almost 12 years ago, I wrote an article for the *Health Policy Newsletter* called "Health Care and the Iway."[1,2] In 1995, the World Wide Web was not yet a household concept, early adopters used Lynx or Mosaic, not Internet Explorer or Firefox, and used telephone dial-up not broadband (cable or DSL) to access the Internet from home. We've since survived the "dot com" crash, geared up for HIPAA, and can't live without our email, cell phones, Blackberries or instant messaging. The Web (1.0) has become a marketing must for health care providers, an important resource for health care consumers, and a commercial success.

Web 2.0 is the "participatory" or "read/write" Web, emphasizing tools and platforms that enable the user to talk back. Blogs, wikis, podcasts, and now vidcasts (video podcasts) account for an increasingly important segment of the Web. This article delves further into podcasting and its potential impact on health care.

Podcasting – What is it?

Podcasting involves the recording of audio programs that are then made available for download from a website. A variation on the older Internet radio websites, which streamed audio content, podcasts allow the user to time- and space-shift the program. That is, users can download and play the program on a portable digital audio player any time and any place. Although inspired by the iPod, you don't have to have an iPod to listen to or make podcasts. You can listen to them right on your computer or download them to any digital music player. Listening rather than watching or reading allows the user to learn while walking, exercising, riding public transit or driving.

Podcasting is the fastest growing Web 2.0 technology, probably because of its inherent simplicity and ease of use. Some say podcasting will become a mainstream application like the TiVo video recorders—in fact, podcasting is kind of like TiVo for radio. Podcasting is exceeding the growth rate of the DVD, which holds the record as the fastest growing consumer entertainment technology.

Podcasting – Who is using it?

Tech savvy amateurs, including many bloggers, were the first to podcast. Education institutions of all sorts are beginning to make course content available as podcasts. Professional broadcasters and syndicated radio shows are now making their content available as podcasts. NPR's "In the Media" was one of the first to appear. Apple was late to the game but gave podcasting a big boost about a year ago when they began to add podcasts to their iTunes music store directory. Now a search on iTunes lists almost 5,000 educational podcasts.

Podcasting – Three Scenarios and Implications

Student

John had to leave his pharmacology class early to attend to some urgent personal business, but he knew he could catch his professor's podcast the next morning. That night, he "docked" his iPod so it could charge its batteries and, while he slept, his iTunes "podcatcher" downloaded the previous day's lectures. In the morning, he grabbed his iPod and listened to the lecture he missed while riding the bus to school. Hearing the banter and questions from students and his professor's animated answers, he arrived at school feeling well prepared for the next lecture.

Jefferson is evaluating several commercial products that will capture lecture audio, computer displays and even video and automatically link the podcast content to, the course site in our Blackboard course management system (http://pulse.jefferson.edu). Several universities including Duke, Stanford, UC Berkeley and the University of Michigan are using *iTunes U*, a free service from Apple, to distribute course podcasts to their students and a subset of free podcasts to the public.

Clinician

Dr. Smith, a primary care physician, catches up with his continuing medical education (CME) while riding the train. He has a 15-minute walk to the station and has been using his smart phone/PDA lately instead of lugging around his heavy laptop computer. His phone has mp3 player software and can easily store 10 hours of audio programs. While recharging his phone last night, it automatically downloaded several CME programs from his med school's alumni site. This morning he decided to review some of the latest thinking on neurological disorders and appreciated that his video phone was able to display the PowerPoint diagrams that accompanied the audio lecture.

Podcasting seems to be a natural for continuing education. Numerous CE sites are becoming available for the mobile practitioner (http://www.cmepodcasting.com/, http://nursingspectrum.netstation.us/, http://www.med.nyu.edu/podcasting/).

Patient

Martha, a 55-year-old, mildly obese mother of four, was waiting in her surgeon's office for her last consult with him before undergoing an angioplasty procedure. The receptionist gave her a video iPod and began to instruct her, but Martha already owned an iPod and needed little help. She learned what to expect before, during and after the procedure. Some of the questions she had jotted down to ask her surgeon were answered during the video presentation. After a brief consult with her surgeon to help clarify her remaining questions, she was allowed to take the iPod home to learn more about her risk factors and strategies for reducing them.

One of the first web sites to provide extensive audio and video podcasts for patients is the Cardiovascular Multimedia Information Network of the Arizona Heart Institute (http://cvmd.org/). Its creator, cardiovascular surgeon Dr. Grayson Wheatley[3] (Jefferson Medical College, Class of 1994), has gained a lot of publicity as the first physician to replace magazines in his waiting room with video iPods.

Who pays for all of these "free" podcast subscriptions? Many, of course, are underwritten by educational institutions and big media, but many more are supported by amateurs with something to say and startup companies with venture capital. Like Web 1.0, Web 2.0's podcasting is quickly becoming a marketing opportunity for health care providers and the pharmaceutical industry, and an increasingly important educational resource for health care students and consumers. Although podcasting promises to be the ultimate targeted marketing outlet, the advertisers have been slow to build the mechanism to help "monetize" podcasts and make them a commercial success. Stay tuned.

Podcasting – Learn More

Learn more about podcasting and other e-learning technologies by subscribing to "Rod's Pulse Podcast" (http://www.rodspulsepodcast.com).[4] The web site is a blog with "show notes" for each episode and instructions for subscribing using the various podcatchers. Comments and feedback are welcome.

REFERENCES AND NOTES

1. Murray, R.B. (1995). Health care and the "Iway." *Health Policy Newsletter*, 8(1): Article 2. [http://jdc.jefferson.edu/hpn/vol8/iss1/2]
2. "Iway", a synonym for information highway coined by Bob Metcalfe, inventor of Ethernet. *InfoWorld* April 25, 1994 v16 nl7 p63(1)
3. Listen to my interview of Dr. Wheatley at http://rod4jefferson.blogspot.com/2006/05/rpp-16-interview-grayson-wheatley-md.html.
4. Disclosure: this is a shameless plug for the author's own podcast.

Personal Health Records and Electronic Health Records: Navigating the Intersections

MEGAN J. HARTMAN, MS

PROJECT DIRECTOR
DEPARTMENT OF HEALTH POLICY
JEFFERSON MEDICAL COLLEGE

With the surge in consumer-driven health care, health care leaders and advocates expect and encourage members of the general public to become better health care consumers. The personal health record (PHR) can be an important tool to assist patients in managing their care and communicating about their health. Further, the use of "integrated PHRs" promises to contribute to the transformation of the health care system from provider-centric to patient-centric. While definitions and formats of PHRs vary, an integrated PHR can be described as electronic records that are capable of communications, data exchange, and full integration with health care information systems.[1]

In late September 2006, the Agency for Healthcare Research and Quality (AHRQ), American Medical Informatics Association (AMIA), Kaiser Permanente Institute for Health Policy, and The Robert Wood Johnson Foundation sponsored a roundtable discussion with key stakeholders and health care and technology experts to explore the facilitators and barriers to fully-integrated personal health records, linking PHR and electronic health records (EHR) systems. The group was charged with identifying:

- The "transformative potential" of integrated PHRs,
- Barriers to realizing this potential, and
- A framework for action to move integrated PHRs closer to the health care mainstream.

The groups classified the "transformative potential" of a fully-integrated PHR into five major categories:

- transforming the care processes;
- interactive communication;
- information exchange;
- consumer activation; and
- convenience and efficiency.

At the same time, the group recognized the major barriers to integration and realizing any benefits, such as:

- challenges of changing the culture of health care systems;
- lack of a common framework, including standards and infrastructure;
- trust; and
- marketing the PHR to increase consumer awareness and understanding.

Several common themes emerged, and the group generated possible action steps to help overcome some barriers and strive to achieve potentials. These included:

- Develop PHR certification standards;
- Develop and disseminate standards of practice for PHR deployment, administration and use;
- Promote industry standards to encourage integration, such as a common set of utilities;
- Promote integrated PHRs by national entities, and
- Further assessment and research related to PHR use, i.e., effectiveness, business care, liability issues, special populations, etc.

It will take a great deal of work to develop, disseminate and fully utilize an integrated PHR. This roundtable was a powerful first step in bringing together key organizations and strategic thinkers primed to promote the PHR and its transformative potential.

REFERENCES

1. Raymond B. The Transformative Potential of Integrated Personal Health Records. Prepared for the Roundtable: Personal Health Records and Electronic Health Records: Navigating the Intersections. September 28-29, 2006. Kaiser Permanente Institute for Health Policy. Oakland, CA.

Health Policy Forum – September 13, 2006
The Role of Healthcare Quality Ratings in Marketing

Tom DeSanto
Executive Vice President
Aloysius Butler & Clark

More health care facilities are using quality and health care ratings as part of their marketing strategy. Common health care ratings that are showing up in ads include JCAHO certification, Press Ganey, Baldridge Award, and *US News & World Report.*

Why do organizations utilize these ratings and awards in their marketing? Third-party endorsement is useful for building credibility, differentiating the facility from its competitors, and maintaining market share. Still, ratings are often suspect, in that there is no standardized methodology used, and there is currently no evidence that these ratings and endorsements actually will improve market share.

Marketing is approached from two different perspectives, to gain market share and to protect it. Facilities have used these types of marketing to:
- Prove improvement
- Make a competitive statement
- Build credibility
- Create value
- Express culture
- Affirm relationships

There are ten criteria facilities can utilize to determine whether it is useful and appropriate to include the various ratings and awards as part of a marketing plan. Basically, they consist of answers to the following:

To what degree is the rating:
- important to your CEO, board and physicians?
- able to help your organization reach its marketing goals?
- compatible with your overall marketing messages?
- an effective way to differentiate from your competitors?
- meaningful to your physicians, patients and community?
- worthy of the resources required to promote it?
- valuable in motivating staff and employees?
- reflective of your mission, brand and culture?
- essential for helping to promote a specific service line?
- likely to be sustained in the near future?

Listen to the podcast of this Forum presentation and view the slides with examples of marketing materials at: http://www.jefferson.edu/dhp/education_ls.cfm#2

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.

January 10, 2007
Update on Healthcare Governance
Charles Elson, JD
University of Delaware

February 14, 2007
Response of the Commonwealth to Proposed Changes to Medicare
Lawrence M. Clark
House of Representatives
Commonwealth of Pennsylvania

March 14, 2007
Pennsylvania 2020 Vision Report
Nora Dowd Eisenhower
Secretary for PA Dept. of Aging

April 11, 2007
SMART – Strengthening the Mid-Atlantic Region for Tomorrow
Thomas Kingston
Managing Director, SMART Board

Department of Health Policy Presentations

Brixner D, Maio V. Analysis of Prescribing Patterns of Antihypertensive Agents Before and After Publication of the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). 9th Annual European Congress of the International Society for Pharmaco-economics and Outcomes Research. Copenhagen, Denmark, October 2006.

Gagne JJ, Breitbart RE, Maio V, Horn DL, Hartmann CW, Swanson R, Goldfarb NI. Costs Associated with Candidemia in a Hospital Setting. 46th Annual International Conference on Antimicrobial Agents and Chemotherapy. San Francisco, CA, September 2006.

Crawford A, Chapman H. Implementing SAS and Enterprise Guide to Enhance a Graduate Biostatistics Curriculum. NorthEast SAS Users Group Meeting. Philadelphia, PA, September 20, 2006.

Goldfarb NI, Crawford AG, Koran J, Chapman H, Nash DB. Physician Engagement to Promote Ambulatory Quality and Safety Among the Jefferson University Physicians. Poster presentation at the University HealthSystem Consortium 2006 Quality and Safety Fall Forum. Baltimore, MD, October 2006.

Alvarez K, Hartmann CW, Sciamanna CN, Mui S, Blanch DC. A Novel Website to Improve Asthma Care: Qualitative Analysis of End-user Experience. 11th World Congress on Internet in Medicine. Toronto, Ontario, Ca, October 2006.

Alvarez K, Hartmann CW, Sciamanna CN, Mui S, Blanch DC. A Novel Website to Improve Asthma Care: Qualitative Analysis of End-user Experience. Poster presentation at the Academy Health Annual Research Meeting. Seattle, WA, June 2006.

Sciamanna CN, Alvarez K, Miller J, Gary T, Bowen M. Attitudes Toward Nurse Practitioner-Led Management of Multiple Chronic Diseases in Primary Care Settings. Poster presentation at the Academy Health Annual Research Meeting. Seattle, WA, June 2006.

Alvarez K, Sciamanna CN, Rogers ML, Shenassa ED, Houston TK. Patient Access to US Physicians Who Conduct Email Consults. Poster presentation at the Academy Health Annual Research Meeting. Seattle, WA, June 2006.

Crossan L, Lofland J, Robbins J, Plumb J. At risk and overweight adolescents in Philadelphia health care centers: prevalence, risk factors and co-morbidities. American Public Health Association 134th Annual Meeting. Boston, November 3 -7, 2006.

Sarfaty M, Feng Shibao. Addressing disparities in colorectal cancer. American Public Health Association 134th Annual Meeting. Boston, November 3 -7, 2006.

Sarfaty M. – Presider – Quality care in Cardiac Care, Cancer, Gout, and Long Term Care.

New Publications from the Department of Health Policy

Breitbart RE. Book Review: Physicians as Leaders: Who, How and Why Now? *Am J Med Qual.* 2006;21:355-356.

Crawford AG, Sciamanna CN. Introduction to case studies on medication reconciliation. *Am J Med Qual.* 2006;21:291-292.

Epstein K, Yuen EJ, Riggio JM, Ballas SK, Moleski SM. Utilization of office, hospital, and emergency department for adult sickle cell patients: A five year study. *J Natl Med Assoc.* 2006;98(7):1109-1113.

Leas B, Goldfarb NI. Literature Review. *Am J Med Qual.* 2006;21(5):352-354.

Maio V, Yuen EJ, Novielli K, Smith KD, Louis DZ. Potentially inappropriate medication prescribing for elderly outpatients in Emilia Romagna, Italy. *Drugs Aging.* 2006;23(11):915-924

Marcus BH, Napolitano MA, King AC, Lewis BA, Whiteley JA, Albrecht AE, Parisi AF, Bock BC, Pinto BM, Sciamanna CA, Jakicic JM, Papandonatos GD. Examination of print and telephone channels for physical activity promotion: Rationale, design, and baseline data from Project STRIDE. *Contemp Clin Trials.* 2006 May 12. [Epub ahead of print]

Napolitano MA, Whiteley JA, Papandonatos G, Dutton G, Farrell NC, Albrecht A, Bock B, Bazzarre T, Sciamanna C, Dunn A, Marcus BH. Outcomes from the Women's Wellness Project: A community-focused physical activity trial for women. *Prev Med.* 2006 Aug 16. [Epub ahead of print]

Nash DB. Guanxi! *Biotechnology Healthcare*. 2006;3(4):6.

Nash DB. Hospital-acquired infections: raising the anchoring heuristic. *Am J Med Qual.* 2006;21(6 Suppl):5S-6S.

Nash DB, Skoufalos A, Hartman M, Horwitz H, eds. *Practicing Medicine in the 21st Century.* Tampa, FL; American College of Physician Executives, 2006.

Nash DB. Foot Soldiers for EBM. *P&T.* 2006;31(8):418.

Nash DB. STHFT Happens! *P&T.* 2006;31(9):409.

Nash DB. Leadership. *P&T.* 2006:31(10):558.

Nash DB, Greene RA, Loeppke RR, McCall N, Moorhead T. Insights from the 2006 Disease Management Colloquium. *Dis Manag*. 2006;9:189-194.

Orr PM, McGinnis MA, Hudson LR, Coberley SS, Crawford AG, Clarke JL, Goldfarb NI. A focused telephonic nursing intervention delivers improved adherence to A1c testing. *Dis Manag.* 2006;9:277-283.

Sarfaty M, Feng S. Choice of screening modality in colorectal cancer education and screening program for uninsured. *J Cancer Ed.* 2006;21:43-49.

Sciamanna CN, Alvarez K, Miller J, Gary TL, Bowen M. Attitudes toward Nurse Practitioner-led chronic disease management to improve outpatient quality of care. *Am J Med Qual.* 2006;;21(6):375-381.

Yetman S, Goldfarb NI. Literature Review. *Am J Med Qual*. 2006;21(6): 418-420.

Jeff-ISPOR Student Chapter Chartered out of the Department of Health Policy

Seina P. Lee, PharmD, MS
Postdoctoral Outcomes Research Fellow
Department of Health Policy
Jefferson Medical College

The **Jefferson** Chapter of the International Society for Pharmacoeconomics and Outcomes Research (**Jeff**-ISPOR) debuted to Jefferson students during the Student Organizations Fair held on September 12, 2006. The attendees, including Jefferson Medical College students, enjoyed their first glance at this new, thought-provoking group on campus.

Today more than ever before, studying the healthcare systems is crucial. Access to health care, the provision of quality care, paying for care, and the effects of care are all areas that working healthcare professionals recognize need improvement for the benefit of patients. **Jeff**-ISPOR will strive to uniquely bring educational and networking opportunities within health services, pharmacoeconomic, and outcomes research to Jefferson students, enabling them to think about, and start improving, the healthcare systems in which they participate.

Jeff-ISPOR, based in the Jefferson College of Graduate Studies, is led by fellows and faculty from the Department of Health Policy at Jefferson Medical College. The Department has strongly and consistently been involved with ISPOR at the national level, which has facilitated the natural and needed next step of creating a local student chapter. The Department has attended and exhibited research at every ISPOR international meeting to date and boasts a rich network of knowledgeable researchers, educators, and healthcare professionals, who will serve as a valuable resource for the new chapter's ongoing activities.

ISPOR, the parent affiliate, is an international organization promoting the science of pharmacoeconomics and health outcomes research. ISPOR's mission is to "translate pharmacoeconomics and outcomes research into practice to ensure that society allocates scarce healthcare resources wisely, fairly, and efficiently." As of 2005, ISPOR has over 2,700 members internationally. About 40% of its membership comes from the pharmaceutical industry, 30% from academia, and the remainder from various research, practice and government organizations. Half of ISPOR's members are in the United States, followed by Europe (27%), Asia (5%), and Canada (5%).[1]

Currently, there are 30 ISPOR student chapters nationally and an additional six chapters located in Canada, Europe and Asia.[1] ISPOR student chapters overwhelmingly are initiated and supported by schools of pharmacy. **Jeff**-ISPOR is proud to bring innovation to this trend by hosting medical and graduate students within its chartering membership. The chapter plans to lay a strong foundation within the entire Jefferson community creating a network of members from diverse research and practice disciplines. The creation of **Jeff**-ISPOR will also provide an established organization for the future school of pharmacy student body.

The founding Executive Board includes Seina Lee, PharmD, MS, and Joshua Gagne, PharmD. Dr. Laura Pizzi, Research Associate Professor of Health Policy, will serve as the Faculty Advisor. If you would like to learn more about **Jeff**-ISPOR, please contact Seina Lee at seina.lee@jefferson.edu or (215) 955-6639.

REFERENCES

1. International Society for Pharmacoeconomics and Outcomes Research. Available at: www.ispor.org. Accessed September 14, 2006.

Seeking: Program Director, Master of Science in Public Health
Jefferson College of Graduate Studies, Thomas Jefferson University

Responsibilities: The Program Director will be ultimately responsible for every aspect of the generalist MSPH educational program, a program of the Jefferson College of Graduate Studies. The Program Director will also have a primary appointment in the medical school-based Department of Health Policy. The Director will expand enrollment; link to other Departments in the University; manage governance, the accreditation process, and student advising; and develop additional areas for course instruction. The Director will also represent the program to the University and the public health community (local, regional, national). As a faculty member, the Director will be expected to contribute to the program by conducting funded research, teaching graduate courses, and supervising/mentoring students.

Qualifications: Candidates should possess a doctorate in public health or a related discipline from an accredited research-level university, a record of scholarly research including peer-reviewed publications, and research funding commensurate with rank. An MPH from an accredited program is preferred, although other public health-related degrees are acceptable. The individual must demonstrate the ability to establish an externally funded program of research as evidenced by publications and funding from the National Institutes of Health, the Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality and/or comparable national funding source (associate professor level), or an emerging program of research and post-doctoral training (assistant professor level). The successful candidate will be familiar with national trends in public health education and the accreditation process, and be able to work with various internal and external constituencies. Leadership experience in the public health field is preferred.

For More Details, Please contact Elizabeth Lopez at 215 955-5463 or at Elizabeth.Lopez@jefferson.edu

Health Policy NEWSLETTER

Department of Health Policy
Jefferson Medical College
1015 Walnut Street, Suite 115
Philadelphia, PA 19107

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Tel: (215) 955-7417
Fax: (215) 923-7583
Web: www.jefferson.edu/dhp/

Questions? Comments?
David.Nash@jefferson.edu