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FROM THE EDITOR

Losing My Dad

I always knew that one day the phone call would come. I just could not imagine processing the news and hanging up the phone. Like most physicians, I have delivered news of the death of a loved one and have been at the bedside when families were holding vigil. Many years ago, as a house officer, I participated in the prolonged care of persons whose case was hopeless from the start. None of this prepared me for the call about my dad's death this past winter.

My dad's passing, and my thoughts about his death, have given new meaning and motivation to my new role as Dean. I am more motivated today than ever to ensure that health care professionals are trained to work together to provide the most appropriate care and support to their patients.

There is a robust literature by physicians writing about the death of their parents and it seems to be especially focused on the death of the father.[1,2,3] I had been collecting some of these essays and even shared them with my dad over the years, hoping he would understand the role of a physician son and the difficult decisions that families face as elderly loved ones become frail, cognitively impaired, and severely ill.

My father was the middle son of three brothers, born just before the Great Depression to immigrant, non-English speaking parents on the Lower East Side of Manhattan. He went to kindergarten speaking only Yiddish and had to quickly learn the language. My grandmother, a widow most of her life, did not read or write English. Although he was raised in a single parent household on welfare, as an adult he was relentlessly upbeat.

Other aspects of my dad's childhood may sound familiar to children of first-generation Americans: the rapid road toward assimilation, with education as the escape valve from the ghetto. My father was a well educated man. He graduated from the Cooper Union in New York City and eventually attended the first class of the Sloan School of Management at the Massachusetts Institute of Technology. He became an entrepreneur, creating a successful business from scratch that eventually went public. His business acumen was all "relationship based," flowing from his uncanny ability to make friends.

My father never lost his temper and always encouraged my brother and me in our various pursuits, especially those related to school. He instilled in us a sense of pride in our accomplishments, patriotism for our country, and a belief that the future held limitless possibilities. His most cherished role was that of grandparent. Nothing brought him more pleasure than extended family vacations and other life events like bat mitzvahs, weddings, and the like. He truly reveled in the company of his five grandchildren and, despite protestations from my mother, tried hard to spoil all of them mercilessly.

Before his death, I encouraged Dad to undertake a project to write his memoirs and contracted with Mary O'Brien Tyrell, a writer in Minneapolis, to

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help him with the task. Ms. Tyrell visited with him, listened carefully to the story of his life, and helped him to document it for posterity.

I had some trepidation in creating this contractual relationship between my dad and Ms. Tyrell. Stories abound whereby elderly men, in particular, focus so much on their war-time service and business escapades and conveniently nearly forget about their wives and children! The project took nearly two years of work, but I was grateful that my father eventually saw it through. Ironically, the package containing the forty hardcover copies of his memoirs arrived on the evening of the day he died. It became a prized – and instant – family heirloom.

How does all of this relate to my motivation for our new school? Here's the medical side of the story. Two weeks prior to his death, my dad suffered a small cerebral hemorrhage and was hospitalized in a local community hospital near his home in southeast Florida. I had an opportunity to visit him in the hospital, where he recovered quickly. Although he suffered no long-term motor problems, he clearly was left with some cognitive deficits.

During his stay in the hospital, my physician brother and I attempted to communicate with the multiple consultants who were caring for our father. As the number of consultants increased, the communication became more fractionated. Our non-system is so fragmented and poorly designed that I can only imagine the frustration encountered by family members without a clinical background during the hospitalization of a loved one. My dad suffered a hospital-acquired infection that derailed his overall care plan until he was finally discharged after a nearly two-week stay in the hospital. His discharge coincided with our family December holiday vacation to Florida, so he had the opportunity to visit with all of his grandchildren. The very next day, I got the dreaded phone call that he had died in bed at home.

As a son and physician, I am grateful for some of the blessings of the brief time period between his illness and his death.

First and foremost, my dad had an opportunity to see all of his grandchildren while he was still able to carry on a conversation and to sit at the table for a family meal. He avoided a re-hospitalization, whereby my brother and I would have undoubtedly had to make difficult decisions regarding ceasing intubation, life support and related medical intervention, something he never would have wanted to endure.

The arrival of his memoirs, within hours of his death, was just like my dad – waiting till the last minute to complete a project. Regrettably, he never got to actually hold the book in his hands.

I am also grateful that we avoided what many families increasingly face – that is, according to Winakur[2], the American narrative "of aging, disability and dementia that is played out in your family, in your home, when the numbers, the data, the statistics become your loved ones, your spouse, your parents and then yourself, you will finally understand how wrong-headed so much of current public healthcare policy is today."

Delivering the eulogy at his funeral, I noted that my brother and I and our wives – all physicians – were grateful that my father did not endure a prolonged hospitalization with all sorts of unnecessary testing, consultation, and the like. I could see many of the white-haired heads all nodding in vigorous agreement as I expounded upon our gratitude that a final bedside vigil never became necessary. My heart ached for all of the families whom I know have had to endure just such a vigil, and I felt a wave of relief knowing what could have been.

So there you have it. I'm grateful, saddened, and feel a big hole in my heart. Paradoxically, I am also energized, motivated and excited about my work and our new school. More than ever before, I am committed to helping to fix this mess so that other families will get a sense of patient-centeredness, better coordination of care, and better communication from their doctors and other caregivers. As Bobrow[3] has noted, "parents must die before their children and so my father passed in accordance with his wishes without ever having used a cane or a walker or ever having to rely on anyone other than close friends or family."

While my dad's death was unexpected, his passing was quick enough to burden no one. After sixty years of marriage my mom is lonely, but she is grateful for his lack of suffering. The enduring lessons of my dad's life remain as an important guidepost for me. His advice was always sought as the highest level of family counsel. His intellect and his understanding of relationships allowed him to grasp the key facts and mollify stakeholders in any situation. Clearly, I will need to call upon these skills too, as we move forward with some of the possible solutions to fix our broken system. ■

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As always, I am very interested in your views. You can reach me by email at david.nash@jefferson.edu.

Stimulus Money and Health Care Research and Investment

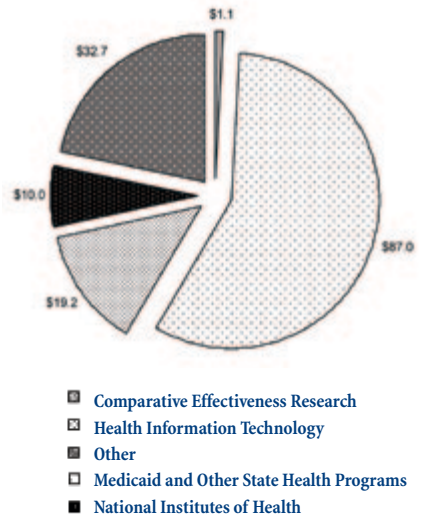
On February 17, 2009 the American Recovery and Reinvestment Act (ARRA) – or, as commonly referred to in the media, the Stimulus Bill – was signed into law. The legislation allocates $787 billion for federal stimulus spending in an attempt to curb the current economic recession. Of the total, $150 billion has been allocated to health care (Figure 1). Health care represents the largest proportion of dedicated funds as well as the largest sector of the economy.[1] Thus, recovery and well-being of the economy is inexorably tied to the condition of the healthcare industry. The $150 billion allotment is viewed as the jumping-off point for the Obama administration's healthcare agenda, which seeks to increase access to services while controlling cost. Because this will have both immediate and long-term effects for everyone in the nation, it is imperative for all to understand the broad health policy implications.

Over half (58%) of the health care stimulus funds – $87 billion– will be devoted to states in the form of matching federal assistance for Medicaid.[2] The remainder of the health care stimulus dollars are pegged for three broad initiatives: comparative effectiveness research, health information technology, and increased funding ($10.4 billion) for the National Institutes of Health (NIH).[2,3] These three initiatives have the potential to profoundly affect healthcare policy and the future direction of the healthcare industry.

Specifically, the ARRA apportions $1.1 billion for comparative effectiveness research, one of the more controversial funding initiatives.[2] Because comparative effectiveness is in its nascent stage in the United States, many have presupposed its implications and have a deep-rooted misunderstanding of this form of science. In its simplest form, comparative effectiveness research can be boiled down to the comparison of alternative treatments for a medical condition to determine the best overall treatment strategy.[4]

In practice, it is not this simple; there are many methodological and policy challenges. Foremost, researchers must determine the appropriate outcome measure for which to compare distinct or contrasting interventions. Another important component of comparative effectiveness research is economic evaluations of interventions. However, interventions which improve health outcomes do not always save money and, in fact, can be significantly more expensive than the current standard of care. As such, policy makers are forced to determine at what costs they are willing to fund interventions which improve healthcare.

Figure 1: Allocation of Health Care Stimulus Funds ($150 Billion)



While there are clear methodological and political challenges to conducting comparative effectiveness research, it should not be discounted nor touted as the savior of health reform. Rather, when implemented as part of an overall evidence-based medicine agenda, comparative effectiveness research has the potential to curb rampant health care inflation and improve overall quality of care.

To oversee funding of comparative effectiveness research and to help alleviate the fear of the government using findings from this type of research to directly dictate medical coverage, the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER) was established on March 19, 2009. Comprised of a 15-member expert panel, the FCC-CER role is to submit reports to Congress on the comparative effectiveness research being conducted; it will not be able to mandate coverage or set healthcare policy.[1,4]

The health care appropriation will also direct $19.2 billion to healthcare technology and infrastructure investments with the ultimate goal of the implementation of an electronic health record for every person in the United States by 2014.[2] To achieve this goal, the funds will initially be used to provide incentives to doctors and hospitals to adopt the use of electronic health records.[1]

The money will also be used to train workers in the use of health information technology and improve the security of electronic health records.

Finally, the legislation allocates an additional $10.4 billion to NIH (approximately 1/3 of the current NIH budget), which must be spent in two years.[2,3] Of the total, $2.2 billion is dedicated to capital improvements of facilities, infrastructure and equipment to improve healthcare infrastructure and provide jobs as a way to stimulate the economy. The remaining $8.2 billion is intended for peer-reviewed research grants.[2]

This tidal wave of money devoted to health care marks the beginning of a new era in health policy, where costs are controlled and quality is demanded. Innovation is imperative, and novel ideas and approaches to solving the health care crisis are welcomed from all disciplines. In order to sustain lasting improvement, policy makers must remember to continue to invest in the nation's healthcare system after the stimulus funds expire. ■

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2009 Annual Quality/Risk Management Retreat: An Approach to Patient Safety

Peter J. Pronovost, MD, PhD, FCCM
Professor, Johns Hopkins University School of Medicine
Medical Director, Center for Innovation in Quality Patient Care

April 22, 2009

The Jefferson Health System (JHS) Quality Council and Mountain Laurel RRG Risk Management Committee hosted, *An Approach to Patient Safety*, a Quality/Risk Management Educational Retreat on April 22, 2009. The featured speaker for the event was Peter Pronovost, MD, PhD, FCCM, the Director of the Johns Hopkins University Center for Innovation in Quality Patient Care and author of more than 200 articles and chapters in the fields of patient safety, quality health care, and evidence-based medicine.

Dr. Pronovost's presentation was organized into two sections. The first half of the program was dedicated to the issues and problems in appropriately measuring patient safety. It is critical to understand how and what to measure in order to provide a clear and accurate picture of what is going on. He spoke about learning from mistakes, and described teamwork tools, including daily goals, morning briefings, shadowing, active listening, and culture check-ups. He also discussed difficulties in translating evidence into practice.

In the second half of the program Dr. Pronovost spoke about strategies that can be used to improve patient safety. He explored attitudes, culture, and methods that are required to make substantial progress in improving patient safety within healthcare organizations. He stressed the use of a conceptual model based on structure, process and outcome to provide a context and culture of safety. In particular, he spoke about how he approaches the "Science of Safety" by including both measurement issues and strategies to get interdisciplinary groups to work together to improve system performance.

Dr. Pronovost described some of the projects in which he is involved, including several that focus on improving care in Intensive Care Units (ICUs). For example, he described a patient safety scorecard that he and his colleagues have developed and used as a framework for safety improvement in the ICU (refer to Table 1).[1]

It was especially interesting to see how Pronovost's approach takes into account both the technical (evidence-based) aspects of patient safety, as well as the behavioral/cultural aspects of instituting change within work groups that are part of a larger organization. By using such an approach, one can examine changes from several perspectives, including the changes in structure, process, and outcomes that result from an effort to change safety within an ICU. ■

For resources, training modules, and toolkits related to this topic, visit: www.safercare.net.

Table 1: Patient Safety Scorecard

Domain	Definition
How often did we harm patients?	Measures of health care-acquired infections
How often do we use evidence-based medicine?	Percentage of patients who receive evidence-based interventions
How do we know we learned from our mistakes?	Percentage of months per year the ICU learns from mistakes
How well have we created a culture of safety?	Annual assessment of safety culture at the unit level

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Jefferson Students' Improving Knowledge of Issues in Health Policy

Annual expenditures on health care in the US exceed $2 trillion.[1] The organization and financing of the healthcare system have a major impact on the practice of medicine, patients' expectations, and outcomes. How well do Jefferson Medical College (JMC) students understand the US healthcare system at the beginning of their medical education? Has this changed over time? How does this compare to students in the Master of Public Health (MPH) program?

A recent national survey of medical students identified gaps in their knowledge of important issues facing the US healthcare system.[2] Using the audience response system, 13 selected multiple-choice items from the national survey were administered to first-year JMC students on the first day of a series of lectures introducing the organization and financing of the US healthcare system and to MPH students enrolled in PH 508: Health Policy – An International Perspective.

Table 1 offers a sample of the exam items, while Table 2 provides a summary of the results.

While this type of casual sample is certainly not conclusive, it appears that there is a trend of improving scores. JMC students performed better than their national peers in 2005, 2006, and 2007. JMC students in the fall of 2008 and Jefferson MPH students who responded to the same items in January 2009 scored substantially better than their peers from the earlier years.

How well did the students perform on specific items? In 2005-2007, almost 40% of JMC first year students incorrectly believed that the United States has a lower infant mortality rate than any other nation in the world. In the fall 2008 and January 2009 exam, 80% of both JMC and MPH students responded correctly. On the item asking about health care spending, by 2008, over 90% of students knew that the US spends more per capita on health care than any other country in the world.

When asked to estimate the approximate number of people in the US without health insurance, two-thirds of the MPH students knew that the correct response is between 40 and 50 million; less than 50% of the most recent class of JMC students responded correctly. In earlier years JMC students had even more significantly underestimating the number of people without health insurance. In all years, almost all of our students did demonstrate an understanding of some of the consequences of lack of health insurance such as not having a regular source of care, having avoidable hospitalizations for diseases such as asthma and diabetes mellitus, and delayed diagnosis of cancer.

Why have the scores improved over time? Perhaps all the attention paid to healthcare in the fall 2008 presidential campaign heightened our students' knowledge of some of the important issues facing the US healthcare system. Hopefully, proposed reforms to the US healthcare system will make the current exam items obsolete. ■

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Table 1: Student Knowledge Exam Items

True or False

1. The United States has a higher life expectancy than any other nation in the world.
2. The United States has a lower infant mortality rate than any other nation in the world.
3. Government-administered health insurance (e.g., Medicare) requires more money per person for administrative costs than private health insurance.
4. The United States is the only industrialized nation in the world not to guarantee access to health care for all of its citizens.
5. The United States spends more per person on health care annually than any other nation in the world.
6. People without health insurance are less likely to have a regular source of medical care.
7. People without health insurance are more likely to suffer from avoidable hospitalizations for diseases such as asthma and diabetes mellitus.
8. People without health insurance are more likely to suffer from delayed diagnoses for diseases like cancer.
9. Most individuals without health insurance are in families where no one works.
10. Raising the cost of co-payments or deductibles does not affect whether patients will go see their doctor.
11. The number of uninsured individuals in the United States increased over the last decade.
12. Where, approximately, did the United States rank, out of 191 countries, in a 2000 World Health Organization (WHO) report on "health systems performance?"
    a. Near first place
    b. Near 10th place
    c. Near 20th place
    d. Near 30th Place
    e. Near 40th place
13. How many uninsured people are there in the United States today?
    a. Fewer than 10 million
    b. 10 to 20 million
    c. 20 to 30 million
    d. 30 to 40 million
    e. 40 to 50 million
    f. Over 50 million

How did you score? Test your knowledge. See page 11 for the answers.

Table 2: % Correct Responses on Selected Items Concerning the US Healthcare System

Results from national survey published in *Academic Medicine*	Jefferson Medical College – 1st year students				Jefferson MPH students
	Fall 2005	Fall 2006	Fall 2007	Fall 2008	Jan 2009
68%	72%	72%	73%	79%	80%

Note: There were 21 student respondents from the MPH class. The JMC entering class size is 255. Not all students were in attendance and not all responded to every item.

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The University Clinical Skills and Simulation Center: A Jefferson Gem

Part II: Interview with Dale Berg, MD and Katherine Berg, MD Co-Directors of the University Clinical Skills and Simulation Center (UCSSC)

Now that the Clinical Skills Center has been in the Hamilton Building for well over a year, what type of an impact do you feel that this facility has had on the students and their experiences?

KB: The students are very excited; and it's also been nice for GME. It allows us to expand our pre-existing curriculum and evaluation tools, to develop in new areas and serve the needs of many others. The building provides a venue for educators of all disciplines and professions to get together and teach and develop. Members of different departments are crossing paths and working together in an exciting learning environment.

DB: One of the fundamental advantages of a simulation center is that it provides a great venue for getting faculty to markedly increase the time spent directly teaching students the skills they used to teach at the bedside.

KB: The Skills Center team works closely with faculty and provides educational consultation as ideas and programs are developed. For example, we work with the clerkship or program director to assess and discuss their needs; develop a set of teaching objectives; and create a plan for product development needed to teach the program. Most of the time, the faculty will run their individual program and we support and provide the mechanism to produce it.

DB: This building is a catalyst for creating a collegial, team approach to curriculum development and implementation. It allows for cross-pollination from various fields and professions. It is a place to learn that is safe for the learner, and for the simulated patient whether it be a mechanical simulator, a human (standardized patient) simulation or a hybrid of the two. Teaching core skills across professions creates a rich, dynamic learning environment. That's why we are so excited that Jefferson Center for InterProfessional Education (JCIPE) is the cornerstone of this movement, led by Christine Arenson, MD and Molly A. Rose, PhD, CRNP.

As faculty, you have the opportunity to observe students going through this unique educational process. What is that like?

KB: We teach all 4 years so we do get to see how students develop over time. First year students come in wide-eyed and nervous; by 4th year they are more relaxed. The amount of knowledge they acquire in those four years is breathtaking. They go from being a student to becoming a colleague, and get to a point where they are actually teaching one other. This is particularly true with Jefferson's unique Advanced Physical Diagnosis (APD) course, an elective that is immensely popular in the 4th year. Approximately 75 students devote one month to immersion in the clinical skills set of physical examination. The course consists of not only learning the skills, but interpreting them, applying them to clinical situations and then, translating the simulation and skills directly to bedside learning and teaching through faculty rounds with real patients.

DB: The APD course helps learners refine their skills so they can make clinical decisions in the absence of imaging or lab support. In those situations, a Jefferson-trained clinician will be able to call upon the skills set that requires only a history and physical at minimum to provide care to their patients and develop a reasonable diagnostic and therapeutic paradigm. Our view is that because a primary care provider encounters undifferentiated problems, he or she must master history and physical examination with great acumen.

Describe the feedback, assessment, and evaluation process. How is it standardized? Is there a variation depending on the program?

KB: We do both formative and summative assessment, at every level. Most of our summative assessment is done via standardized patients and checklists. At the end of the year all 3rd year students take an Objective Structured Clinical Exam (OSCE), which includes 11 stations of standardized patients. The exam consists of different scenarios where students must exhibit their communication skills, physical exam skills, counseling skills, and data recording/documentation skills. Students who don't pass must spend a month in a remedial course (directed by Dr. Joseph Majdan) to get their clinical skills up to our standards. The OSCE also provides a venue for the students to prepare themselves for the Competitive Exams (CX).

At the end of the 3rd year clerkship, in addition to the Standardized Patient (SP) assessment, we also conduct a hybrid of the SP and the mechanical simulation. The scenarios include an acute process that requires the student to put in an IV or NG tube, for example. Rather than doing the procedure on the SP, the student performs the procedure on the model. For instance, in OB/GYN, for an SP who is "in labor," the student would have to deliver a baby on Noelle™ (a simulation mannequin that delivers babies). The student would also have to communicate with the SP during the procedure. It's very difficult to both have the skills, the hand-eye coordination, and also communicate to a patient what you need them to do.

DB: Jefferson is really in the forefront with this innovative hybrid – or, as we like to call it, a *chimera* – model of simulation that combines plastic with a human example. For example, the cardiopulmonary patient simulator, Harvey® gives you *in vitro* sounds of a murmur along with a real patient who exhibits that same murmur.

KB: Although it has been shown that SPs are fairly good at assessing history taking, communication skills, and the physical exam, we are also studying the effectiveness of having the SP grade the students on their technique of a procedure.

Would the SPs need more training in order to achieve that?

KB: Yes. We record all the sessions. We also have another standardized patient simultaneously evaluating the SP's performance. In other words, there is somebody behind the mirror

or behind the curtain, and we have somebody who is watching the scenario on tape in real time. They both complete the same checklist. We compare responses to determine how closely they coordinate. Observation in real time is preferred over the SP who is with the student and completes the checklist after the student leaves the room.

DB: Using checklists, faculty leaders supervise and set exacting standards for training these SPs. There are specific steps and nuances in physical examination and history taking that we expect our second year students to be able to perform. After their training at the Center, the SPs know these steps and become an extraordinary resource for teaching. We like to think of them as teacher extenders in that they assist the faculty in teaching the skills set in a humanistic yet controlled way.

Are the scenarios used constantly evolving?

DB: The Center allows us to effectively democratize the process of developing simulation support and curriculum for various programs across the University and in the region. Faculty with ideas for projects, programs, and research come in from any department, source or site on campus and we work with them to implement a program based on their ideas. We will sit down together to create a template, come up with ideas and then write a screenplay; or, if they want to write a script, we help to edit it so that we can produce it. With the assistance and expertise of Rob Hargraves, managing producer of Jeff Players, and a cinematographer from the Jefferson Medical Media Department, we write a screenplay, cast actors, set up a credible stage, rehearse, and then produce and edit. A prime example is the series on teaching conflict resolution in the ER, which we developed in collaboration with Alan Forstater, MD, of Emergency Medicine. Of the 11 different scenarios shared by Dr. Forstater, we have 5 available as professional quality video clips for teaching and role modeling purposes. Using our Jeff Players acting and production group, we have created a library of over 45 competency-based professional quality teaching video trigger clips.

How do we know if the use of simulation and SPs make a difference in outcome?

KB: That is the big question nationwide and many studies are being proposed. Most of the research done has been qualitative: "yes, I feel better; yes, I feel more prepared; yes, I think this is a good curriculum." While the jury is still out, I think that it does make a difference, especially in terms of confidence.

DB: The policy of the University Simulation and Clinical Skills Center (UCSSC) is that educational research should be conducted on new programs with an eye toward publishing the results. This will thus increase the credibility of our teaching and of our Center. We are currently working with Ed Jasper, MD, Clinical Assistant Professor and Director of Emergency Medical Services, to develop a scientific assembly for the fall of this year.

KB: We try to perform qualitative and quantitative research. We have had many abstracts and presentations accepted to national, international and regional meetings over the past year. More research projects are planned for the future.

DB: We are lucky to have resources like the Center for Research in Medical Education (CRIME) and, in particular, J. Jon Veloski, MS, who is the Director of Medical Education Research at the Center and a distinguished researcher in this field. Together, we work with faculty at our UCSSC research meeting to develop research protocols, and foster collaborative writing and scientific thinking of methods for teaching and uses of specific clinical skills sets.

What else would you like our readers to know?

KB: I would modify the old model of *see one, do one, teach one* – it's *see one, practice one and simulation, do one, teach one*. We are not trying to supplant the whole idea of patient-centered medical education, we are just trying to add that little practice step.

DB: This is the 21st century iteration of providing training and practice to a new generation of health care providers. Simulation allows a teacher to develop metaphors in innovative ways and provides the opportunity to collaborate with others on campus with a zest for teaching and learning. This is a place where educational research is going to take off. Jefferson is in the forefront of this new paradigm for teaching. ■

Interview Part I appeared in the March 2009 issue and is available at: http://jdc.jefferson.edu/hpn.
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The Mayo Clinic Health Policy Center

National Symposium on Medical and Health Education Reform

April 26, 2009

The Mayo Clinic convened a National Symposium on Medical and Health Education Reform in Rochester, Minnesota. Health care professionals and educators from a variety of disciplines were in attendance, with the goal of developing a list of recommendations to support the reform agenda.

Dr. Denis Cortese, president and CEO of the Mayo Clinic, opened the symposium by presenting the 4 cornerstones of health reform: 1) create value, 2) coordinate care, 3) reform the payment system, and 4) provide health insurance for all. Meaningful education for health professionals is an important factor in achieving these goals and in improving the overall quality and safety of health care. This includes interdisciplinary education focused on teamwork and care coordination.

Key takeaway messages from the symposium include the need for: a shared vision; development of competencies that lead to progress toward goals; assessments that adequately measure performance; educational opportunities in training and in practice to support and reinforce an integrated delivery system; and a common language and communication tools across disciplines. ■

Master of Science in Healthcare Quality and Safety (MS-HQS)

One of our new degree programs is a Master of Science in Healthcare Quality and Safety. Students who complete this degree will be able to apply advanced management and leadership skills to develop approaches that address problems related to the measurement and improvement of healthcare quality and patient safety.

Graduates will be able to apply the quantitative and qualitative analytic skills they acquire in a variety of settings, including inpatient facilities, outpatient and office care, nursing home and home health programs, psychiatric and drug treatment programs, and agencies providing end-of-life care. Our students will also find work with health insurance organizations, governmental agencies at the state and federal level, research and consulting firms, and advocacy organizations.

We are eagerly preparing for our first cohort of students, who will begin classes in September. Classes will be offered across three 14-week sessions each year, with breaks between each session. Our classes will be held in the evenings, since we expect that many of our students will be working full-time and attending school part-time.

We have hosted three open house events for prospective students to learn more about our program, and also sponsored advertisements on public radio, in newspapers, and on transportation systems in Southeastern Pennsylvania. Also, our brochures were widely distributed at local events and lectures related to health care quality and safety.

Applications are being taken online for the fall 2009 and spring 2010 semesters. The admissions process includes a personal statement, official transcripts from colleges and universities attended, GRE scores, and two letters of recommendation. There is a $25 fee, and standard application forms to complete. There is no deadline; applications are being reviewed on a rolling basis in batches in order to provide rapid turnaround. Eligible candidates will be called in for a personal interview. ■

Susan DesHarnais, PhD, MPH
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Complete information on the program and the application process is available online at http://www.jefferson.edu/population_health/quality_safety/, or you may call (215) 503-5305.

The Impact of Education on Health Care Quality

The 18th Annual Dr. Raymond C. Grandon Lecture

Thomas J. Nasca, MD, MACP

May 7, 2009

To kick off his keynote presentation at the 18th Annual Dr. Raymond C. Grandon Lecture, Thomas J. Nasca, MD, MACP, the former Dean of Jefferson Medical College, had an important reminder for the physicians in the audience: the work they do produces a social good. That social good, Dr. Nasca continued, is the equitable distribution of the "good" of health care and the restoration of health – wherever possible to members of society.

Dr. Nasca's lecture, "The Impact of Education on Healthcare Quality," touched on the challenges facing medical education in the United States and the importance of understanding the fundamental roots of the medical profession.

Dr. Nasca is currently the Chief Executive Officer of the Accreditation Council for Graduate Medical Education (ACGME), a private, non-profit council that evaluates and accredits medical residency programs throughout the United States. A board-certified internist and nephrologist, Dr. Nasca received his undergraduate degree from the University of Notre Dame in 1971, and his medical degree from Jefferson Medical College in 1975. In 1992, he joined Jefferson Medical College and Thomas Jefferson University Hospital as Vice Chairman of the Department of Medicine, where he directed the undergraduate and graduate medical education programs of the department.

Having established that healthcare is one of the goods of society, Dr. Nasca posited that social justice is what compels physicians to administer its distribution. Taking it one step further, Dr. Nasca cited the Hippocratic Oath. "It comes down to nine words," Dr. Nasca said, "*these things I do solemnly swear, upon my honor* – the last nine words of the Hippocratic Oath compels us to do this."

In order to improve quality and safety outcomes, Dr. Nasca suggested physicians look to Tiger Woods as a role model. Woods, the number one golfer in the world, is known for grueling practice sessions where he'll hit the same difficult shot – a buried lie behind a tree, for example – 100 times before moving on to another, which he will also hit 100 times. Physicians, Dr. Nasca said, don't practice challenging situations intentionally; they practice circumstantially. Medical students are encouraged to study, Dr. Nasca noted, but there is more to medicine than knowledge.

While healthcare professionals must always strive for improvement, Dr. Nasca concluded, it is important to remember that the quality of healthcare provided in academic medical centers is "statistically, significantly better in every metanalysis" than what is provided in non-teaching hospitals. "We should be proud of what we do because we do it well," Dr. Nasca said. "That's what we're committed to. We're committed to continuing excellence." ■

To listen to an audio recording of this lecture visit: http://jdc.jefferson.edu/hplectures/6/.

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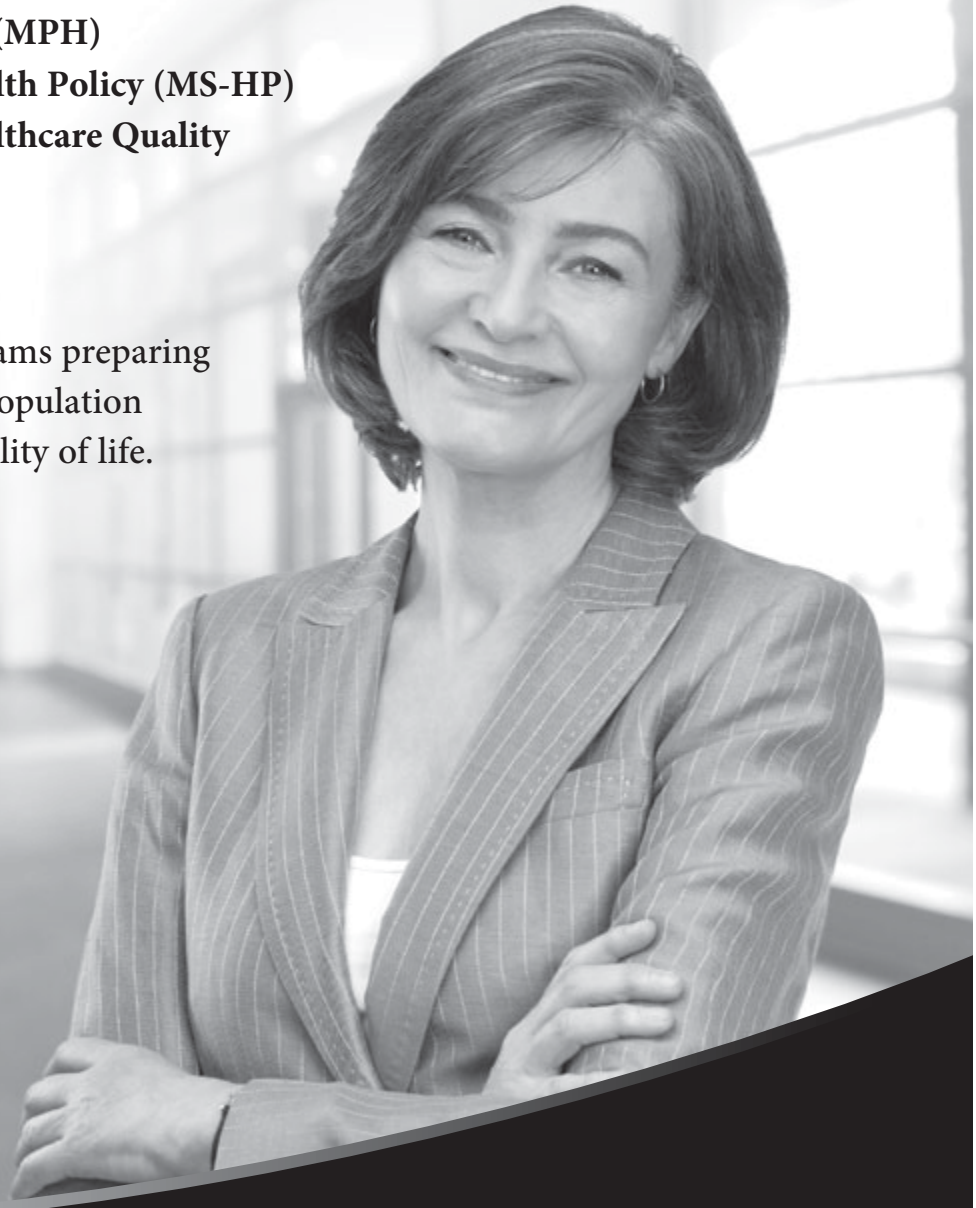

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THOMAS JEFFERSON UNIVERSITY

The Patient Navigator Outreach and Chronic Disease Prevention Act of 2005: A bipartisan approach to improving access to care and addressing health disparities

Too frequently, patients with the greatest health care needs have the least ability to comprehend, access, and navigate the U.S. health care system. A variety of factors, including: low educational levels (and resultant issues regarding literacy in general and health literacy in particular); limited English proficiency (LEP); poverty; and a lack of knowledge on the part of the practitioner towards patients' cultural beliefs and practices, can exacerbate this chasm between the healthcare consumer and the provider. It can be difficult and time-consuming for providers to help some patients to understand how best to participate in their own care. *Patient navigators* were created to provide appropriate support to this patient population in an effort to improve their health outcomes.

Patient navigators may be community health workers, lay health educators, peer health promoters, medical assistants or nurses who serve as liaison between patients and providers to promote health among groups that may lack access to adequate health care. The purpose of a Patient Navigator is to help reduce health care disparities; facilitate communication between patients and providers; assist patients in overcoming barriers to care; shape perceptions individuals may have about disease and specific health-related behaviors; provide outreach services and educational support; and offer culturally and linguistically competent assistance.

In 1989 Dr. Harold Freeman, a surgical oncologist at Harlem Hospital, became concerned over the large numbers of women from the local community presenting with late-stage breast cancer, despite the availability of routine screening for the disease. As the National President of the American Cancer Society, he conducted a series of hearings throughout the US to get feedback from community members about the impact of cancer on their lives. After hearing common accounts of significant barriers to care, he determined that the obstacles for cancer prevention, early detection, treatment and support were surmountable. In 1990, Dr. Freeman created the first "patient navigation" program at Harlem Hospital Center in New York City, funded by a grant from the American Cancer Society[1].

In 2005, policymakers came together to support the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (Public Law 109-18). With unanimous support in Congress, and under the leadership of Senator Robert Menendez (D-NJ), the Act amended the Public Health Service Act and became Public Law, authorizing the Secretary of Health and Human Services to make grants through 2010 for the development of patient navigator programs. A total of $25 million was awarded over five years for patient navigator programs through the Community Health Centers at Health Resources and Services Administration (HRSA), the Office of Rural Health Policy, the National Cancer Institute (NCI), and the Indian Health Service.[2] The overall purpose of the funding is to determine if patient navigators help reduce barriers to access to care and improve health care outcomes in underserved patient populations.

Research has shown that patient navigator interventions produce greater rates of screening and follow-up on diagnosis, resulting in better health outcomes. For example, in a study on colorectal cancer screening within a large urban hospital, two patient navigators were hired for a study period. Broken appointment rates went from 67% to 5% in one month, with the likelihood of keeping the appointment for the colonoscopy increasing by nearly three times[3]. Another colorectal cancer screening study within a minority community health setting compared two groups of patients with similar demographic characteristics who were recommended colonoscopy services by their physicians. The patients from the navigator-assisted group had a 15.8% compliance rate, compared with only 5% in the non-navigator-assisted group. The navigator-assisted group also achieved higher rates of fecal occult blood test completion than the non-navigator-assisted group (42.1% vs. 25%).[4] Ronald Myers, PhD, DSW, Professor in the Department of Medical Oncology at Jefferson Medical College, is currently leading a patient navigation project funded by the NCI Center for Reducing Cancer Health Disparities. Dr. Myers' study, *Increasing Colon Cancer Screening in Primary Care Among African Americans*, seeks to determine the impact of preference-based message tailoring navigation on colorectal cancer screening in primary care at a population level. Einstein is a participating site for the study, with investigators from the Center for Urban Health Policy and Research serving as part of the research team.

In the studies mentioned, Patient Navigator Programs helped reduce health care disparities by facilitating communication between patients and providers; assisting patients in overcoming barriers to care; providing outreach services and educational support; and offering culturally and linguistically competent assistance. Patient navigator programs that yield sustained long-term clinical benefits and improve health outcomes and compliance are likely to also provide economic benefits to our health system. By funding programs that target underserved patient populations, the Patient Navigator Act of 2005 has the potential to contribute to improved access and efficiency of care and engage patients into taking a more active and informed role in their own health care. ■

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* This work was completed while Ms. Urrea was an intern at the Center.

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Follow-On Biologics, Patient Safety and Policy, Focus of JSPH Program in DC

National Press Club

April 21, 2009

On April 21st, JSPH sponsored an event at the National Press Club in Washington, DC entitled: *"Regulation of Follow-on Biologics: Ensuring Quality and Patient Safety."* Supported by an unrestricted educational grant from sanofi-aventis, the event brought together a wide range of experts in the medical field including doctors, scientists, economists and others who discussed the quality and safety issues surrounding the creation of a regulatory pathway to bring follow-on biologic drugs to market in the United States.

Featured speakers included: Michael McCaughan, Editor in Chief of the Pink Sheet; Ann Witt, JD, Health Counsel to Rep. Henry A. Waxman; Brian Harvey, MD, PhD, VP, Regulatory Policy, sanofi-aventis; Terry Hisey, Vice Chairman, U.S. Life Sciences Leader, Deloitte LLP; and Geno Merli, MD, FACP, FHM, Chief Medical Officer, Thomas Jefferson University Hospital and Director, Jefferson Center for Vascular Diseases at Jefferson Medical College.

Research and development costs for biologics are very high and, as a result, therapy with these agents for patients with chronic diseases is very expensive. Because these products are derived by modifying living organisms, the end product is especially sensitive to damage or contamination, and small differences in the manufacturing process may have unforeseen and unintended effects on therapeutic action.

There is a movement to spur the development of "follow-on" biologics (FOBs) similar to the original products in an effort to improve access and lower overall costs to the health care system. Congress is intent on passing legislation enabling the Food and Drug Administration (FDA) to develop a regulatory pathway for FOBs similar to the pathway for generic forms of traditional drugs. Well crafted legislation for FOBs will afford an opportunity to reduce drug costs and make better quality healthcare more affordable for millions of American families.

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Currently, there are competing bills under consideration in the House; one authored by Rep. Henry A. Waxman (D-Calif.), Chairman of the House Energy and Commerce Committee, and the other drafted by Rep. Anna Eshoo (D-Calif.). In the Senate, Charles Schumer (D-NY) has introduced a companion to the Waxman proposal.

At the conference, there was broad support for greater accessibility of FOBs. However, significant concerns were expressed for patient-safety, "interchangeability" problems and product testing issues that must be thoroughly addressed.

Some key themes on patient safety which emerged from the event are as follows:

1. Patient safety must be the number one priority, including adequate safety testing prior to the approval of any FOB.

2. The US should adopt some of the more successful and proven provisions of European regulation, such as its clarity around the circumstances and extent of testing required of FOBs.

3. An FOB approval pathway must be comprehensive and recognize the complex nature of all biologic medications, including proteins and polysaccharides.

4. Biologic efficacy is not the same as biologic effectiveness. FOBs must be evaluated for patient outcomes.

The outcome of this debate is likely to have far-reaching implications with regard to access, cost, safety, and therapeutic impact for thousands of patients with serious, life-threatening, and chronic diseases. ■

The conference webcast has been archived and can be accessed online at: www.visualwebcaster.com/FOB-Policy-Forum.

Student Knowledge Exam: Correct Responses

(1) False (2) False (3) False (4) True (5) True (6) True (7) True (8) True (9) False (10) False (11) True

(12) *e. Near 40th place* (13) *e. 40 to 50 million*

Health Policy Forums

The Public-Private Balance in Healthcare: Political and Economic Tipping Points

C. Alan Lyles, ScD, MPH
Henry A. Rosenberg Professor of Public, Private, and Nonprofit Partnerships
University of Baltimore

March 11, 2009

The United States Constitution's separation of authorities between our national and state governments, coupled with an historically significant role for the private versus the public sector, produces a tale of too many moving parts. Health is a state responsibility and federal involvement is, with some exceptions, a consequence of programs that rely on federal funding. The complexity of this relationship was presented by Alan Lyles, ScD, MPH, a Visiting Professor in the Jefferson School of Population Health and the Henry A. Rosenberg Professor of Public, Private and Nonprofit Partnerships at the University of Baltimore.

Dr. Lyles described the pastiche of market-based health insurance, accrediting authorities and care provision that precludes a unified – or even coherent – national health policy. Instead, maintaining a balance is more like pushing string – it is achieved through contractual, financing and regulatory procedures rather than direct authority. This arrangement can lead to innovation in health care services, but it can also pose competing pressures on participants. The marketplace has a short-term horizon and is accountable to shareholders for specific financial results. By contrast, government policies reflect a longer horizon and are based on equity and efficiency goals. The accidents of political and economic history rather than planned rational design produced the unwieldy health care system that currently exists. Its costs, inefficiencies, even pathologies, have led to an emphasis on evidence-based decisions. Where the politics of health care reform seem to have a 1,000 points of 'no,' the cost of not changing appears unsustainable. This describes the perennial condition confronting health care reformers. In summary, the collapse of our economy, the disappearance of employment-based insurance and the urgency of American industry's regaining global competitiveness are tipping points that may propel significant change in the tottering balance between public and private sector roles. ■

The Impact of Serious Medication Errors for Health Care Providers

Zane Robinson Wolf, PhD, RN, FAAN
Dean and Professor
School of Nursing, LaSalle University

April 8, 2009

Medication errors have the potential to cause serious harm to patients. What is often not considered is the profound impact these errors can also have on the personal and professional psyche of health care providers. Zane Robinson Wolfe, PhD, RN, FAAN, Dean and Professor of La Salle University's School of Nursing, presented her extensive research on medication errors, including the historical and cultural context of responses to errors.

Dr. Wolfe first explained the framework and interplay of the landscape for errors and subsequent consequences. Health care is stressful work performed in high-consequence systems where there is a significant potential for error. The level of personal and professional responsibility for patient care, and the expectations surrounding these responsibilities, carries a certain weight and burden. Health care errors are in complete conflict with the goals of alleviating suffering and preventing illness. Additionally, the notion of a perfect nurse or doctor is a model that is reinforced through education and peer approval.

Traditionally, there has been a culture of blame and silence related to error. Some of the consequences of this culture are underreporting of error events and clinician self-blame. This culture has also served to hinder meaningful improvements in practices and systems.

Dr. Wolfe also described research related to the disclosure of errors. Patients not only want to be told about errors during their care, they want to know why and how the error occurred, and what will be done in the future to prevent similar errors. Patients and family members want a sincere, prompt, and compassionate apology. There is sometimes a disparity between patients and relatives and their desire for open, honest communication and what physicians actually do. Physician reluctance to fully disclose is often based on their own emotions, discomfort, and fears.

The emotional impact of an error on a provider is not something that is typically openly discussed. Dr. Wolfe explored the psychological dynamics that often take place, even long after an error has been made. There is often a barrage of emotions from doubt, self-blame, sleep loss, lack of job confidence, anxiety, embarrassment, guilt, and remorse. On a more practical level, providers may face real consequences, such as probation, suspension, termination, or criminal prosecution.

Dr. Wolfe discussed the process that takes place when an error has occurred and she emphasized the need for support, education, resources, and counseling. Ideally, organizational approaches such as Employee Assistance Programs (EAP) and team interventions help to diminish the long-term emotional impact and affect change. ■

Upcoming Health Policy Forums

Innovative Approaches to Medical Education

September 9, 2009

M. Brownell Anderson, M, Ed
Senior Director, Education Affairs
Association of American Medical Colleges

Philadelphia's Public Health Priorities and Initiatives: Implications for Improving the Health of Vulnerable Populations

Wednesday, October 14, 2009

Donald Schwarz, MD, MPH
Deputy Mayor, Health and Opportunity
Philadelphia Department of Public Health

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Building Patient Centered Medical Homes in America's Poorest City – Camden, NJ

November 11, 2009

Jeffrey Brenner, MD
Medical Director
Camden Coalition of Healthcare Providers

Achieving Cultural Competency: Using a Case-Based Approach for Teaching and Learning

December 9, 2009

Lisa Hark, PhD, RD
Project Manager, Online Medical Education
Wills Eye Institute

Horace M. DeLisser, MD
Associate Dean, Spirituality and Cultural Competency
University of Pennsylvania School of Medicine

Book Review

M Robinson, Novelli A, Pearson C, Norris L, eds. *Global Health and Global Aging* San Francisco, CA: Jossey-Bass; 2007.

Global demographic transformation in the 21st century will most likely be characterized by population aging. In 2006, 11 percent of the world's population was 65 years or older. This number is expected to reach 22 percent (nearly two billion people) by 2050. *Global Health and Global Aging* is a comprehensive report that offers diverse positions and perspectives from 41 international experts, and a thought-provoking foreword by Robert N. Butler, MD, a leading authority on aging and President and CEO of International Longevity Center - USA.

The book is organized into five major sections. Part One, *The World and Its Aging Population*, presents an overview of the topic, including a global synopsis of demographic trends and a discussion of international policies and institutional leadership challenges affecting the aging population.

Part Two, *Countries with High Rates of Longevity*, highlights the opportunities and successes of countries with record high rates of longevity. Chapter 8, by Pekka Puska, the director general of the National Public Health Institute of Finland (KTL), describes well-planned actions in Finland that had a positive effect on lifestyles and led to a decrease in chronic diseases, thereby resulting in increased health, functional capacity, and well-being in old age.

As is evident in Part Three, *Countries Facing Rapid Population Aging in the Next Twenty to Thirty Years*, issues of aging and global health facing different countries can take a dramatically different shape. While the average life expectancy in Europe is 75, it hovers around 50 years in the developing world largely due to poverty, malaria, TB, AIDS, and vaccine-preventable diseases. But as the fight against infectious diseases gains ground, older populations will grow in the developing

Continued on page 14

world as well, and chronic conditions will come to the forefront.

Developing countries will be presented with a unique set of challenges as their populations age mainly because, as Alex Kalache, chief of the World Health Organization's Aging and Life Course Program, states in Part Four, "industrialized countries became rich before they became old, while developing countries will become old before they become rich." Entitled *Leaders in Research and Innovative Programs*, Part Four highlights novel transportation, housing, financing, and education programs developed in government, business, and social sectors to create healthy environments and improve the healthcare and quality of life of the aging population. The experiences and research programs discussed can serve as examples for countries seeking sustainable solutions to the issues facing their aging population.

Part Five, *Epilogue: The Road Ahead*, looks to the future and discusses country-specific opportunities for the improvement of programs, attitudes, and policies developed for their aging population.

There are a few key themes that emerge throughout the book. First, each culture offers unique resources and insights to the new realities of its aging population. Most importantly, global health and aging is an international phenomenon and demands a new international perspective and collaboration. To promote better health, countries around the world need to draw from the collective experience and wisdom to strengthen their health systems with an appropriate emphasis on the needs of their own aging population.

Global Health and Global Aging is a wonderful resource for those seeking to better understand the circumstances, challenges, threats, and opportunities facing aging populations worldwide. Besides being a well organized volume, written by high-profile public policy experts, it might satisfy the reader to know that all the book's royalties will go directly to AARP, the non-profit advocacy and policy organization dedicated to the needs and interests of those 50 and older. ■

Reviewed by
Safiya Abouzaid, PharmD
Pharmacoeconomics and Outcomes Research Fellow
Jefferson School of Population Health

The Greater Philadelphia Schweitzer Fellowship Program: Celebration of Service Ceremony

May 20, 2009

Left to right: Nicole M. Cobb, Program Director; Christine Chung, Stephanie Staples, Ashley Darcy, Noel Ramirez, Elizabeth Daly, Cameron Bass, Megan Riley, and Program Chair, David B. Nash, MD, MBA (Dean, Jefferson School of Population Health). Not pictured: Yewah Jung, Erin Lewis, and Anita Yang.

For more information about the Greater Philadelphia Schweitzer Fellowship Program contact:
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School of Population Health Publications

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