Health Policy NEWSLETTER

In This Issue

From the Editor

The Meaning of Mission

Virtually every modern healthcare organization in the United States devotes considerable time and energy to crafting a "Mission and Vision Statement." Development of these value-based declarations of purpose helps the leaders of these organizations to succinctly state what they stand for and what they aspire to become. There are even irreverent websites that poke fun at the entire enterprise through the use of specialized software that allows one to generate a "customized" mission statement simply by filling in the blanks.

For those organizations that take it seriously, a carefully articulated mission and vision can drive the entire enterprise by assuring that each individual understands his/her role and how it contributes to the overall organizational goals. I have had the privilege of learning the true meaning of mission in healthcare through my decade of service on the Board of Trustees of Catholic Healthcare Partners (CHP), one of the country's largest not-for-profit healthcare systems, headquartered in Cincinnati, Ohio. In this article, I will outline the scope of the CHP Mission and then reflect upon how my experience as a member of their board influenced my point of view.

The CHP system consists of more than 100 organizations, including "acute care hospitals, long-term care facilities, housing sites for the elderly, home health agencies, hospice programs, wellness centers, and more."[1] They are divided into nine regions, each of which provides a comprehensive range of services that meet the healthcare needs of people in Indiana, Kentucky, Ohio, Pennsylvania, Tennessee, and nearby states. CHP is the largest employer in Ohio, and the tenth largest integrated delivery system in the United States. Its thirty-three core hospitals with thousands of physicians, nurses, pharmacists, and others provide services to millions of patients.

CHP's mission is to "extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and underserved." CHP expresses its core values of compassion, excellence, human dignity, justice, sacredness of life, and service through the activities of its nearly 35,000 associates in each of its organizational components. All of these activities eventually report up to the Corporate Board through the home office in Cincinnati.

The CHP Corporate Board is diverse; membership is not limited to those of the Catholic faith. Its members collectively represent the five religious orders who came together to form the system and various outside experts.

As a board member, my particular responsibility was to serve as Chair of the Board Quality and Safety Committee. The committee was the focal point for setting the quality and safety agenda, integrating that agenda with the organization's overall strategic plan, and promoting public accountability for all services rendered throughout CHP. Aspects of CHP's mission were directly expressed through the committee's work. While I am very proud of our accomplishments and remain grateful to the staff in Cincinnati who supported our work, the true meaning of "mission" became clear to me through other aspects of my involvement with CHP.

The five religious orders who came together to form CHP include the Grey Nuns, two different communities of Sisters of Mercy, the Sisters of the Humility of Mary, and the Franciscan Sisters of the Poor. Over the past five years, the CHP Board has visited each of the Mother Houses of the religious sponsors in an effort to seek out the spiritual center and to create, in the board, a deeper meaning of service to the poor and underserved.

These pilgrimages to each of the Mother Houses included visits to a convent in rural Pennsylvania and an overseas trip to Dublin, Ireland to the national historic site devoted to Sister Catherine McAuley, the founding Sister of Mercy. The board's spiritual journey culminated with our September 2008 retreat to the Vatican, the seat of the Catholic Church. The Board's journey to Rome included opportunities for shared prayer, reflection and education.

continued, p.2

Jefferson Medical College

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According to Michael D. Connelly, the President and CEO of CHP, the retreat was "intended to promote a deeper understanding of your personal call to the vocation of healthcare ministry, provide an understanding of the Catholic imagination and theological world view and their implications for Catholic health ministry, and strengthen relationships between board members as part of the community of leaders in health ministry." We were going to Rome, in part, to delve deeper into the meaning of mission and our individual role in living that mission.

We were given a series of readings to complete prior to the embarking on our spiritual retreat. Among the materials was All the Pope's Men: The Inside Story of How the Vatican Really Thinks,[2] by John Allen, Jr. Allen, a prize-winning correspondent for the National Catholic Reporter and CNN analyst on Vatican affairs, addressed our group following our visits to various Vatican offices.

The Board visited several different dicasteries (the various departments and offices that assist the Pope in the government of the Church) during the spiritual retreat. These visits provided us all with a better appreciation for the scope and breadth of Catholic healthcare worldwide. America's 70 million Catholics compose only six percent of the global Catholic community. The dicasteries are responsible for everything from protecting the doctrine of the faith to convening global health conferences on AIDS prevention, malaria eradication, and dozens of other healthcare topics. Each dicastery had a unique personality, determined in large part by the leadership and the particular organizational culture. These dicasteries report more or less independently to the Pope and, as such, sometimes operate in relative isolation from one another.

On a more personal level, the spiritual retreat to Rome brought the meaning of mission more clearly into focus. Health care is an integral part of the Church and serving the sick is seen as an opportunity to become closer to God. My understanding of this mission deepened as I observed the behaviors of my Board colleagues and the Sisters who represented the five religious orders. In addition to their religious training, most of the Sisters are highly trained experts with graduate degrees in pharmacy, nursing, hospital administration, theology, and jurisprudence. The Sisters truly embody this mission on both a spiritual and practical level. The way in which they serve is so selflessly palpable, it has given me a deeper understanding and appreciation of the mission of CHP, which clearly has no religious boundaries.

When I look back upon my years of service with Catholic Healthcare Partners, several themes emerge. Certainly, the hard work of the Inaugural Board Quality and Safety Committee is among my proudest professional accomplishments. The collegial way in which the Board embraced its fiduciary responsibility for promoting public accountability for the work of CHP stands out as a key career achievement. The committee felt empowered via the support we received, personally and professionally, from Mike Connelly. He challenged us to go beyond the typical governance report for Quality and Safety and link our goals to the overarching strategic vision of the entire organization. Mike Connelly helped me to further understand the meaning of mission from a perspective different from that of a Sister.

In our cynical modern world with all of its attendant greed, financial crises, and calls for higher levels of reimbursement, my service to CHP will remain as a cornerstone of my own personal mission. My professional work in health services research and consulting in healthcare governance[3] was enriched via my experience with CHP. The meaning of mission in healthcare is much clearer to me. I hope that I will be able to bring this deeper understanding of the true role of healthcare governance to my new responsibilities as a board member for Main Line Health right here in Bryn Mawr, Pennsylvania. CHP has given me a great gift, one I want to use wisely. As always, I am interested in your views and you can reach me at my email address, which is david.nash@jefferson.edu.

You can learn more about CHP by visiting their website: www.health-partners.org.

David B. Nash, MD, MBA

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2. Allen JL. *All the Pope's Men: The Inside Story of How the Vatican Really Thinks.* Doubleday, NY 2004.
3. Nash DB, Oetgen W, Pracilio V (eds.) Governance for Health Care Providers: The Call to Leadership. The Productivity Press, Chicago, IL, 2008

HEALTH POLICY FORUMS: WINTER 2009

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

January 14, 2009
BeWell.com – The Value of Social Media in Health Communication
Cheryl Heiks
Director of Communications and Events
LLuminari Inc.

February 11, 2009
Public Policy and Cardiovascular Disease: Making the Connection
Timothy Gardner, MD
President
American Heart Association
Medical Director
The Center for Heart and Vascular Health
Christiana Care Health System

March 11, 2009
The Public-Private Balance in Healthcare: Political and Economic Tipping Points
Alan Lyles, ScD, MD
Henry A. Rosenberg Professor of Public, Private and Nonprofit Partnerships
School of Public Affairs' Health Systems Management
University of Baltimore

Chronic Illness Care Education: Reflections on a Longitudinal Interprofessional Mentorship Experience

Collins L, Arenson C, Jerpbak C, Dressel, Kane P, Antony R, Necky J, Oduneye A
Jefferson Center for InterProfessional Education

The prevention and management of chronic disease is a leading healthcare concern. Currently 133 million Americans live with at least one chronic condition and seven out of ten deaths are due to chronic disease.[1,2] Well-functioning teams of highly trained professionals are needed to provide rational, patient-centered, evidence-based care of chronic disease.[3] While there has been some evidence to show that interprofessional patient-centered care improves health outcomes, evidence to support interprofessional educational interventions is sparse.[4] This article describes a longitudinal research study that incorporated the use of mentors with chronic illness into the training of future health care professionals. The study implemented a qualitative analysis of student reflection essays to assess the impact of this training approach.

To address the gap in chronic illness care education, Thomas Jefferson University developed and implemented an interprofessional education program for a mixed audience of students in medicine, nursing, occupational therapy, and physical therapy. The keystone of this program is the use of a health mentor. The health mentor is an adult of any age who has one or more chronic medical conditions and who volunteers to meet with a small group (3 or 4) of students 4 times a year for 2 years. Mentors were recruited from Jefferson outpatient practices, community organizations, and continuing care retirement communities in the Philadelphia area. Each mentor received an individualized orientation to the program by Jefferson faculty that included a review of program goals, objectives, and logistics.

At the end of the first year of the program, students were each asked to respond to the following prompt: *In the health mentor program, the mentor is the teacher. Please describe the impact your mentor has had on your education as a future health care provider.* Student essay responses were qualitatively analyzed and entered into the NVivo 8 data analysis software program, a program which allows for importing, sorting and analyzing of separate text files. Independent coders from 4 different disciplines (medicine, nursing, OT, and public health) reviewed the essays. Coder consensus was established through weekly meetings where themes were operationally defined, differences in coding were reconciled, and a definitive theme set was agreed upon.

In total, 60 papers (15 from each discipline) were reviewed and coded before no new themes emerged. Student essays addressed personal learning experiences during this mentorship program including their overall understanding of chronic illness and their attitudes toward chronic illness, aging, and inter-professionalism. The following seven major themes were identified in students essays: 1) Ability to see patient-mentor as person/individual, 2) Increased positive attitudes toward chronic illness care, 3) Increased positive attitudes toward elderly and aging, 4) Broader understanding of the role of the health care provider, 5) Increased understanding of the importance of health care provider-patient communication, 6) Importance of patient-centered care, and 7) Deeper understanding of the healthcare system.

Findings from this study suggest that a longitudinal, interprofessional mentorship program may be a promising tool for the development of higher-quality interprofessional healthcare teams. Our results lend support to other research that calls for early exposure to chronic disease prevention and management in health professions training.[5,6] Repeated visits with health mentors in the community, instead of the hospital, gave students an alternative first-time exposure to chronic illness.[7] The longitudinal relationship with mentors gave students insight into the importance of empathy and a holistic approach to care. Attentive listening, allotting enough time, and the importance of developing a rapport during the interview process were noted by participants as positive outcomes of this program.

This study suggests that early, longitudinal patient contact may help to prevent the negative connotations many students come to associate with chronic illness during their later clinical experiences. Further work is needed to assess the impact of the full two-year curriculum on longer term attitudes and behavior (i.e. at graduation and in practice). Students will be followed using the Jefferson Longitudinal Study to monitor these outcomes. Community health mentors with well controlled chronic conditions can have a positive impact on health professions' student attitudes and should be utilized in chronic illness care education.

For more information on this program contact Lauren Collins, MD at Lauren.Collins@jefferson.edu.

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Public Policy for People with Disabilities: the UN and WHO Perspectives

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Like other social issues, globalization has had an impact on governmental policies towards disability. Legislation in one country can have a significant impact on international organizations – such as the United Nations (UN) and the World Health Organization (WHO) and on the policies of other countries. For instance, the United States (US) Americans with Disabilities Act (ADA) of 1990 provided an important model to these organizations and many countries. The reverse can also be true; international approaches can impact the legislation of individual countries. For example, the broader definitions of disability included in the UN Convention on the Rights of Persons with Disabilities influenced advocates who sought passage of the US ADA Amendments Act of 2008, signed into law on September 25, 2008.

Increasingly, awareness of international concepts related to social problems provides insight into issues likely to be addressed in one's own country. This paper reviews recent UN and WHO actions likely to influence the public policies of most countries towards people with disabilities, including those of the US.

Disability is a significant issue in the US. Based on the 2002 Survey of Income and Program Participation, The United States Census Bureau News reported in 2006 that 51.6 million Americans (18% of those responding) reported having a disability.[1] US public policy addresses both the rights and the financial needs of people with disabilities.[2,3] The laws implementing these policies were largely the result of advocacy efforts of people with disabilities and their US organizations.

Internationally, disability is an even greater problem than it is in the US. Approximately 10 percent of the world population, which is equivalent to 650 million people, has a disability.[4] Disability does not exist in isolation; it is linked to unemployment, poverty, reduced health status, lower educational levels and abusive behavior, particularly of children and women. Globally, 10% of disabilities from injuries are from war; particularly from unexploded ordinance including landmines.[5] The UN refers to disability as multisectorial, i.e. programs addressing disability require the involvement of multiple governmental departments dealing with these related social problems. Estimates are that 25% of the world's population is directly affected by disability when the impact on caregivers and family members is considered.

On a global scale, the UN General Assembly adopted the Convention on the Rights of Persons with Disabilities and an Optional Protocol to the Convention (Convention) on December 13, 2006.[6,7] This Convention entered into force on May 3, 2008, after it received its 20th ratification. This status requires that a Conference of Member States elect a Committee on the Rights of Persons with Disabilities in 6 months. The Convention aims to ensure that persons with disabilities enjoy all human rights and fundamental freedoms on an equal basis with others. It lists the adaptations member countries must make to enable people with disabilities to exercise their rights effectively. The need for these requirements is based upon an analysis of the rights that have been violated and those that need reinforced protection.

Within the United Nations, the WHO is taking the lead in implementing the Convention, particularly its health aspects.[8] One of its initiatives includes disseminating information on the Convention, emphasizing its importance and supporting Member States in their implementation obligations. Another initiative is appropriately incorporating disability issues within WHO projects and programs, and assuring that WHO offices, information resources and employment opportunities are accessible.

At the request of the World Health Assembly, WHO is developing a *World Report on Disability and Rehabilitation* to thoroughly discuss and examine the importance of disability, assess the current situation and determine what will be needed in the future. The report will investigate the current data and patterns in disability and rehabilitation, etiologies of disabilities, and key issues including rights, access and equality. Furthermore, it will develop a plan for change on the national and international levels based on the best available scientific evidence while promoting awareness on the state of disability and rehabilitation.

These mandates to protect the human rights of people with disabilities will affect all of the institutions of countries that incorporate them into their laws, much as the US has done with the ADA Amendments of 2008. They will have the same impact as the laws that protect the rights of women and underrepresented minorities. Organizations such as Thomas Jefferson University and Thomas Jefferson University Hospital will need to consider these mandates as they examine policies related to employment and acceptance of students, as well as programmatic goals and competencies.

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Diffusion of Radiologic Technology in Sub-Saharan Africa: A Jefferson College of Health Professions Study

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According to the World Health Organization (WHO), industrialized nations must share the responsibility for providing healthcare among the disadvantaged.[1] Socioeconomic progress in poor and hard-to-reach populations hinges greatly on health services, including new technologies and the means to effectively employ them. Certainly, a nation's health and degree of economic development is linked to its national security and prosperity, a theory also known as "health creates wealth."[2]

With regard to the diffusion of medical technology internationally, more than three-fourths of the global population have no chance of receiving an examination utilizing diagnostic imaging.[3] In 1985, WHO recommended that all institutions in developing nations possess at least 1 ultrasound machine.[4] The need for ultrasound in developing nations was further supported in a 2003 article by Goldberg.[5]

The countries of sub-Saharan Africa (SSA) are among those in desperate need of advanced imaging technology. Factors that thwart its profusion in SSA are poor planning, lack of professional training, maintenance problems—due to poorly trained and/or a dearth of skilled repair technicians—and insufficient financial resources.[6,7] That funding challenges affect the diffusion of medical technology[8] in SSA is not surprising, given that the public sector healthcare budget ranges from $20 to $50 per capita (as compared to the United States' budget of $5,700 per capita). In SSA the lack of established policies for technology assessment and maintenance makes appropriate purchases and keeping the existing devices in service problematic.[6] When a society is unable to use a currently available technology, there may be healthcare implications related to missed diagnoses or the inability to monitor treatment.[9]

As in many other non-industrialized nations, AIDS and other endemic diseases are a primary focus of healthcare in SSA, and rightly so. However, the importance of radiologic technology to aid in the diagnosis of the sequelae of these diseases and treatment follow-up cannot be overstated.[10]

An unfunded study was conducted as part of a master's thesis in the Radiologic and Imaging Sciences program at Thomas Jefferson University's College of Health Professions. The purpose of the study was to examine the manner in which advanced imaging technology, including computed tomography (CT), magnetic resonance imaging (MRI), ultrasound (US) and nuclear medicine (NM) has spread throughout SSA. It was hypothesized that SSA would have a substantial amount of US equipment, and less CT, MR and NM equipment. It was further hypothesized that a significant amount of the equipment would be nonfunctional due to the lack of trained biomedical technicians in SSA.

A survey was sent to 156 institutions in SSA via email and the postal service with the goal of examining the pattern of diffusion of these modalities, and the status of functional equipment. A total of 40 (25.6%) completed surveys were returned and revealed that 100% of the institutions that responded had ultrasound equipment (commensurate, perhaps, with the 1985 WHO recommendation that every institution in all developing nations should have at least 1 ultrasound machine). After US, CT was the most common modality, followed by MRI and then NM. With regard to the presence of functioning equipment, ultrasound was the modality with the most equipment out of service (41%), followed by CT and NM. All of the MRI units were reported to be functional. While almost half (46%) of the institutions reported having biomedical technicians in-house, there was no correlation between the presence of these technicians and the amount of functioning equipment. The study results confirmed the need for better trained biomedical technicians who have reliable access to replacement parts, and it was theorized that the biomedical technicians are not trained to repair advanced imaging equipment.

The chief limitation of this study was its small sample size, and a comprehensive database of healthcare institutions within SSA would likely improve the ability to perform future research. While this study focused on the nations of SSA, the results should translate to other impoverished nations facing similar funding struggles in the socialized medicine environment. Improved funding by governmental and nongovernmental agencies for advanced imaging equipment would offer more opportunities to the people of these nations for improvement in diagnosis and treatment of disease.

More developed countries can assist these nations in need through donations of "gently used" and/or refurbished radiologic equipment. However, the cost of upgrading and repairing these expensive technologies may be prohibitive for the recipient nations, and create a worse situation than not having the machines.[11] The Radiological Society of North America (www.RSNA.org) and the American College of Radiology International Volunteer System (https://internationalservice.acr.org/) have resources for volunteer physicians who wish to aid in the training and use of this equipment.

Helping lesser developed neighbors attain the means to improve the health of their populations necessarily takes many forms, and advanced diagnostic imaging is an important component in the diagnosis and treatment of disease. Radiologic equipment is very expensive to both own and maintain, especially for those countries with limited economic resources. The effective diffusion and adoption of radiologic technology represents a critical "weapon" of disease prevention and cure, and therefore, merits concerted international public health attention.

continued, p.7

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Yuen EJ. Shaping the face of grief: Understanding culture and diversity. NHPCO's Second National Conference on Access to Hospice and Palliative Care, Minneapolis, MN, August 18-20, 2008.

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Medical Travel: Global Impact and Local Response

Leonard Karp
President and
Chief Executive Officer
Philadelphia International
Medicine

The global dimension of healthcare is expanding and changing at an unprecedented rate. As emerging nations accelerate their economies, creating a middle class, swelling numbers of health care consumers are willing to travel to secure what they perceive to be high quality medical care. Conversely, growing numbers of uninsured patients in the developed world, facing the high cost of medical care at home, are traveling abroad to seek lower cost alternatives.

Both patterns are part of what is often referred to as medical tourism and medical travel. While *medical tourism* is generally defined as the practice of seeking elective care abroad, often in hospitals advertising an area's tourism attractions as much as their medical competencies, *medical travel* pertains more to the acquisition of highly skilled clinical care as the reason for the travel.

Medical tourists often seek lower cost alternatives than those available at home, and referrals center on executive physicals, elective reconstructive surgery, and some orthopedic procedures. Medical travelers are more typically seeking life-saving treatment not available in their home country, and are less concerned with price than with outcomes.

The competition to attract these traveling patients is growing more intense. India, Korea, Singapore and Thailand have national programs to advertise and support their medical tourism industry. Korea is in the midst of a government-sponsored advertising effort to lure medical tourists seeking plastic surgery. According to the Korean Ministry for Health, Welfare and Family Affairs, the Korean medical institutions made $61.6 million from overseas patients in 2007, a nine percent growth from the previous year.[1] Thailand's Bumrungrad Hospital reports treating more than 1,000 international patients per day.[2] India's Apollo hospitals are advancing throughout South Asia, attracting patients from the Middle East, Europe and even the United States. Hospitals in Britain, Germany and Eastern Europe are also competing for the medical tourism dollar.

Inbound travel to the United States for medical care is valued at more than $1 billion a year by the United States Department of Commerce. Medical travel was significantly curtailed by the events of Sept. 11, 2001, but is now exceeding the pre-9/11 volumes. Significant American medical destinations are the Mayo Clinic, Cleveland Clinic, Johns Hopkins, the hospitals of the Texas Medical Center, Partner's International hospitals in Boston, and other centers in New York City, Los Angeles, Miami, Seattle and Philadelphia.

The reliability of data regarding cross-border patient care is suspect. For instance, while Bumrungrad Hospital claims 400,000 international patients annually, a report in *The McKinsey Quarterly* estimates the current global market to be between 60,000 to 85,000 inpatient medical travels a year. The McKinsey estimate is based on definitions that limit the medical traveler to one who specifically seeks medical care in a foreign country, not expatriates seeking care in their country of residence or tourists seeking emergency care abroad.

This market niche represents new opportunities and implications for American academic medical centers. The benefits to providers attracting international patients are big. In addition to filling beds and increasing revenues per bed, such patients may boost an institution's domestic prestige.[3]

There are pitfalls – from visa policies to payment risk. International patients need additional attention – they are in a strange land, seeking care provided by professionals with different customs who speak a different language. Establishing the infrastructure to support international patients is expensive. The price can be as much as 10 to 20 percent of the cost of the care.

The models to gain access to the medical travel market are varied – and several have failed. The Miami Medical Alliance was created in the late 1990s by the Miami Chamber of Commerce and leading teaching hospitals in the region. Its primary purpose was to coordinate an executive physical program, and to conduct an advertising campaign in Latin America and the Caribbean. The program collapsed after 9/11. Despite this setback, programs in New York, Cleveland, Houston, Los Angeles, and elsewhere remain strong.

The Philadelphia region has developed its own model through the direction of Philadelphia International Medicine (PIM). A collaborative effort of the area's leading teaching hospitals, PIM's mission is kept simple – market for global medical travelers and provide the support concierge services international patients need. PIM carries out its mission by targeted marketing efforts, establishing physician exchanges, developing customized education and training programs and doing in-country visits to key international hospitals. Its patient base comes from throughout the world, but is concentrated in Middle Eastern countries such as Saudi Arabia, Kuwait, the United Arab Emirates and Qatar. India is a growing source of patient referrals, as is the Caribbean basin. Patients primarily come to the region to seek specialized oncology services, orthopedic care, treatment for various neurologic diseases and for all aspects of pediatric care.

By establishing a one-stop shop for international patients, PIM is able to reduce the infrastructure cost for any one institution. PIM began as a limited liability corporation in 1999.

Its owners – The Children's Hospital of Philadelphia, Fox Chase Cancer Center, Pennsylvania Hospital, Temple University Hospital, Thomas Jefferson University Hospital and the University of Pennsylvania Medical Center provide funding support and benefit through shared patient support services. The state and city provided some financial assistance in PIM's early years.

continued next page

PIM provides support for patients and their families through care managers who work closely with the patients from initial contact through discharge. The PIM care managers call patients in their home countries prior to arrival, making sure treating physicians have up-to-date medical reports in advance of the patient's arrival, while pre-certifying patients with their insurance company or other sponsor. PIM works closely with international insurers, embassies and the patients themselves to resolve reimbursement issues in advance of the patient leaving their home.

PIM is also viewed as a regional economic development initiative. Its patients stay at local hotels, often for six weeks for more. Their families utilize the Philadelphia region's restaurants, shop for gifts for family back home, and rely on local interpreters, medical equipment suppliers, and other services. Starting from a base of zero, PIM is now seeing growth in patient billings of more than 25 percent in 2008 over 2007. For the region, the result has been impressive with almost $150 million in new economic activity; about 3,800 international patient encounters annually over the last three years; and a health care consulting program that has seen the organization plan two academic medical centers in Korea over the last five years.

As it ends its first decade of service, PIM is weighing new ways to advance its mission. One goal is to diversify its geographic base. For example, PIM is increasingly active in Asia and recently signed its first payer contract with an Indian health insurance company. In the Spring, PIM completed a feasibility study to develop an international hospital on Jeju Island, South Korea, and it is now considering a project to build and manage the hospital. Another goal of PIM is to expand its service base. PIM is offering its services to additional hospitals that have an interest in medical travel but lack the infrastructure to manage an international patient population.

Should PIM be successful in achieving its goals, it will see a sustained 11 percent growth in international patient revenue; a joint effort to plan, build and operate a specialty hospital abroad; and a growing recognition from international health care organizations that the Philadelphia region is one of the leading international medical destinations of choice.

For more information about PIM, visit its website at www.philadelphiamedicine.com.

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Magnet® Designation – Is It Worth It?

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Since 1984, healthcare leaders have been watching the growth of the Magnet Recognition Program®. This program was developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that provide nursing excellence by:

- Promoting quality in a setting that supports professional practice;
- Identifying excellence in the delivery of nursing services to patients/residents; and
- Disseminating "best practices" in nursing services.[1]

Popular publications such as *Reader's Digest* and the *New York Times*[2] have advised readers to select a Magnet® hospital for excellence in nursing when they have the opportunity. One may wonder what this Magnet® designation is and how it really makes a difference.

Main Line Hospitals (Bryn Mawr, Lankenau, and Paoli Hospitals), began their "journey" toward Magnet® designation in 2002. In order to qualify, the three hospitals were required to make a serious assessment of organizational structure and nursing practice to identify where the fourteen "Forces of Magnetism" that comprise the evidence-based framework were apparent. These "Forces" relate to aspects of practice such as: nursing voice and image, ability to participate in decisions that affect practice, collegiality, professional development, quality improvement and research.[1]

When practice didn't align, efforts were made to change the process and/or structure. For example, with strong leadership, nurses designed and implemented a career ladder to reward practice excellence and provide opportunities for career growth for nurses at the bedside.

In addition, they developed a unit-based shared decision-making model with unit councils that provide staff an opportunity for input into policies and practices. Unit councils are generally comprised of nurses who represent all shifts within the unit level. Nurses also initiated a structure and process for nursing research and innovation with a variety of other improvements such as: enhanced use of evidence-based practice; strengthened interprofessional relationships; and introduction of a residency program for new graduate nurses. Nurses at all levels of the organization worked to embody the "Forces of Magnetism."

In September 2005, efforts were rewarded when Main Line Hospitals received the coveted American Nurses Credentialing Center's (ANCC) Magnet® designation for a four-year term. At that time, only 2% of all hospitals and approximately 10 hospital systems had achieved the designation. We realized that the bar had been raised and it was important to continue to move forward. To this day, the Main Line Health Magnet® journey lives on. Nurses know that receiving this designation carries with it a level of accountability, not only to their organization but to the nursing community globally.

At Main Line Hospitals, change continues and the Magnet Recognition Program® has set the stage as a model program for other disciplines to follow. Several non-nursing departments have embraced a shared decision-making model and have begun to establish unit councils similar to the nursing department. The therapeutic disciplines have adopted a career ladder system to encourage and reward growth in their areas of expertise. Nurses have examined a research question, discovered new information, changed practice and shared experiences and knowledge through international presentations and journal publications. The past 3 years has seen an increase in bachelor- and master-prepared nurses, and in the number of board certifications for nurses. After 46% of their staff achieved board certification, The Bryn Mawr Hospital pediatric unit was recognized by the national Pediatric Nursing Certification Board for their commitment to excellence.

In general, the entire organization focuses on empowering those who are closest to the patient to make recommendations and decisions. Nurses at Main Line Health (MLH) are presently in the process of a "second generation" redesign of their shared decision model which will create an opportunity for every nurse to have input into areas of practice such as their environment, clinical issues, professional development, quality improvement and research. This model will better link the unit councils within the organization to other existing committees, enhancing decision making between and among staff and leaders.

An example of one initiative at MLH that uses Magnet® forces is a collaborative educational program titled the "Terrific Trio." This program linked a physician, staff nurse and a content expert together to collaboratively investigate the latest evidence dealing with a current topic. The team facilitated focus groups to understand clinical practice issues such as reduction of hospital infections and post-operative pain management at MLH hospitals. Practitioners then used the findings and current evidence to present practice recommendations to a multidisciplinary audience. The first program dealt with reducing catheter-associated urinary tract infection (CAUTI). Since this program, each hospital established a multidisciplinary team to further study and reduce catheter days and related infections. Each hospital has implemented a CAUTI prevention "bundle" and one has seen a 65% reduction in catheter days and overall reduction in catheter-related urinary tract infections.

Based on extensive new research, the ANCC announced changes to their program aimed at building capacity for the future of nursing (and healthcare in general).[3] Their intention is to promote and disseminate the best possible health care outcomes. As the ANCC works to keep up with the changing healthcare environment, so must all who aspire to achieve this designation. As the Magnet® journey to excellence attracts more organizations, it is more likely to impact change and positive outcomes on a broader scale.

Main Line Health has found participation in the Magnet Recognition Program® to be very valuable in terms of patient care outcomes, nurse - physician collegiality, educational achievement, and overall nursing satisfaction. Currently, the Magnet® journey to excellence has expanded to Bryn Mawr Rehabilitation and Riddle Memorial Hospitals under the direction of Chief Nursing Officer, Nancy Valentine RN, PhD, MPH, FAAN, FNAP. These organizations will apply for their initial Magnet® designation while Lankenau, Bryn Mawr, and Paoli Hospital seek re-certification. Main Line Health is committed to this level of excellence and will continue to build on these achievements within its expanding system.

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Hospital-Community Collaborations to Address Diabetes

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Recent data indicate that 24 million Americans have diabetes, which is now the sixth leading cause of death in America (accounting for 200,000 deaths each year).[1] Even more alarming is that nearly one third of these individuals are unaware that they have diabetes. It is estimated that the annual cost of health care for a person with diabetes in 2007 was $11,744.[2]

It has been well established that minority populations are disproportionately affected by type 2 diabetes,[3,4,5] based on both clinical factors (insulin resistance, impaired glucose tolerance, gestational diabetes, obesity) and social factors (lack of physical activity, and poverty).[6,7] Much of the burden associated with diabetes could be prevented with diabetes education, and vigilance in monitoring eating patterns and physical activity.[8,9] The Diabetes Prevention Program (DPP) was a large randomized clinical trial to prevent the development of type 2 diabetes in persons at high risk. It provided the most definitive evidence to date of the benefits of modest weight loss and increased physical activity.[10] Overweight participants with impaired glucose tolerance who lost approximately 7% of their initial weight and exercised 150 minutes a week decreased their risk of developing type 2 diabetes by 58% compared to control participants, and by 31% compared with metformin-treated individuals.

In order to translate research into practice, it is important to find ways to engage communities in collaborative efforts aimed at preventing diabetes and reducing risk for diabetes-related complications. Albert Einstein Health Network (AEHN) has initiated exactly this type of program, The Einstein Community Diabetes Working Group, to collaborate with community organizations in the Philadelphia area. The multidisciplinary group is headed by Mary Beth Kingston, RN, MSN, Chief Nursing Officer for AEHN. Members of the working group are engaged in a number of projects that address diabetes in our communities. Below we highlight three projects underway:

• **Geographical Information Systems (GIS) mapping of diabetes-related data and resources.** This project, conducted by the Einstein Center for Urban Health Policy and Research, focuses on understanding the impact of diabetes on our home cluster area zip codes. De-identified hospital admission data with diabetes-related diagnoses are plotted out to create maps that allow us to compare density of patients with diabetes-related hospitalizations by zip code and to conduct further comparisons based on age and medical co-morbidities. The second phase of the project involves mapping of community resources, with a focus on physical activity and nutritional resources, religious and social centers, and other factors of the environment relevant to implementing diabetes-related intervention programs. Plans are underway to use the full mapping for a hospital-community forum on diabetes.

• **DiaBEATes Nurse Champions** is a joint Nursing/Gutman Diabetes Institute program designed as a proactive approach to deal with the large AEHN patient population with hyperglycemia. Gutman Diabetes Institute is headed by Nadine Uplinger, MS, RD, CDE, BC-ADM, LDN and Arthur Chernoff, MD, FACE. The Institute's primary focus is on educational efforts for inpatients, outpatients and Network staff members. This two-phased project provides intensive diabetes education to interested nurses that includes case studies representative of encounters that Certified Diabetes Educators have with inpatients on a daily basis. Nurses who receive this training then serve as a resource for their units and guide staff nurses in the daily glycemic management of their patients. It is expected that providing a diabetes resource nurse on each unit will result in better glycemic management of the patients with diabetes. We continue to explore opportunities where these nurses can utilize their diabetes knowledge in community settings to help individuals with diabetes manage their chronic disease and live better lives.

• **Church Collaborative** – In 2006, Einstein embarked on a partnership with Beloved St. John Church Evangelistic Church, a 2,800-member congregation in the Logan section of Philadelphia. The church embraces the idea of collaboration and understands the importance of good health, wellness and education. Over the past year, health initiatives conducted at Beloved by Einstein staff have included wellness, cholesterol, diabetes and blood pressure screenings. We are currently developing several diabetes-related interventions in collaboration with members of Beloved's Health Ministry team. Plans include programs dedicated to exercise, education, and healthy eating along with peer-to-peer support groups to increase awareness and change behaviors about diabetes and heart disease.

• Einstein is supporting a program to look at the effectiveness and outcomes for an on-going diabetes self-management support group vs. traditional diabetes self-management education. This collaboration between Gutman Diabetes Institute and St. Luke's Episcopal Church in Germantown began in September 2008. Following a series of diabetes self-management education classes, on-going support sessions will be held bi-weekly for a 10-month period. Anticipated outcomes are reductions in blood glucose levels (hemoglobin A1C), weight reduction as measured by lower body mass index (BMI), and improved emotional coping skills as measured by the Diabetes Distress Scale.

Einstein is continuing to build and explore potential relationships with other churches in the community in an effort to improve access to meaningful diabetes services. It is essential to offer diabetes education in the community where people gather, worship and solidify relationships. This also provides a unique forum for Einstein health professionals to see how their patients live and interact within their own community.

Ms. Uplinger serves on the National Board of Directors for the American Association of Diabetes Educators (AADE) and is the Secretary for the Greater Philadelphia Diabetes Coalition. She is also on the American Diabetes Volunteer Leadership Council. For information about diabetes activities at Einstein, contact Nadine Uplinger, Director, Gutman Diabetes Institute, UplingerN@einstein.edu.

continued, p.12

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The Importance of a Performance Improvement Team in Ambulatory Care

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Research indicates that academic faculty practice quality improvement initiatives are increasingly important to the success of a healthcare organization.[1] While such initiatives have long been at the core of inpatient care, the quality of care provided in the outpatient setting has, until recently, been defined and measured by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures.[2] In response to growing evidence of opportunities to improve the quality of care and stakeholder demand for provider accountability, the evaluation of outpatient healthcare quality is becoming more prevalent.[3,4] As payment methodology for healthcare services becomes increasingly linked to quality indicators, institutions will be distinguished from their competitors and financially rewarded based on the success of their quality improvement programs.

As an academic, multi-specialty faculty practice plan, Jefferson University Physicians (JUP) provides the highest level of patient care, trains future physicians, and undertakes numerous research activities. Recognizing the need to measure and improve the quality of outpatient care, JUP administration instituted the JUP Clinical Care Subcommittee (CCS) in the fall of 2003 to provide oversight of ambulatory care quality. A JUP Performance Improvement Team (consisting of 2 funded full-time employees and in-kind staff support from the Department of Health Policy) serves as an internal "consultant" to JUP practices to advance the quality of patient care. Supported by the vision and leadership of the CCS, the Performance Improvement Team has assisted JUP practices to successfully meet the challenges of improving quality in a changing healthcare system.

Initially, the Clinical Care Subcommittee focused on departmental projects. In 2007, attention shifted to national performance improvement initiatives, including pay for performance. The results of these initiatives have positioned JUP at the forefront of national efforts to advance patient safety and improve outcomes in the ambulatory care setting.

This article provides a glimpse of the recent accomplishments of the JUP Performance Improvement Team.

Continuous Quality Improvement Initiatives

A pilot study was recently completed to assess the American Board of Internal Medicine Performance Improvement Module, the aim of which is to help primary care practices identify opportunities for improvement in patient satisfaction, clinical care, and practice systems. Results of this study are pending publication.

The Team helps JUP administration to ensure that successful performance improvement initiatives expand across all practices. One example is a smoking cessation initiative that provides physicians with feedback regarding individual chart documentation of patient smoking history, as well as training in smoking cessation counseling. The program, developed in collaboration with the Jefferson Office of Continuing Medical Education, provides physicians the opportunity to earn Continuing Medical Education (CME) credit.

Patient Safety

JUP is one of the first academic practices in the United States to implement the Physician Practice Patient Safety Assessment (PPPSA) tool. The University HealthSystem Consortium has recognized these pioneering efforts, and invited the team to present their experience with the safety tool at the UHC 2008 Quality and Safety Fall Forum. The PPPSA tool, created as a group effort by the Health Research and Educational Trust, Institute for Safe Medication Practices, and the Medical Group Management Association, helps practices identify potential

continued, p.13

opportunities for improvement within the domains of medication safety, patient handoffs and transitions, personnel competency, and practice management and culture.[6] In collaboration with the Risk Management Department, the Performance Improvement Team will identify best practices across JUP provider practices and provide recommendations for patient safety and quality improvements.

Pay for Performance

On July 1, 2007, the Centers for Medicare and Medicaid Services (CMS) introduced the Physician Quality Reporting Initiative (PQRI). The PQRI program is a Medicare value-based purchasing initiative that targets individual healthcare providers.[7] The program currently rewards physicians with a financial incentive for reporting quality indicators, but CMS has indicated that PQRI is the first step toward a pay-for-performance program. Recognizing the potential impact of the program, 16 JUP practices now submit quality of care measures to CMS. The successful implementation of this initiative and the development of reports to track performance have earned the Team invitations to present at national forums, including the American Medical Association's Physician Consortium for Performance Improvement. Additionally, the Team's involvement in the PQRI Initiative has helped to forge a relationship with CMS. At the local level, the Performance Improvement Team works to ensure compliance with HEDIS quality indicators and other pay-for-performance measures.

Electronic Medical Record (EMR)

The JUP Performance Improvement Team has been actively participating in the implementation of the Allscripts EMR system. Team members have attended meetings on workflow changes and developed quality parameters to ensure alignment with national quality measures. In order to optimize the performance improvement capabilities of the EMR system, the entire JUP Performance Improvement Team has attended clinical and administrative training sessions.

The healthcare environment is changing, with an increasing demand for improvement of patient quality and safety. Payment programs rewarding provider performance are growing rapidly. Under the leadership of the JUP CCS, the Performance Improvement Team provides support for quality improvement activities, which has the potential to drive the national ambulatory quality improvement agenda. The patient safety and quality outcomes achieved through the efforts of the JUP CCS and the Performance Improvement Team will contribute further to the success of the JUP practices.

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Health Policy Forums

What Language Are You Speaking? Why Patient Communication is a Patient Safety Issue

Mario Moussa, PhD, MBA
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September 10, 2008

There is no argument that effective communication is critical to the success of any work environment. Communication within the health care environment can be particularly complex, challenging and, at times, even troubling. Negative patient experiences and outcomes can sometimes be attributed to poor communication and misperceptions among health care providers.

Mario Moussa, Principal, Center for Applied Research (CFAR) and co-author of the book, *The Art of Woo*, presented a framework for exploring communication styles. Dr. Moussa has worked closely with hospitals and providers and, through his research, he has captured the communication gaps and misunderstandings that affect the quality of care. For example, through interviews he was able to illustrate the mixed messages that occur directly between nurses, attending physicians, and residents. He also discovered a consistent lack of awareness and misperception that clinicians express about the training and expertise of their colleagues.

Moussa believes that people communicate on six different channels: authority; rationality; vision; relationship; interests/incentives; and politics. Moussa explains the importance identifying your own channel while tuning in to the channel of the other person with whom you are interacting. This is one way to overcome barriers, sell ideas, and facilitate change. Moussa also emphasized the significance of relationship building and developing a deeper understanding of the cultural context of an organization or interaction.

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http://www.cfar.com/html/index.html

continued, p.14

Assessing Physician Performance: Challenges and Opportunities

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October 8, 2008

As the nation's health care landscape is changing towards an increased focus on value and accountability, quality measures are no longer used solely to measure health plan performance. Quality measures are also used to evaluate the quality of care at the individual provider level and the provider group level (i.e. group practice of physicians). Various aspects of patient care processes and outcomes are evaluated based on a multitude of standardized performance measures used by stakeholders. In his presentation, Louis H. Diamond, MD, VP and Medical Director of Thompson Reuters, reviewed the current state and national trends in performance measurement and improvement. Dr. Diamond outlined the many challenges and opportunities encountered in assessing physician performance, and offered his vision and recommendations for the future.

Recent trends in assessment of physician performance include the development of programs that utilize various "types" or domains of measures, such as structure, process, outcome, appropriateness, and patient experience. Derived from clinical care guidelines, these measures have been developed by various stakeholders. Frequent measure developers include The American Medical Association Physician Consortium for Performance Improvement (AMA PCPI), The Centers for Medicare and Medicaid Services (CMS), and The National Council for Quality Assurance (NCQA). Once endorsed by The National Quality Forum (NQF), these measures may be included in pay for performance, Maintenance of Certification, and performance-based programs for re-licensure.

Utilizing quality measures for assessment of provider performance naturally creates both challenges and controversies. Multiple questions and concerns remain regarding technical aspects of data collection, physician attribution and accountability, co-morbid conditions, changing scientific evidence, and impact of patient preference and behavior. Opportunities for improvement include enhancing information collected through quality measures with information from patient registries, electronic medical records, and laboratory data. Merging various health plan data with CMS data will provide physicians with information about the entire practice.

Dr. Diamond offered several recommendations in his vision for improvement of the current chaotic "measurement system." Nationally, the focus should be on determining priorities and creating a coordination of efforts to improve care and contain costs. From these coordinated efforts, a new accountability system for physicians and other healthcare providers could evolve. Dr. Diamond concluded his presentation by emphasizing the need for funding of health care research. Quality management and improvement depends on the integration of a robust cycle of evidence, measurement development, and evaluation into the provider workflow.

Women's Wellness Guide

Leslie Stiles
Executive Director
PA Commission for Women
November 5, 2008

Women often carry the responsibility of handling multiple roles and tasks, often putting aside their own health concerns as they prioritize the needs of their family members. It is not unusual for women to delay routine examinations, screenings, and subsequent treatment as they negotiate time and access to services. Leslie Stiles, Executive Director of the PA Commission for Women (PCW), would like to see this change.

Ms. Stiles, a long time advocate for disenfranchised women, discussed the mission and goals of the Pennsylvania Commission for Women (PCW). PCW emphasizes the identification and advancement of Pennsylvania women and girls; and the importance of providing opportunities to empower women and girls to reach their highest potential.[1] The Women's Wellness Guide is one initiative of many programs developed by PCW. It is aimed at reaching women, to educate and engage them, and encourage them to take control of their health.

The Women's Wellness Guide is actually an interactive self-service, touch-activated kiosk designed to offer women basic information on a range of topics such as: heart disease and stroke; cancer; osteoporosis; asthma; depression; diabetes; and weight management. Content is derived from the Centers for Disease Control and Prevention, National Institutes of Health, and the PA Department of Health and is reviewed by panel of medical experts. The content and literacy level is designed at the 5th grade reading level. Additionally, bilingual (English-Spanish) content is available and plans are underway to reach other limited English proficient (LEP) women with other commonly used languages in PA. The kiosk has an optional audio component.

One of the greatest advantages of the Women's Wellness Guide is that it can be placed in a variety of settings, providing access to otherwise hard-to-reach audiences. For example, a bilingual kiosk has been placed in the waiting room of the Allegheny County jail. Other venues will include WIC offices, public welfare agencies, and supermarket chains.

PWC is very interested in efficacy and outcomes. Collaborating with the vendor, St. Andrews Development Inc., Highmark will compile data to determine the impact of the guide. In its early stage of analysis it will be difficult to determine an effect on behavior change or health, but it may be possible to capture intentions to change. Ms. Stiles is very hopeful that the Women's Wellness Guide will become a model program, and one that is unprecedented in PA.

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A N N O U N C I N G A N E W B O O K !

Governance for Health Care Providers

THE CALL TO LEADERSHIP

David B. Nash • William J. Oetgen • Valerie P. Pracilio

Physicians, nurses, pharmacists and other health care providers are increasingly accepting positions at the board's table. While these professionals are well-versed in the clinical aspects of medicine, they are often unfamiliar with the business side of health care. Understanding the principles of governance and the board's role in decision-making are crucial to the success of the organization. Those who accept a dual role as a health care provider and board member must learn about their role as decision-makers and stewards. **They must answer the call to leadership**.

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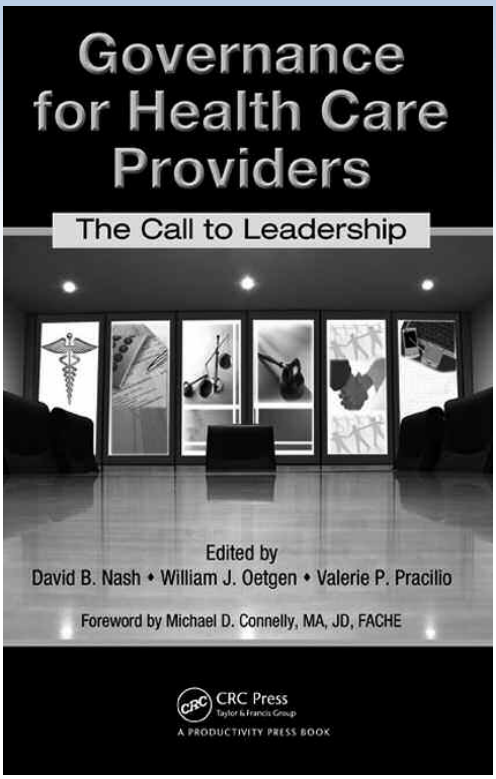

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