Jefferson™ School of Population Health

Health Policy NEWSLETTER

SEPTEMBER 2009
Vol. 22, No. 3

GUEST EDITORIAL

Dare to Compare

Introduction

As part of the American Recovery and Reinvestment Act (ARRA), Congress mandated that the Institute of Medicine (IOM) establish a list of Comparative Effectiveness Research (CER) priorities by June 30, 2009. ARRA authorized a $1.1 billion down payment to support national CER efforts. Of the total funds, $400 million is to be released by the Secretary of Health and Human Services, and is likely to be targeted towards topics consistent with the IOM list. Another $400 million is to be released by the National Institutes of Health (NIH), and the remaining $300 million is to be dispersed by Agency for Healthcare Research and Quality (AHRQ). At the time of this writing, there were two Congressional proposals to sustain national CER efforts. In a recent interview about health reform, President Obama supported CER in saying "There's always going to be an asymmetry of information between patient and provider. Part of what I think government can do is to be an honest broker in assessing and evaluating treatment options."[1]

What is Comparative Effectiveness Research?

The IOM Committee defined CER as "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition, or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels."[2,3]

The report states six characteristics of CER:

1. CER has the objective of directly informing a specific clinical decision from the patient perspective or a health policy decision from the population perspective.

2. CER compares at least two alternative interventions, each with the potential to be "best practice."

3. CER describes results at the population and subgroup levels.

4. CER measures outcomes - both benefits and harms - that are important to patients.

5. CER employs methods and data sources appropriate for the decision of interest.

6. CER is conducted in settings that are similar to those in which the intervention will be used in practice.

The premise of CER is simple: we should invest in the medical treatments that are proven to be effective in defined patient populations in real-world practice settings. CER can be conducted using a variety of approaches, including randomized trials, prospective observational studies, database analyses, and systematic reviews - all methods of population health research. CER is conducted in settings that are similar to those in which the intervention will be used in practice.

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The IOM Committee created a list of 100 recommended priorities, through a structured review of potential topics identified through a national survey. The full list is available at: www.iom.edu/cerpriorities. Priorities in the top quartile include comparing the effectiveness of treatment strategies for: atrial fibrillation; hearing loss; dementia; prostate cancer; dental caries; ADHD and obesity in children; prevention of falls in older adults; chronic care management programs; biologics for inflammatory diseases; screening, prophylaxis and treatment programs for methicillin resistant staphylococcus aureus (MRSA) and healthcare acquired infection; and genetic and biomarker testing for certain cancers. A broad array of interventions was recommended to evaluate these priorities, including systems of care; pharmacological treatment; behavioral treatment; prevention; procedures; testing, monitoring, and evaluation; devices; standard of care; alternative treatment; provider-patient relationships; and treatment pathways.

CER provides clinicians and health plans with the ability to compare treatments to each other (or to usual care) rather than to placebo, and to understand the effectiveness of treatments in defined populations. Though manufacturers will continue placebo-controlled trials in order to meet FDA requirements, CER will provide real-world evidence on competing treatments via head to head trials, observational studies, and database analyses (for example, patient registries or claims datasets). CER will also elucidate the effectiveness of treatments in groups typically underrepresented in clinical trials, such as children, the elderly, and minority groups.

Role of Economic Analysis in CER

Applied health economic analysis is an important component of CER because it reveals which treatments yield maximal value. Applied health economics involves weighing effectiveness and costs of competing treatment interventions, typically via formal cost effectiveness analyses. First published nearly two decades ago, best practices for cost effectiveness analysis have stood the test of time - with a significant increase in published studies in recent years.[4] Opponents to including cost in CER fear that it may impede patients' access to expensive care; however, cost effectiveness analysis often recommends the use of more expensive treatments if they produce better outcomes. Thus, cost effectiveness does not necessarily translate to cost savings, but may instead mean better results for the dollars spent. This type of analysis becomes increasingly important when competing treatments are equally effective, or have marginal differences in effectiveness.[5]

Jefferson School of Population Health: Committed to Developing the CER Workforce

The IOM Committee report noted that the career pathways for CER are not clear, and there is a lack of federally funded graduate and post-graduate training programs aimed at grooming investigators in population health research. The committee predicted a "substantial need" for experts in the disciplines of CER, including outcomes research, observational data analysis, cost effectiveness, statistical modeling, and epidemiology.[2]

The Jefferson School of Population Health anticipates this growing national need for CER researchers. Through our existing two-year postdoctoral fellowships in applied health economics and outcomes research, JSPH has trained more than 30 professionals in the methods of CER during the past 15 years. This past year, we doubled the number of available fellowship slots from 2 to 4. Moving ahead, we are committed to further building the CER workforce with graduate-level degrees centered on CER methods, particularly a Master of Science degree in Applied Health Economics (presently in development). This degree will focus on the methods of cost effectiveness analysis, observational studies, health utility and quality of life outcomes research, and economic modeling. It will be the first in the US to emphasize important population health interventions such as screening programs, vaccinations, occupational and physical therapy, surgical techniques, dietary modification and exercise regimens. We believe that the CER workforce of the future will be called upon to evaluate this broad array of population health interventions in addition to the traditional evaluation of new drugs and devices.

As we move forward in shaping this degree, we welcome your views and opinions. With your input, we hope to build a strong and sustainable program which develops national leaders in CER. ■

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JSPH Hosts Open House Nov. 14, 2009

Attend the Jefferson School of Population Health Graduate Open House on **Saturday, November 14, 2009** to explore continuing your education in public health, health policy and healthcare quality and safety.

This is an exciting opportunity to meet directly with faculty and staff and learn more about these innovative programs.

The event will be held 11 am-2 pm in Jefferson Alumni Hall, 1020 Locust Street, Philadelphia.

Register today by calling 215-503-5305.

For further information on the Jefferson School of Population Health visit www.jefferson.edu/population_health/

Graduate programs featured at the open house:

Public Health
Master of Public Health (MPH)
Certificate in Public Health
MD/MPH
JD and MJ/MPH
MSN/MPH

Health Policy
Master of Science in Health Policy (MS-HP)
Certificate in Health Policy

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

Readers Respond to *Losing My Dad*

The June issue of the *Health Policy Newsletter* featured an editorial about Dr. Nash's experiences surrounding the passing of his father. Dr. Nash received an overwhelming outpouring of reactions and comments to this editorial from over 100 colleagues across the nation. His article stuck a chord with many on both a personal and professional level. We have compiled a list of excerpts from letters to Dr. Nash that represent and capture our reader's reactions.

I applaud you for articulating your feelings the way you did. Thank you for openly sharing your feelings and your compassion. The lack of communication in coordinating various specialties and sub-specialties can be the difference between life and death of a patient.

I am particularly touched at your vivid and accurate description of the disconnected, fragmented system of care we have.

Thank you for sharing this part of your life with us. It does remind us how important it is to look at health care from the other side of the hospital bed.

I very much appreciated your lead article ***Losing My Dad****, very poignant with many layers of take-home messages.*

I just read your column in the newsletter about your father's death. It was moving and lovely, and it made me really get a sense of his life and yours. But it was also a wonderful piece on the critical importance of health care reform. I expect that, were your father to read it, he'd be proud and not a bit surprised at your focus on the vital connection between the past and the future. The irresistible pull of the opportunity to make things better for those to come – to keep them from suffering what we know how to prevent – your passion for that screams out from your writings…As a health care consumer and a teacher of future health professionals, thank you for the passion you bring to this work – and for sharing it so boldly with your peers.

I am writing to you to say please continue to do whatever you can to get the message out to your colleagues, on the importance of speaking in laymen's terms to ***both the family and the patient.*** *Please continue to stress, not only are these individuals sick, they are someone's father, son, brother, etc. I have hope with you leading this drive that the breakdowns in communication will be minimized and the burden on the families will be lessened to give them the freedom to care for their loved one rather than fight to understand and figure out how to work with multiple departments and systems.*

Your commitment to working to find solutions to "our broken system" as someone in a position to make a difference is encouraging.

Your article touched me deeply. It was lovingly written and your views are so important.

I think you did a service writing eloquently about him, expressing the circumstance that healthcare is about people we care for in deep personal ways, as well as people we don't know.

I read your very touching description of your father's death and tribute to him and his life. I wanted to let you know that I found its message to be quite relevant and heartfelt. Thank you for sharing it. It is a constant reminder of how much work there is still to do when one hears stories that have impacted those we know and care about personally.

What I felt in your story was the need to not let your father be 'just a patient' to these people, but to be a memorable person. It is the difference between caring for people's problems and caring for people with problems, and caring about people with problems.

I valued your perspective which entwined the significance of being family-centered with being patient-focused. In a meaningful way, your reflections poignantly add to the call that it is indeed time for change in health care delivery, and it begins with us.

You nailed medical reality in your editorial about your dad in the Jefferson ***Health Policy Newsletter****.*

You have allowed your personal experience to further heighten your sense of the quagmire of the current public healthcare policy, especially as it relates to us non-clinicians.

I wanted to write to let you know how much I enjoyed your editorial. It was poignant and so apropos for anyone who has gone through end of life decline with parents.

Your editorial in June's ***Health Policy Newsletter*** *was inspiring. You are so correct about the problems of fragmented care.*

Although our country trains the brightest physicians, possesses the best medical tools, and spends the most funds supporting its care delivery, it appears that one of its greatest deficits stems from poor communication and unsuitable attitude. This is most evident in the care of the elderly and of people with disabilities.

I thought your letter was a wonderful tribute while at the same time personalizing many of the issues in the healthcare system.

You very poignantly point out the paradox of feeling the loss of your father with the drive and energy that you feel in your role of Dean of the School of Population Health. I admire your reflections and wish to reinforce that your work is so incredibly important to us all, for those of us who have or who will also suffer the challenges of our healthcare systems.

The story you wrote about his passing, and your memories of life with him, was wonderful to read and brought back many of my own thoughts about my dad. Very good of you, and no doubt, good for you!

Your recounting of your dad's story will help us deal with our family member's end of life considerations. Thanks for sharing what must have been a difficult column to write.

It strikes me that we spend many hours and years of training to learn how to assist in the natural process of birth and very much less time in the learning how to assist the natural process of dying. I hope that students in your medical school are taught how to deal with dying in an empathetic and supportive manner and to understand that death is not "the enemy" but the ultimate outcome for us all. Learning how to deal with death and dying is a skill and your insights and empathy will be valuable to the students you teach.

All comments have been published with permission from the writers.

Population Health: Shifting the Focus from Obesity to Healthy Weight

Dr. Thomas R. Frieden, director of the US Centers for Disease Control and Prevention (CDC), has noted, "Reversing obesity is not going to be done successfully with individual effort. We did not get to this situation over the past three decades because of any change in our genetics or any change in our food preferences. We got to this stage of the epidemic because of a change in our environment and only a change in our environment again will allow us to get back to a healthier place."[1]

As part of my sabbatical this past spring, I had the good fortune to join the Jefferson School of Population Health. My work focuses on public and private sector initiatives to achieve a population-wide healthy weight. A co-authored previous book, *Obesity, Business and Public Policy*,[2] examined public policy, economic, nutrition and lifestyle factors that contribute to the increase in obesity among Americans.

The first aim of my sabbatical is to complete a work-in-progress. The title, *Weight and Wellness: Innovations in Public Programs and Private Initiatives*, indicates the shift from problem identification toward solutions.

Since interventions must be implemented in environments that are influenced by state legislative actions, the second aim of my sabbatical is to identify funding for the next compilation of the University of Baltimore Obesity Report Card™.[2]

The statistics are staggering. Finkelstein, et al. estimate that 9.1% of US medical expenditures in 2006 were attributable to excess weight.[3] Although the costs and medical consequences of excess weight are well-known, effective long-term interventions for individuals and populations are not. In 1990, the United States' obesity profile showed no state having a prevalence greater than 10%. By 2007, only one state had a prevalence of ≤ 20%; 30 states were above 25%, and 3 were above 30%.[4] More than 12% of U.S. preschool children,[5] and 34% of adults,[6] are now obese.

This dramatic change occurred even though weight reduction is a national health priority.[7] Long-term follow-up of an intensive weight loss program reported that just 40% of subjects had even a 5% weight loss after five years, and only 25% had a 10% weight loss after seven years.[8] There is no magic bullet for weight loss. Monotherapies such as pharmacotherapy, dietary restriction, or exercise are unreliable for the long term; impacts are typically modest and of brief duration, and recidivism frequently occurs.

Prevention of weight gain and treatment of obesity require individual, organizational, and public resources. Examples of current initiatives in the private sector include the National Business Group on Health's *Institute on the Costs and Health Effects of Obesity* and its *Wellness Impact Scorecard*.[9] In the public sector, more than 180 communities have participated in the CDC's *Healthy Communities Program*.[10] As William H. Dietz, MD, PhD, director of CDC's Division of Nutrition, Physical Activity and Obesity observes, "Reversing this epidemic requires a multifaceted and coordinated approach that uses policy and environmental change to transform communities into places that support and promote healthy lifestyle choices for all people."[11]

Without direct national authority over health, national strategies to coordinate an obesity policy are limited. Some mechanisms that are useful in working within these constraints are voluntarily aligning interests, developing national public-private consensus goals, and publishing informational report cards. The University of Baltimore Obesity Report Card™ for example, assigns letter grades to each state based on eight dimensions of its legislative efforts on obesity - overall and for childhood obesity in particular.[2] As expected, there is variation in the grades, and feedback suggests that eliciting competition among states for recognition may be a key motivator when direct authority is lacking. ■

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Additional Resources:
Trust for America's Health. F as in Fat: How Obesity Policies are Failing America. Washington, D.C. August 2008. http://healthyamericans.org/reports/obesity2008/Obesity2008Report.pdf .
World Health Organization. Global Strategy on Diet, Physical Activity and Health. http://www.who.int/dietphysicalactivity/en/index.html.

The Case for Taxing Employer-Sponsored Health Insurance

As Congress continues its debate over healthcare reform, one of the central issues is how to expand access to health insurance while controlling skyrocketing costs. One proposal, which has partial endorsement from the President, involves taxing employer-based health insurance benefits. To understand the implications of such a tax, it is important to examine how employer-based health insurance has become ingrained in the American healthcare system.

The current employer-based system of health insurance has been in place for almost 70 years. During World War II, to combat the threat of inflation during and after the war, wage freezes were implemented by Congress.[1] A key ruling by the War Labor Board found that health insurance and other fringe benefits did not constitute wages and, as such, did not violate wage control laws.[1] Logically, firms began to offer health insurance as a way to attract skilled labor. In 1954, the IRS ruled that health insurance offered through employers would not be taxed.[2] This was a major policy decision with significant implications for employers, employees, and the US Treasury. The tax policies surrounding employer-based health insurance led to employer-based health insurance becoming deeply rooted in the American economy. By 2008, employer-sponsored health insurance covered 60% of the non-elderly and amounted to a subsidy of $200 billion annually.[3]

There are several implications of a tax code that allows for tax-free employer-sponsored health insurance. Foremost, a tax subsidy for employer-based health insurance creates an incentive to purchase the most expensive health insurance plans. This has two key consequences. First, employees have an incentive to devote more of their compensation to health insurance rather than cash wages and thus, must forgo other expenditures.[4] While employees have less money to consume other goods, they have health insurance plans that provide benefits they may not need. As a result, individuals may utilize more healthcare services, causing inflationary pressure in healthcare. Second, this tax subsidy is inequitable because it provides a larger tax break to individuals in higher marginal tax brackets. For example, it is estimated that the current tax subsidy will save $2,780 for a family with an income greater than $100,000 a year. However, the same subsidy will only save $102 for a family making less than $10,000 a year.[5]

The current system of employer-sponsored health insurance covers 60% of Americans.[6] The other Americans are either uninsured (16%) or are covered through Medicare or Medicaid (24%). Many individuals who do not have health insurance or are unable to pay for healthcare, still receive care. Yet, there are significant costs associated with the care that hospitals provide for those who are unable to pay. A study by the Urban Institute in 2001 showed that of the $35 billion dollars in uncompensated care delivered to the uninsured, $30 billion was financed by the government.[7] A report by the Heritage Foundation suggests that healthcare costs for the uninsured will raise the overall cost of health insurance premiums by $948 for families and $322 for individuals.[5] The issue of the tax subsidy greatly affects all US citizens.

As members of Congress debate the future of healthcare in America, they must seriously consider reforming the current tax policy. Although Congress has not determined at what amount to tax benefits, economists have argued that the tax benefit should be capped at $840 per person and $2,100 per family in a year.[8] Therefore, the additional benefit above the tax cap would be taxed and could then be used to finance healthcare services for the uninsured. The tax cap plan would also help control healthcare costs. A strong case can be made that with a tax cap, more people would shift to healthcare plans that require greater cost sharing. By adopting health plans in which there are high copayments, individuals will be more conscious of the services they purchase. This could ideally reduce unnecessary healthcare spending and thus help control cost.[8]

Tax reform can be a good start to overall healthcare reform. However, it is not a solution by itself and must be coupled with overarching reform of the entire system. ■

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***Prescriptions for Excellence in Health Care* Coming Soon!**

Look for the Fall '09 issue of the *Prescriptions for Excellence in Health Care* supplement in October.

A Summer Internship Brings Abundant Experiences

I could not have planned a more opportune time to intern at the Jefferson School of Population Health (JSPH). The health care reform debate that dominated this summer's headlines provided a stimulating backdrop for my time here. Besides serving as a constant source of relevant information for me to follow and research, the attempts at health care reform left me with no doubts that the work being done here every day is of the utmost importance.

As exciting as the headlines may have been for those of us interested in health policy, they had some stiff competition as preparations were made for the first day of classes at the new Jefferson School of Population Health. Dean Nash will tell you that the very first students arrive for classes on September 9, 2009; however, I feel that I have already had that privilege. My internship has been an invaluable learning experience thanks to the faculty and staff.

Provided with a very "cozy" cubicle situated right in the middle of things at the JSPH office space, I was able to delve into my research assignment regarding the comparative effectiveness movement. The volume and dynamic nature of the information was overwhelming at first, but with guidance from Dean Nash, I was able to grasp an understanding of the health care system that I know will be essential to my success as a future health care professional.

Despite a fondness for that little cubicle, a break from reading the news articles and medical journals was always welcome. Luckily for me, opportunities to apply my new knowledge were provided regularly by Dean Nash and the other faculty. I attended weekly research meetings where I learned of the innovative projects being conducted through the school. I tagged along with Dean Nash to various University and Hospital committee meetings. I went to Harrisburg to attend a meeting with the Technical Advisory Group for the Pennsylvania Health Care Cost Containment Council. On another notable occasion, an interesting cab ride up Broad Street brought me to Einstein Hospital where Dean Nash was giving Grand Rounds. I truly realized that day what JSPH is all about. It's essentially about teaching and promoting a "healthier" way to deliver health care through system transformation and quality assurance.

I am sure that I learned more this summer than I have been able to process or appreciate thus far. I suspect that my time at JSPH places me a few steps ahead of my fellow Public Health students at George Washington University. More importantly, I believe that my internship will be an unmatched resource as I endeavor to become a medical professional and future leader in the changing health care world.

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Family Preparedness: An Important Step in Emergency Management

Since the terrorist attacks on September 11, 2001 and Hurricane Katrina in 2005, the federal government has increasingly promoted disaster preparedness to ensure its agencies, state and local healthcare organizations, and American families are prepared to respond to emergency situations. Recent pandemics like swine flu (H1N1) further emphasize why hospitals need to be prepared for a sudden influx of patients.

The Joint Commission requires hospitals to develop and follow emergency management standards. This has prompted the Emergency Management Committee at Thomas Jefferson University Hospitals (TJUH) to reexamine the hospitals' policies and procedures related to emergency operations and discuss ways to improve emergency responses and communications. This Committee's efforts also include educating physicians and staff about the importance of family preparedness.

At hospitals like TJUH, when an external disaster occurs, designated physicians and other employees are summoned to work, and often will need to report during non-business hours to provide additional services during a major disaster. If employees fear leaving their families and pets to fend for themselves, the hospital's ability to implement its emergency operations plan may be compromised. Furthermore, the delivery of continuous and effective patient care could be disrupted.

Family preparedness is a strategy that assists individuals, families, and communities in avoiding or reducing the negative impact of a natural or man-made disaster through the development and implementation of a specific plan. The US Department of Homeland Security has recognized that a lack of family preparedness has prevented physicians and hospital employees from reporting to work during disasters. Because of this finding some health care organizations, such as the Kaiser Permanente health care system in California, have implemented family disaster preparedness trainings for staff. More in-depth studies are needed to determine the impact of these family preparedness training programs on staff response.

One of the most comprehensive training programs is the government-sponsored *Ready* campaign, initiated by the Department of Homeland Security in 2003 to "educate and empower Americans to prepare for and respond to emergencies, including natural disasters and potential terrorist attacks."[1]

The *Ready* campaign encourages people to follow three basic steps in order to be prepared to respond to emergencies: *Get a Kit, Make a Plan, Be Informed.*

The *Get a Kit* step encourages families to use supplies they have to "make it on their own" for at least three days during a disaster. Recommended supplies include: one gallon of water per person per day, a three-day supply of non-perishable food, a battery-powered radio and flashlight (and extra batteries), first aid kit, whistle, one filter mask (or cotton t-shirt) per person, moist towelettes, wrench or pliers, manual can opener, plastic sheeting, duct tape, garbage bags and ties as well as any *unique* family needs, such as prescription medications or important documents.[2]

The *Make a Plan* step guides families in developing a specific plan to prepare for a future emergency. Each family should create a communications plan, including important contact information, a plan for creating a

shelter as protection from contaminated air and/or flying debris, and a plan to leave the disaster area using multiple routes and various types of transportation.[2]

The *Be Informed* step encourages people to become aware of potential threats in their state and local community. Responses to natural disasters and terrorist threats can be extremely different, meaning it is important for families to be aware of their areas' vulnerabilities and able to adapt to various situations. The *Ready* campaign website[1] offers a wealth of information, including responses to different types of threats, and emergency planning templates, tools and tips for creating emergency supply kits.

It is important to mention that September is the sixth annual National Preparedness Month (NPM 2009). This particular campaign will focus on changing perceptions of emergency preparedness in an effort to help people understand that preparedness goes beyond standard security measures; it also involves communication and education of families, communities, and businesses.[3] NPM Coalition membership is open to all public and private sector organizations in the hope that they will share preparedness information with their customers, employees, and communities.

TJUH's Emergency Management Committee encourages all citizens, especially physicians and other health care employees, to explore resources such as *Get a Kit, Make a Plan* and *Be Informed* so that they may feel more confident about their ability to respond appropriately to a disaster situation. ■

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Greater Philadelphia Schweitzer Program Accepts New Fellows

After a competitive selection process, 14 graduate students from local health and human service schools have been selected as 2009-2010 Greater Philadelphia Albert Schweitzer Fellows. Honoring the legacy of Dr. Albert Schweitzer by committing to a year of service with a community agency, Schweitzer Fellows will devote over 2800 hours of service to local communities. Schweitzer Fellows continue their conventional professional training while participating in the entry year of the Schweitzer Fellows Program. This year's newly selected group enlarges a rapidly growing network of Schweitzer Fellows who are committed to supporting each other on lifelong paths of service.

This year's Fellows represent the following colleges and universities:

Drexel University College of Medicine
Temple University Graduate School
Thomas Jefferson University
- Jefferson Medical College
- Jefferson School of Health Professions
- Jefferson School of Population Health

University of Medicine and Dentistry of New Jersey
- School of Osteopathic Medicine
- Graduate School of Biomedical Sciences

University of Pennsylvania
- School of Medicine
- School of Social Policy and Practice

With much excitement, we welcome the 2009-2010 Fellows and look forward to sharing more details about their projects as the year progresses.

For further information on the program, including opportunities to collaborate with a community site, and/or sponsor a Fellow, please contact Nicole Cobb, MAOM, Program Director of The Greater-Philadelphia Schweitzer Fellowship Program, at 215-955-9995, or Nicole.cobb@jefferson.edu. You may also visit: www.schweitzerfellowship.org/features/us/del.

Nicole M. Cobb, MAOM
Project Manager
Jefferson School of Population Health
Program Director
Greater Philadelphia Schweitzer Fellowship Program

Standing from left to right: Jennifer Abraczinskas, Tanya Keenan, Kristen Topping, Nathaniel Amos, Manisha Verma, Alexander Potashinsky, and Usha Kumar
Seated from left to right: Hyun Hong, Heidi Swan, Caryl Chornobil, Alesia Mitchell, Valencia Barnes, Erica Khan, and Farhad Modarai

MSN/MPH Dual Degree Program to Be Offered at TJU

In its 2003 report, *Who Will Keep the Public Healthy? Educating the Public Health Professionals for the 21st Century*,[1] the Institute of Medicine (IOM) challenged educational institutions to fundamentally change the preparation and training of health care professionals in order to address the needs of diverse populations in a climate of healthcare reform. In addition, our nation's preventive health agenda for the next decade, *Healthy People 2020*, is on the horizon. It will emphasize assessment of major risks to health and wellness, changing public health priorities, and emerging technologies related to health preparedness and prevention.[2] Nursing has a legacy of involvement in disease prevention and health promotion activities dating back to the days of Florence Nightingale, who asserted that nurses providing preventive care required "more training" than those providing "sick" care.[3]

Against this backdrop, beginning in fall 2009, Thomas Jefferson University's Schools of Nursing and Population Health will collaborate to offer a joint graduate degree – Master of Science in Nursing (MSN) / Master of Public Health (MPH). The purpose of the MSN/MPH degree is to provide an opportunity for nurses to integrate advanced practice nursing with public health research and practice. Advanced practice nurses (APNs) are prepared at the MSN level and typically include: clinical nurse specialists, adult, pediatric, and subspecialty nurse practitioners, nurse anesthetists, community health nursing specialists and information systems nurse specialists. The MPH program augments traditional advanced practice nursing concepts with coursework in behavioral and social public health theory and application, biostatistics and data analysis, advanced epidemiology, environmental health, policy advocacy, and program planning and evaluation models.

Nursing leaders are calling for increased proficiency and involvement of nurses in addressing public and population health policies. For example, Hansen-Turton et al. evaluated the impact of master's prepared advanced practice nurses (APNs) in successfully advocating for recent nursing-related legislative reforms in Pennsylvania.[4] They urged nurses and APNs to continue to develop advocacy skills and speak with a unified voice in order to build strong relationships with policy makers, civic leaders, business leaders and policy advocates.

The MSN/MPH dual degree builds on the population-focused competencies required for health care and public health providers in the 21st century, with increased emphasis on leadership skills and developing and implementing population-based and community programs.[5,6] A 2007 qualitative study by Robertson and Baldwin queried 10 APNs working in community-health positions and identified five defining characteristics of their roles: advocacy; involvement in policy setting at local and state levels; leadership centered on empowerment and a broad sphere of large-scale program planning; project management; and partnership building.[5] Other researchers have noted that if public health activities are to continue to be a driving force behind the improvement of population health status, decisions regarding the allocation, management and the administration of public health resources must be driven by an informed, competent, public health workforce.[7] As the largest group of health care providers, nurses and APNs must be capable of contributing to the discussion.

The combined MSN/MPH degree provides value-added education for APN graduate students who plan to seek leadership positions in public health agencies, serve as directors of community-based programs, participate in grant writing to support population and community-based programs, work in global health initiatives and /or become educators in academic institutions. This dual degree program will appeal to professional nurses and APN graduate students who have a strong interest in:

* Community systems
* Public health (local, national and international)
* Health care reform legislation
* Health care quality and safety
* Health policy
* Population health management
* Injury control and prevention
* Disease prevention and health promotion
* Public health and community-based participatory research

MSN students are eligible to transfer 6 to 12 credits into the MPH program, depending upon the MSN track in which they are enrolled. In addition to the public health core areas of statistics, epidemiology, behavioral and social theories, environmental health, public health policy, and the US health care system, Jefferson's MPH program includes elective courses in cultural competency, health communication, GIS mapping, and global health. The MPH requires a community clerkship experience which can be combined with the MSN clerkship where appropriate, and a final Capstone project.

Both the MPH and MSN programs are available on a full-time or part-time basis. Typically, MSN/MPH students take many of their nursing courses prior to beginning their public health studies. Interested students may apply to both schools simultaneously or they may apply to one school first and upon acceptance, apply to the second school. For further information about the MSN/MPH dual degree program, contact the Jefferson School of Nursing at 215-503-5090 or the School of Population Health at 215-503-0174. ■

Theresa Pluth Yeo, PhD, MPH, MSN, AOCNP
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Molly A. Rose, PhD, RN
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Making a World of Difference

Jefferson School of Population Health Summer Seminar

July 16, 2009

This year's Summer Seminar was the first one organized under the auspices of the new Jefferson School of Population Health (JSPH). The program was focused on the mantra of the new school: "Making a World of Difference in Health Care."

David B. Nash, MD, MBA, JSPH's founding dean, opened the morning by welcoming Michael Vergare, MD, Senior Vice President of Academic Affairs at Thomas Jefferson University. Dr. Vergare expressed his excitement over the type of important and relevant programming offered by JSPH to develop leaders to guide the industry during this time of change.

Dr. Nash shared his vision of JSPH as an institution that is part of the solution to problems with the healthcare system. He reviewed the main goals of the seminar: to review the school's progress as it prepares to welcome its inaugural class and to reinforce a systems approach to healthcare.

Dr. Caroline Golab, JSPH Associate Dean of Academic and Student Affairs, opened the official program by providing an overview of the school's mission, goals, and academic programs. She explained how its programs dovetail with the National Quality Forum's National Priorities and Goals, such as engaging patients and their families in healthcare decisions; reducing healthcare-related injury; and improving patient-provider communication. Dr. Golab succinctly stated, "We must fundamentally change the ways in which we deliver care. And that's what we're all about."

The panel of speakers included the directors of the respective Master's programs: Rob Simmons, DrPH, MPH, for the Master of Public Health (MPH) program; JoAnne Reifsnyder, PhD, for the Health Policy (MS-HP) and Chronic Care Management (MS-CCM) programs; Susan DesHarnais, PhD, MPH, for the Healthcare Quality and Safety (MS-HQS) program; and Laura Pizzi, PharmD, MPH, for the proposed Applied Health Economics (MS-AHE) program. The audience also heard from the Assistant Dean of Continuing Professional Education, Alexis Skoufalos, EdD, and Associate Dean of Research, Neil I. Goldfarb.

Dr. Rob Simmons, director of the MPH program, defined public health as "an interdisciplinary field of study and practice with a primary goal to

prevent illness, disease, and injury and to promote and protect health while supporting human rights and social justice." The mission of the MPH program is to "enhance communities through the development of public health leaders…through practice and service." The program trains students based on specific public health competencies and core public health values. Students can practice in a variety of settings from federal, state, and local public health agencies and non-governmental health organizations to educational institutions and international health organizations. Dr. Simmons concluded by announcing that JSPH's MPH program won re-accreditation for seven more years.

Health Policy, as described by Dr. JoAnne Reifsnyder, is "where the rubber hits the road." She explained that there is "a lot about healthcare that is exemplary but it is often obscured by what is dysfunctional." The systems approach to healthcare was built into the JSPH, MS-HP curriculum. Dr. Reifsnyder believes this distinguishes it from other health policy programs in that it was designed to enable students to master applicable, "real-world" skills.

Dr. Susan DesHarnais pointed out that JSPH's MS-HQS program is one of only two in the country. Jefferson's program is unique in its focus on practicing healthcare professionals. Dr. DesHarnais' passion is to ensure that healthcare workers are trained in quality and safety. Training professionals to better communicate with each other and with patients is a key component of improving healthcare.

Dr. Reifsnyder again took the podium to describe the Master of Chronic Care Management, a program in development which will be the *first* of its kind in the nation. Management of care is crucial to meaningful health care reform, and is achieved by *designing systems* that will help manage chronic illnesses. JSPH faculty are engaged in literally writing the textbook for this course, tentatively titled, *Population Health Management*.

The last program that was discussed was a proposed Master of Applied Healthcare Economics. Dr. Laura Pizzi reinforced that understanding costs is an essential part of healthcare. This new program would focus on "applied" health economics rather than "traditional" as other, similar programs do. Dr. Pizzi described the program as one that will prepare "professionals to shape health policy through applied health economic analyses."

Dr. Alexis Skoufalos spoke about the importance of continuing professional education. She reminded the audience of the need for developing "lifelong learners" and insisted that it is crucial "for leaders to remain actively engaged in [the learning] process in order to remain competitive." Dr. Skoufalos stressed that JSPH's continuing professional education programs create a "bridge between academic and research programs and include the real-world application of key concepts."

To complete the circle that is the JSPH mission, Neil Goldfarb emphasized the significance of research. The JSPH research team has developed a list of properties of an "idealized" research agenda, including items such as being innovative, impactful, and promoting inter-professional collaboration. Progress has been made in many of the areas on the list, and the research team will keep taking advantage of their current resources while looking for new opportunities.

In his closing remarks, Dr. Nash expressed his gratitude to the JSPH team and the Jefferson community for their support. He asked the audience to join him in making sure JSPH is making a difference in healthcare. ■

Lisa Chosed, MA
Program Coordinator
Jefferson School of Population Health

Developing Future Public Health Leaders: Experiential Advocacy Training

A fundamental change has occurred in the preparation and training of public health professionals, guided by the 2003 landmark IOM report, *Who Will Keep the Public Healthy? Educating the Public Health Professionals for the 21st Century*.[1] The report delineated relevant public health skills and competencies and appropriate professional preparation strategies, including an increased emphasis on active, experiential and interdisciplinary learning to address the complexity of future public health problems. A key recommendation was to work to integrate public health training within medical, nursing, and allied health academic programs.

Prior to the mid-20th Century, traditional teaching methods in the US included the professor/teacher lecture, student note-taking, and student reiteration of information back to the teacher on an exam or paper. The renowned educator John Dewey redefined education and described the goal of education as broadening intellect through problem solving and critical thinking skills, and not just memorization.[2] Dewey's philosophy addressed not just formal education but informal adult or lifelong learning through auditory (instruction), visual (observation), and kinesthetic (hands-on activities) learning modalities.

Experiential learning is the process of making meaning from direct experience.[3] The work of Kolb and others have influenced how we teach today where the learner is *creating knowledge* through direct experience that is meaningful to the student with guided reflection and analysis.[4] Public health and healthcare education now embody experiential learning through problem-based learning strategies, simulations, and other methods of "active learning."

The national Public Health Education Advocacy Summit, held annually in Washington, DC, is a prime example of this type of learning.[5] Two hundred public health educators, over half of whom are students, come together for a 2 ½ day training on public health advocacy, culminating in meetings on Capitol Hill with Congressional representatives and their health legislative aides. The public health advocacy priorities and key messages for the summit are established by the Coalition for National Health Education Organizations (CHNEO) over a nine-month period prior to the summit with an emphasis on health promotion and disease prevention.

Prior to the Summit, pre-registered participants are asked to review the national prevention health priorities and do some background research about their Senate and House representatives. This provides an opportunity to learn about their representative's legislative priorities and committee assignments. During the Summit, participants receive advocacy training tailored to their level of advocacy experience, including practicing and rehearsing their *legislative asks* in small groups. They actively apply this experience when they meet with key Congressional aides to advocate for public health priorities. Public health students play an active role in each of these meetings and often serve as small group leaders. After the summit, participants

Continued on page 12

complete an online evaluation and follow up with the legislative aides via email to reinforce key advocacy messages. Upon returning to their university, students share with their colleagues their experiences and lessons learned. The experiences gained from the Summit are embodied in the revised national public health competencies linking academic preparation and public health practice.[6]

Over the past two years, a number of Jefferson public health students have participated in the national Health Education Advocacy Summit. Here are some quotes from a sample of those students:

"The Health Education Advocacy Summit was an enlightening and instructive experience. If we could take one thing away from our time spent, it would be that we have not only a right, but a duty as constituents and public health students to educate our representatives on current pertinent health issue."

"To prepare for my Hill visit on Monday, I researched the topic extensively and, as a result, became very interested in the idea of school health programs."

"My experience at the conference was great. I had done some advocacy for different programs before and really liked how they catered to various levels of experience. I got to meet the representative from my district."

"My experience at the 2009 Health Education Advocacy Summit was truly rewarding. I left the Health Summit with a sense of accomplishment and a set of skills I will be able to utilize during my public health career."

The Jefferson School of Population Health MPH Program will be offering a new course, Public Health Policy and Advocacy, in the current academic year. It will include opportunities for advocacy, such as writing a "Letter to the Editor" and an email to their local, state or federal representative. Some students will choose to participate in the 13th Annual Health Education Advocacy Summit in Spring 2010 as part of their learning to become current and future health advocates, embodying the principles and activities of experiential learning. ■

Rob Simmons, DrPH, MPH, CHES
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Book Review

JE Fetterman, WL Pines, GH Slatko
Pharmaceutical Risk Management: Practical Applications
With a foreword by Janet Woodcock, MD
Director, Center for Drug Evaluation and Research, FDA
Washington, DC: FDLI; 2008.

Given several high-profile recalls in recent years of pharmaceuticals by the US Food and Drug Administration (FDA), the subject of pharmaceutical risk management has become increasingly important. Pharmaceutical risk management refers to manufacturers creating special tools and programs to ensure the safe use of certain high risk products. The FDA's Amendments Act (FDAAA) of 2007 prompted the Food and Drug Law Institute (FDLI) to publish *Pharmaceutical Risk Management: Practical Applications* (2008), a follow up to their 2003 publication, *A Framework for Pharmaceutical Risk Management*. The 2008 edition is a multi-author work written by experienced risk managers who have organized risk management programs as consultants or industry executives; some are alumni of the FDA. It is important to note that this is not a second edition of the 2003 book, but rather an extension of the research and methods presented in the original, with an emphasis on practical applications of risk management principles. The purpose of this publication is to educate pharmaceutical companies, consultants, and other drug industry stakeholders on the new rules for Risk Evaluation and Mitigation strategies (REMS) during pre- and post-marketing drug development.

Pharmaceutical Risk Management: Practical Applications provides the historical context for all of the recent changes in the FDA's requirements for risk management, which culminated with the FDAAA of 2007. The authors describe the Vioxx® withdrawal from the market and how it ultimately compelled the Institute of Medicine (IOM) to issue its report, *The Future of Drug Safety: Promoting and Protecting the Health of the Public*, which pointed out deficiencies in drug safety in the US and made recommendations for correcting them. Some of these recommendations were incorporated in the FDAAA of 2007, including the expanded ability of the FDA to require a REMS if the agency deems the strategy would be "necessary to ensure that the benefits of the drug outweigh the risks of the drug." The legislation also allows the FDA to require a REMS for a previously approved drug if it "becomes aware of new safety information and makes a determination that such a strategy is necessary to ensure that the benefits of the drug outweigh its risks."

The author/s goes on to address specific elements of a REMS or risk management action plan

(RiskMAP). It details the application of risk management to clinical development, regulator approval, clinician acceptance, and outcomes improvement. Incorporating educational interventions into risk management is explored, as is evaluating the performance of risk management plans. The authors conclude with chapters on crisis avoidance and management, and the legal implications of risk management. An extensive appendix is also provided, including three guidance documents on risk management published by the FDA in 2005, the FDAAA of 2007, a list of products with approved REMS in effect when the FDAAA was passed, and a March 2008 draft of the Prescription Drug User Fee Act (PDUFA) IV: Drug Safety Five-Year Plan.

This FDLI publication on pharmaceutical risk management, when accompanied by *A Framework for Pharmaceutical Risk Management* (2003), acts as an excellent primer for individuals devising or interpreting a REMS or RiskMAP for the FDA, and could also be helpful for devising risk management strategies internally or for other regulatory agencies. The book provides first-hand knowledge from a collection of authors who have extensive training and experience in the field of pharmaceutical risk management. Both manufacturers and the FDA hope that effective risk management programs will protect consumers from future recalls and increase the safety of medications in the US. ■

Reviewed by Joe Couto, PharmD, MBA
Pharmacoeconomics and Outcomes Research Fellow
Jefferson School of Population Health

Health Policy Forums

Pennsylvania Patient Safety Authority: Progress on Patient Safety Initiatives

Michael C. Doering
Executive Director,
Patient Safety Authority

May 13, 2009

Pennsylvania has become a leader in patient safety excellence in large measure due to the vision and work of the Patient Safety Authority (the Authority), an independent state agency dedicated to reducing and eliminating medical errors through a variety of solutions. Michael C. Doering, Executive Director, discussed the programs and work of the Authority at a recent Health Policy Forum.

The Authority's primary focus is to help healthcare workers learn from past experiences. It functions as a vehicle for communication, education, and problem-solving. One of its most significant initiatives was the implementation of statewide mandatory reporting in 2004. At the time, Pennsylvania was the first and only state in the US to require reporting of near misses, adverse events, and infrastructure failure. Reporting is required of hospitals, ambulatory surgical facilities, birthing centers, and certain abortion facilities. Starting in June 2009, nursing homes were also required to report Healthcare Associated Infections (HAIs) through the Authority's Patient Safety Reporting System (PA-PSRS).

In 2008, almost 220,000 reports were submitted through PA-PSRS. Upon entry, reports are electronically triaged into a variety of categories and evaluated by patient safety analysts from many medical disciplines. While approximately 8,500 reports resulted in some degree of patient harm, over 96% of the reports describe patient safety events that either did not reach the patient or reached the patient, but caused no harm. The Authority believes every type of report is important as they all point to some type of systemic break down in the processes used to provide care.

The purpose of collecting this data is to effect change and educate. For example, one reported incident related to a misunderstood colored wristband. A patient was incorrectly considered to be DNR due to the misunderstanding. In this case, the error was noticed and there was no harm to the patient. However, the resulting near miss report pointed to a potentially devastating issue. The Authority wanted to capture and correct this problem, and conducted a wrist band survey through Pennsylvania's facility Patient Safety Officers. They were able to identify the variety of colors used for different conditions at different institutions. This obviously creates major concerns as staff move around through different systems. As a result of reporting this error and conducting a survey, the Authority was able to identify a need for action. A group of Pennsylvania facilities took on the challenge and developed a set of standardized colors and attendant policies and procedures. These standards, or slight variations, are now being implemented to varying degrees in 30 states and in the Armed Services.

The Authority has many important educational initiatives. One program, in collaboration with the Hospital and Health System Association of Pennsylvania (HAP), seeks to modify an American Hospital Association program on patient safety education for executive management and hospital board members for use in Pennsylvania. In addition, the Authority has begun a program to assign regional patient safety liaisons to different facilities. The role of the patient safety liaison is to be a resource to facility patient safety officers, provide education, facilitate process and improvement sharing, and conduct regional improvement collaborations. The Authority also offers educational resources for providers and consumers; patient safety method training; and a speaker's bureau.

In the future, the Authority plans to increase collaborative activities at the regional level and with other statewide patient safety-centric organizations. It is also developing the Patient Safety Knowledge Exchange (PasSKEy). PasSKEy is an online community where patient safety professionals can discuss issues, access a library of resources, and share ideas, successful processes and practices. ■

For more information about the Patient Safety Authority visit: www.patientsafetyauthority.org

Continued on page 14

Patient Friendly Billing: Increasing Transparency

Kevin F. Brennan, CPA, FHFMA
Executive Vice President, Chief Financial Officer
Geisinger Health System

June 10, 2009

Billing can be the most complicated aspect of health care and can be frustrating and even alarming for patients. Geisinger, one of Pennsylvania's largest health systems, has made noticeable strides in the past few years to develop a nationally recognized Revenue Cycle that is user-friendly, transparent, standardized, and effective.

Kevin Brennan, Executive VP and CFO of Geisinger Health System, openly shared his insights and lessons learned when he spoke at the Health Policy Forum last June. He first provided an overview of Geisinger Health System, which is an integrated delivery system serving the north central and northeast section of PA. The semi-rural region is home to Geisinger's major hospitals, surgery centers, physician group practices, and a drug and alcohol treatment center. There are currently approximately 500,000 people who access Geisinger Health System regularly. Geisinger is truly an integrated system with a common board of directors, an incentive-based infrastructure, and a centralized billing office. Additionally, Geisinger is also home to its own managed care companies.

Geisinger's growth began to flourish after 2001, when re-organization led to a strategy where growth became a strategic imperative. There was an increased awareness of new collection opportunities; a more activated consumer base; and the development of an electronic infrastructure.

All these differentiating factors contributed to the backdrop leading to improvements in Revenue Cycle processes.

Mr. Brennan emphasized Geisinger's quest for a transparent system, in part driven by the societal expectation of transparency. Early on in the development of a new fee system, it was important to be upright and have measureable improvements. Some of the more important implementation revenue cycle components included: financial/reimbursement analyses; technology tools; market pricing vs. cost analyses; and collaboration across the enterprise. The intention was to have justified, market-based, line item pricing while increasing simplicity. The outcomes focused on a consolidated charge description master; defensible pricing; and improved regulatory compliance.

Mr. Brennan explained the challenge in this process, which inverted many of the historic patient communication processes. In a typical revenue cycle, most business happens at the back end, sometimes long after a transaction or service has taken place. Geisinger has worked very hard to engage patients early on in their pre-service model.

First and foremost, Geisinger patients have direct access to their electronic health records (EHR) and a host of other online resources. This online interaction can function in a variety of ways for patients and providers: patients can update personal demographics, request an appointment, obtain a referral or refill a prescription, and contact a provider via secure email. Additionally, patients can access pricing tools, review their statement and pay their bill online.

Second, Geisinger discusses financial issues (including charity policies) with patients upfront and in advance of the service. An advance fee notice includes: orders on a standardized form; charges associated with the service; estimated out-of-pocket expense; a disclaimer; and time frame for which the quote is valid.

Related to this, Geisinger's online Advance Fee Notice Estimator is a compilation of their top 100+ procedures and insurer benefit information coordinated with their most common carriers. This allows the patient to obtain an estimate on a service instantly. Geisinger also offers a hotline number to assist patients in answering questions regarding fees.

Geisinger will continue to utilize and grow its technological infrastructure, analyze the advance fee notice system, critically review patient satisfaction and analyze its return on investment. ■

To listen to Health Policy Forum podcasts visit: http://jdc.jefferson.edu/hpforum/

JSPH Teams with Navy Doctor for PA Health Ride

The Jefferson School of Population Health will help welcome US Navy Lt. Cmdr. Andy Baldwin, MD, when he completes his 420-mile bike ride across Pennsylvania on Saturday, October 10, 2009 at the "Rocky Steps" of the Philadelphia Museum of Art.

Baldwin, star of 2007's *The Bachelor: An Officer and a Gentleman*, is leading the bike ride to raise awareness of the serious health risks associated with childhood obesity. Baldwin has worked closely with the US Surgeon General on "Healthy Youth for a Healthy Future," an initiative against childhood obesity.

The prevalence of obesity among children in PA is alarming. Obesity in children aged 6-11 has more than doubled in the past 20 years in PA. According to the Pennsylvania Department of Health, more than one-third of school-aged children in the state are overweight or obese.

"Studies show that overweight children risk serious health issues as adults, such as coronary disease, Type 2 diabetes, hypertension, arthritis and even cancer," said Baldwin, an eight-time Ironman Triathlon finisher and three-time USA Triathlon All-American. "As committed citizens and neighbors, we can and must serve as important role models to our children and teach them the power of healthy habits."

The Pennsylvania Health Ride and Kids Fitness Days will start in Pittsburgh on October 4th and end in Philadelphia on October 10th. Along the route, Baldwin and others will host public events for children that highlight physical fitness, healthy eating and bike safety. Riders are welcome to join the Health Ride at any point along the bike route and participate to their level of ability.

For more information on the Health Ride and how you can participate, visit: www.healthride.org. ■

School of Population Health Publications

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Jutkowitz E, Gitlin LN, **Pizzi LT,** Bunz T, Dennis MP. Cost-effectiveness of a functional program to increase quality of life in community-dwelling older adults. Poster presentation at: 19th International Association of Gerontology and Geriatrics, Paris, France, July 2009.

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Kash KM. Do group interventions work for high risk individuals? Presented at: 11th International Meeting on Psychosocial Aspects of Genetic Testing for Hereditary Cancer, Toronto, Canada, April 24, 2009.

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Yuen E. Implementing a mindfulness program for elders. Podium Presentation at: Whole Person Medicine: The Art and Science of Health, Pennsylvania Medical Humanities Conference, Hershey, PA, May 21, 2009.

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