Jefferson™ School of Population Health

Health Policy NEWSLETTER

DECEMBER 2009
Vol. 22, No. 4

GUEST EDITORIAL

Death Talk

I sat with a good friend and his 85-year-old father on the first Sunday night of regular season football. In the course of conversation, his dad asked me what I was working on these days. I mentioned that I was writing a piece in response to the "death panel" rhetoric. Only partly in jest, he quipped, "You're not in favor of them, are you?" We laughed, and I told him that neither I nor any of my colleagues in palliative and end-of-life care would ever support such a notion.

He then spoke poignantly about his wife's death nearly two years ago. From my seat on the sofa, I faced her empty easy chair, next to his, with an afghan tossed casually over the arm as though she had just gone to the kitchen to make tea. His grief was still evident, and he spoke about the emotional turmoil that he and his adult children faced when they, at her urging, agreed to discontinue life support. His son related that although his mother had a living will, just having the document in no way prepared her – or them – for the reality of end of life in the ICU. He said, "We needed the doctors and nurses to talk to us about what was happening. And so often, the message was contradictory. We didn't know what to do." At this, his father looked down and said quietly, "She was ready to go. Death really isn't the worst thing that can happen to you."

For me, this brief conversation was emblematic of our failure to support dying patients and their families to navigate uncharted waters. *They need us to communicate* – both to listen and to offer an honest appraisal of the situation. For those who are facing end of life, death is not the worst thing that can happen to a person. For many, painful, protracted dying while tethered to technology is their greatest fear.

The political wrangling over earlier provisions in House Bill 3200 regarding advance care planning was both disturbing and encouraging. Section 1233, Advance Care Planning Consultation, would have compensated practitioners for a patient consultation to explain advance care planning, use of advance directives, roles and responsibilities of surrogates, and resources available for support. Importantly, the language describes an *optional* consultation – not an obligation – and nothing is required of the patient. He or she is clearly free to use the information from the consultation to create an advance directive, gather more resources, ask about hospice and other options for end-of-life care – or not. Practitioners do this already; but not frequently or comprehensively, and, in some cases, without a great deal of skill or comfort.

That so much of the often rancorous debate has been at odds with the actual language in the bill is disturbing, yet the fact that we are talking about death *at all* in our preternaturally death-averse culture is, to my optimistic eye, a sign of progress. Without death talk, development of the now decades-old hospice option for those approaching end of life could not have taken place. Hospice perhaps remains the best kept secret in a fragmented and depersonalized health care system. Price of entry is a conversation about death – a conversation that many providers avoid until death is near, or never have at all.
Death talk, the common pathway to improved care

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for the dying, remains difficult. Communication about goals of care and illness progression is the portal through which our patients and their loved ones cannot navigate without us. Despite the inroads and experience to date, there remains much work to be done to prevent and treat physical, psychosocial and spiritual suffering experienced by those at end of life and their families. Most persons die in hospitals or, increasingly, nursing homes. Pain is often poorly treated, and patient and family wishes concerning end of life care are frequently not elicited, not recorded, or not communicated among the treating professionals.

The simple truth is that we all die. Technology in the service of patient-centered goals of quality of life and longevity is moral and admirable – sometimes downright awe-inspiring. But we cannot change the fact that people die. Our patients die. Our moms and dads die. Sometimes, poignantly and painfully, our kids die. For each person, at some point, we will not be able to change the fact of death. But we have shown – again and again – that we can profoundly affect the manner in which an individual's death is experienced and the manner in which that death is remembered by survivors. Importantly, once the inevitability of death is acknowledged, *living* becomes the focus in end-of-life care. At that point, patient and family-centered palliative and hospice care can relieve symptoms, support patient and family wishes, listen deeply to help navigate through fears, and assure that survivors will be supported through their grief. This end of life scenario cannot be realized in the absence of communication.

What is most needed to improve care of the dying is conversation. Not a single conversation, but many. Clinician discomfort discussing end of life has been well-documented,[1] and in many ways reflects our nation's cultural discomfort with the topic of death. Studies indicate that physicians are uncomfortable making projections about the course of a disease,[2] particularly in non-cancer conditions where illness progression is unpredictable.[3] Seriously ill patients want information about their illness trajectory,[4] although the timing of such information is key[5] and cultural, emotional and behavioral variations create challenges to effective communication.[6] Clinicians struggle with honest disclosure because of overestimation of survival, concerns that patients will lose hope, and lack of personal efficacy in communicating bad news. Patients and family members have varying needs and desire for information and, even when discussion has taken place, they may not recall the interaction or the content of the conversation.

Without the benefit of honest communications, families may not recognize that death is expected, leaving them without opportunity for planning, preparation, and closure. We need capable clinicians who have been taught both the art and science of communication in the context of serious illness and value its application, even under the most difficult of circumstances. We need to see advance care planning as a process that is ongoing, changing as the patient's circumstances of illness change – not completed in a single conversation and not sufficiently addressed in an advance directive document. We need to separate the policy discussion of advance care planning – that is, both a conversation that patients want *and* a right to participate in health care decisions that was codified by the 1991 Federal Patient Self-Determination Act – from the economic costs of life-prolonging intervention.

Is compensation to practitioners for advance care planning, as had been proposed in HR 3200, good policy? Perhaps. Health policy implies a consensus on issues, goals and objectives, ranking of priorities and directions for achieving those priorities. Yet policy decisions are not formulaic – they are not always made through a rational process of discussion and evaluation, the context for the decision is often highly political, and value judgments are central to decision making.[7] Good policy balances potential benefits and harms. If we focus on the patient at the center of the debate, it seems unequivocal that encouraging practitioners to talk to their patients about end of life in an optional, informational manner is good policy – high potential benefit with minimal, if any, harm – and that compensating them for what can be a time-consuming endeavor, if done well, is fair policy. ■

JoAnne Reifsnyder, PhD, ACHPN
Assistant Professor
Program Director, Chronic Care Management
Jefferson School of Population Health

To learn about a unique End of Life Decision Making study at Jefferson, refer to page 3.

REFERENCES

1. Curtis JR. Communicating about end-of life care with patients and families in the intensive care unit. *Crit Care Clin.* 2004; 20(3): 363-380.
2. Christakis NA, Iwashyna TJ. Attitude and self-reported practice regarding prognostication in a national sample of interests. *Arch Int Med.* 1998; 21: 2389-95.
3. Lamont EB, Christakis NA. Complexities in prognostication in advanced cancer: "To help them live their lives they way they want to." *JAMA.* 2003; 290(1);98-104.
4. Parker SM, Clayton JM, Hancock K, Walder S, Butow PN, Carrick S, Currow D, Ghersi D, Glare P, Hagerty R, Tatterall MSN. A systematic review of prognostic/end-of-life communication with adults in the advanced stages of a life-limiting illness: patient/caregiver preferences for the content, style and timing of information. *J Pain and Symptom Manage.* 2007; 34(1):81-93.
5. Fried TR, Bradley EH, O'Leary J. Prognosis communication in serious illness: Perceptions of older patients. *J Am Geriatr Soc.* 2003; 51(10):1398-1403.
6. Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. *Hematology.* 2002; 1: 464-483.
7. Collins T. Health policy analysis: A simple tool for policy makers. *Public Health* 2005; 119:192-196.

Letter to the Editor

Reader Speaks Out on Taxes and Health Insurance

The article "The Case for Taxing Employer-Sponsored Health Insurance" (*Health Policy Newsletter* September 2009) raises my hackles. It essentially is arguing for a socialized economic system. That is not what this country is based on. The observation that the tax subsidy is "inequitable" for employer provided care ignores the reality that the higher tax break is given to those PAYING MORE TAXES. Further, employer implementation of health care plans is not identical. Some offer more comprehensive plans, others much less so. The company underwriting of plans varies greatly. Given that this structure is the basis of health insurance in the US (with, according to the article 60% of Americans covered this way) why in the world would we look to damage it!? I most fundamentally disagree.

The solutions to the uninsured and Medicare/Medicaid population issues should not be sought by putting the current system at risk! There is no doubt that the wage earning/tax paying population of the US will foot the bill as they do now one way or another. Let us not do damage in the name of solving the parts which require attention. ■

John A. Monnier
Director of Business Services
The Commonwealth Medical College
Scranton, PA

End of Life Decision Making

Palliative care is defined by the World Health Organization as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[1]

Over the past decade there has been significant growth in palliative care in the United States. In 2000, there were 600 palliative care hospital-based consultation programs; in 2005, the number rose to 1200 programs.[2] Among hospitals with over 250 beds, 70% have an in-patient palliative care consultation service.[2]

One of the key components of palliative care is to assist in improving the quality of communication and end-of-life decision making between healthcare teams and patients and their families. A growing body of research has studied the end-of-life decision making process. One such study was completed here at Jefferson by an inter-professional team of physicians, nurses, and researchers from various departments including Family and Community Medicine, the Center for Applied Research on Aging and Health (CARAH), the School of Nursing and Department of Medical Oncology. This team, with its diverse background and experience, brought a unique perspective to the complex issue of end-of-life decision making.

This two-year study, sponsored by the National Institutes of Health and the National Institute of Nursing Research (NIH/NINR),[3] examined end-of-life decision making using hypothetical illness scenarios among older people and their proxy decision makers. Two hundred two elder-proxy dyads (404 subjects) were recruited from community settings including senior centers, continuing care retirement communities, and primary care practices. Inclusion criteria for the elders were: age over 70, English-speaking, and cognition intact. The proxy criteria were: age 21 and over, English-speaking and cognitively intact. Each subject in the dyad was interviewed separately, with the elder being interviewed first. The elder named the person they would want to make decisions on their behalf if they could not and that person was considered the proxy. There did not need to be any legal designation of the proxy, such as a power of attorney document. Both subjects completed a 40-minute telephone interview including: demographics, history of advance directive completion, depression screening, telephone Mini-Mental State Exam (MMSE), an end-of-life values scale, a religiosity scale, and a modified life support preferences questionnaire.

The study team first completed an analysis of end-of-life decisions regarding only one scenario presented to the elder-proxy dyads.[4] This scenario involved advanced Alzheimer's disease. The study team was interested in this sub-analysis around dementia since it is often wrongly not perceived, either by healthcare teams or patients and their families, as a life-threatening condition. We asked both the older person and their proxy about the use of three treatment options: cardiopulmonary resuscitation (CPR), feeding tubes, and palliative care.

The elders were 74% female with a mean age of 77. The proxies were 72% female and a mean age of 60. This analysis revealed interesting preferences for end-of-life care for the hypothetical illness scenario of advanced Alzheimer's disease. Among the elders, 33.8% selected CPR, 21.3% selected tube feeding, yet 79.1% chose palliative care. Interestingly, among the proxy decision makers, 49.8% selected CPR, 43.1% selected tube feeding and 68.7% chose palliative care. Thus, the highest degree of concordance for this illness scenario was with the preference for palliative care.

These findings have interesting clinical and research implications. If the highest degree of concordance among our dyads was for palliative care within an Alzheimer's disease scenario, how would concordance between older patients and their proxies be for other diseases more traditionally viewed as terminal illnesses? This preliminary analysis points our research team toward exploring interventions that provided palliative care treatment options earlier in the course of illness and assisted families with end-of-life decision making. Additional findings from this larger grant will guide our team towards developing interventions to help enhance the end of life decision making process. ■

Susan Parks, MD
Associate Professor
Director, Geriatric Fellowship Program
Co-Medical Director, Palliative Care Consult Service
Department of Family and Community Medicine
Jefferson Medical College

REFERENCES

1. World Health Organization. Palliative Care. http://www.who.int/cancer/palliative/en/. Accessed October 10, 2009.
2. American Hospital Association. AHA Hospital Statistics. Chicago, IL: American Hospital Association; 2007.
3. Study sponsored by NIH/NINR "End of Life Decisions: Differences in Patient and Proxy Treatment Preferences." R21NR010263-02.
4. Parks SM, Winter L, Diamond J, Santana A, Rose M, Myers R, Parker B. Decision making by older patients and their proxies. *J Am Geriatric Soc*. 2008; 56(s1):39. http://www3.interscience.wiley.com/cgi-bin/fulltext/119387161/PDFSTART. Accessed November 20, 2009.

Jefferson InterProfessional Education Center presents:
Interprofessional Care for the 21st Century: Redefining Education and Practice
March 12-13, 2010
For more information visit: jeffline.jefferson.edu/jcipe/2010Conference/

Developing the Connection Between Law and Public Health

Two years ago, Widener University School of Law and Thomas Jefferson University entered into an agreement to establish two joint programs in law and public health: Juris Doctor/Master of Public Health (JD/MPH) and Master of Jurisprudence/Master of Public Health (MJ/MPH). These programs are designed to provide the knowledge and skills required to thrive in health law practice, and public health advocacy and policy. Over the course of four years (for full-time students), candidates for these degrees will learn about the ways in which these two disciplines complement each other to prepare them for careers in health law and public health law and policy.

The Jefferson MPH program, accredited through the Council on Education for Public Health (CEPH), emphasizes competencies including behavioral and social sciences; biostatistics; epidemiology; environmental health; health policy; management and advocacy. The Widener program focuses on core law and health law courses. A capstone project and clerkship offers students the opportunity to apply their knowledge and gain additional health law or health policy experience.

The program is a natural outgrowth of the increasing recognition that the two fields have much to offer each other, and that the successful public health lawyer or policy-maker will gain a substantial advantage from acquiring knowledge in these two related disciplines. Both degree programs support and benefit population health, healthcare and legal professionals, including nurses and policy makers, nursing home administrators, paralegals, government employees, and private-practice lawyers and litigators.

From my vantage point as a law professor specializing in public health law, I'd like to offer a few brief observations about how I see the potential of law to improve public health outcomes, and to suggest a few (by no means exhaustive) career paths that the dual-trained graduate might pursue. Both law and public health are problem-solving disciplines. The public health practitioner uses population-based data to identify problems, and then relies on public health tools such as education and targeted intervention to solve them. But such solutions often have a vital legal component, and the public health practitioner or advocate with legal training has a substantial advantage in understanding how the legal system – whether through legislation, regulation, or litigation – can create positive public health outcomes.

One example of this union of disciplines is related to vaccination programs and its policies. How should the legal system ensure that the population is protected – the public health goal – while recognizing and respecting that some people have sincerely held moral or religious objections to vaccination? How might this apply to H1N1? The states, to varying degrees, allow people to opt out of immunization. Almost all states permit religious exemptions, while a substantial minority also allow opt-outs based on strong moral convictions. How does this law affect standard public health policy and practice?

Serving in an important policy-making capacity, the legally trained public health practitioner can bring an understanding of the law's requirements (and its limits) on deciding this type of issue. It might be, for example, that a "tweak" to the law that would require hearing-based evidence of a sincere religious or philosophical belief against vaccination would limit the exemption's reach while continuing to respect the personal autonomy so valued by the law.

In addition to becoming well-qualified to assume leadership roles in public sector policy matters, graduates might also be drawn to regulatory or compliance positions within the pharmaceutical industry (perhaps as in-house counsel armed with epidemiological and biostatistical knowledge that few other attorneys would grasp), to health care institutions (where the insights of public health and law might be usefully combined to address emerging issues such as inefficiencies and how to combat them), to the insurance industry and health care consulting, to positions at not-for-profit institutions that seek to improve public health outcomes.

Students in the joint programs are already beginning to see and work with these synergies. For example, one student has taken her public health training from Jefferson back to Widener, where she will put her knowledge of the two disciplines together in creating a legal needs assessment for a targeted geriatric medical patient population – one of the most poorly understood groups. Taken a step further, this student's multidisciplinary education will be an asset in Widener's newly launched medical-legal partnership clinic where students will help to design legal strategies and remedies for the underserved population of Chester, PA.

The rich background that these joint programs provide can open up diverse career choices for our graduates as the program develops. The Director of the MPH Program at Jefferson, Dr. Rob Simmons and I are excited about the ever-expanding potential of our joint public health law programs. ■

John G. Culhane, JD
Professor of Law and Director of the Health Law Institute
Widener University School of Law

For more information about joint programs in Law and Public Health visit: www.jefferson.edu/population_health and www.law.widener.edu.

The American Public Health Association 137th Annual Meeting

Philadelphia, Nov. 8-11, 2009

Over 10,000 public health professionals came to Philadelphia in November 2009 for the 137th annual meeting of the American Public Health Association (APHA). The theme of the conference was water and public health. Key national health issues of the H1N1 virus and health reform were also featured through presentations and forums and, as expected, generated much discussion and debate.

Thomas Jefferson University (TJU) was well represented; over 30 professional presentations were made by TJU faculty, staff, students, and alumni at the meeting. The program featured a special 90-minute session on quality and public health developed by the Jefferson School of Population Health (JSPH), moderated by Dr. Susan DesHarnais, Program Director for the MS in Quality & Safety, and featuring JSPH Dean David Nash.

JSPH's booth in the APHA Expo highlighted the new school, its current programs, and its future plans for additional master's degrees and a doctoral degree in Population Health Science. The new JSPH exhibit, with its description of Population Health, received hundreds of visitors during the three-day meeting. ■

JSPH Contributions to the American Public Health Association (APHA)

137th Annual Meeting - Philadelphia, PA

Nov. 8-11, 2009

Sunday, Nov 8th

Cultural and Linguistic Issues in Developing Adaptation of the Geriatric Depression Scale for Laotian Elderly
Jin Hui Joo, MD, MA
Elaine J. Yuen, PhD
Ethan T. Nguyen, BA
Yuko Sakata
Shong Chai Hang
Somsanith Phommachanh

Banning Game-Time Drinking: An Analysis of Pre-Hospital Emergencies at a Large NCAA Division 1 Football Stadium
Patrick T. Gomella, MPH, NREMT-P
James J. Diamond, PhD
Kathryn M. Kash, PhD

Monday, Nov 9th

Quality Improvement in Health Care as a Population Health Priority
Susan DesHarnais, MPH, PhD
David B. Nash, MD, MBA
Dwight N. McNeill, PhD, MPH
Shelley B. Hirshberg, MA

Yoga Use Among Breast Cancer Patients: Exploring Racial Disparity
Krupali Desai, MD (Ayu), MPH
Chanita Hughes-Halbert, PhD
Elaine J. Yuen, PhD
Mary Lou Galantino, PT, PhD, MSCE
Sharon Xie, PhD
Jun J. Mao, MD, MSCE

Community Connectedness and Depressive Symptoms Among Older Vietnamese Immigrants
Elaine J. Yuen, PhD
Giang T. Nguyen, MD, MPH, MSCE
Jin Hui Joo, MD, MA
Ethan T. Nguyen
Yuko Sakata
Sophia Kwon, MPH(c)

What Does It Mean to be Southeast Asian? Disentangling the Labels of Language, Ethnicity and Country of Birth
Giang T. Nguyen, MD, MPH, MSCE
Elaine J. Yuen, PhD
Leah Hsu, MPH
Thoai Nguyen
Kao Kue

Health Literacy Education and Communication in the Philadelphia Immigrant Community
Anna M. Quinn, MPH Student
Maura A. Murphy, MPH Student
Katie E. Thomas, MPH Student

Teaching Cultural Humility and Competence: Lessons From Developing and Teaching a Multi-disciplinary Hybrid Online Course for Public Health and Health Professions Students
Nancy L. Chernett, MPH
Susan Toth-Cohen, PhD, OTR/L
Rob Simmons, DrPH, MPH, CHES
Elaine J. Yuen, PhD

A Survey of Physician Knowledge and Attitudes Regarding Climate Change and Health
Mona Sarfaty, MD, FAAFP
Safiya Abouzaid, PharmD
Elaine J. Yuen, PhD
Erica Frank, MD, MPH

Influenza Prevention and Control in Long-Term Care Facilities
Adam Lynch
Patrina Ross, RN,
Esther Chernak, MD, MPH
Ami S. Patel, PhD, MPH

Public Health Implications of Economic Recession
Jessica M. Robbins, PhD

The Health Home: Origins and Current Developments
Moderator: Amos S. Deinard, MD, MPH
Oscar Arevalo, DDS, ScD, MBA, MS
L. Beth Dixon, PhD MPH
Mona Sarfaty, MD, FAAFP
Beth Lamanna, WHNP, MPH, RN
Jeanne A. Saunders, PhD
Rani A. Desai, PhD, MPH

Tuesday, Nov 10th

Predicting Cancer Patients' Risk of Potentially Avoidable Hospitalization
Daniel Z. Louis, MS
Diane M. Richardson, PhD, MS
Mary R. Robeson, MS
Vittorio Maio, PharmD, MS, MSPH
Lucia Nobilio , Agenzia Sanitaria e Sociale Regionale, Bologna, Italy
Roberto Grilli, MD, Agenzia Sanitaria e Sociale Regionale, Bologna, Italy

Predicting Risk of Hospitalization in Patients with Chronic Conditions in the Regione Emilia-Romagna, Italy
Diane M. Richardson, PhD, MS
Daniel Z. Louis, MS
Mary R. Robeson, MS
Vittorio Maio, PharmD, MS, MSPH
Lucia Nobilio, Agenzia Sanitaria e Sociale Regionale, Bologna, Italy
Roberto Grilli, MD, Agenzia Sanitaria e Sociale Regionale, Bologna, Italy

Mindfulness Meditation for Elders: Preliminary Results from an MBSR Program
Elaine J. Yuen, PhD
Diane Reibel, PhD
George Heckert

Colon Cancer as an Ambulatory Care Sensitive Condition
Elaine J. Yuen, PhD
Mona Sarfaty, MD, FAAFP

Engaging Youth in a Community-based Participatory Assessment Process to Elicit Community Attitudes, Behaviors and Preferences Related to Access to Healthy Food and Safe Places for Physical Activity
Rickie O. Brawer, PhD, MPH
Abbie Santana, MSPH
Shirley Randelman, BS
Melissa DiCarlo, MPH
Sheena Ahlawat, BS MPH Student
Vanessa Briggs, MBA, RD, LDN

Wednesday, Nov 11th

Initiation of Breastfeeding in an Inner-City Patient Population: Cross-sectional Study
Jessica M. Robbins, PhD
Brian R. Torcato, MD
Deepam Thomas, BAMS, MSPH Student
Susan W. Robbins, MD, MPH
Louise M. Lisi, MD, MPH

Jefferson Implements Interprofessional Education Program

This is the first article in an ongoing series focusing on Jefferson's Interprofessional Education (JCIPE) activities.

Interprofessional approaches to practice have been suggested as a way to address the complexity and risks associated with chronic conditions related to the aging population in the United States. Interprofessional education (IPE) is fast becoming an accepted way to prepare future health professionals to successfully collaborate as members of health care teams. The most current definition driving programs of IPE is, "what occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care."[1]

In response to this need for new models of care and education, Thomas Jefferson University implemented the Jefferson InterProfessional Education Center (JCIPE) in 2007 with the mission, "To promote excellence in health through interprofessional education and scholarship." The Center is a collaborative effort, reporting to the Senior Vice President for Academic Affairs, with co-directors from medicine and nursing. Representatives from University administration, faculty from all schools, departments, and research and clinical simulation units, and students participate. The Center has developed a comprehensive approach, consisting of interprofessional preclinical/didactic education, clinical simulation and clinical education within team-care settings in a variety of venues including Thomas Jefferson University Hospitals.
JCIPE has been engaged in a variety of student curricula activities. Two teaching videos on hospital and home care interprofessional practice were planned and produced by Jefferson faculty from medicine, nursing, pharmacy, occupational therapy, physical therapy, radiological science, couple and family therapy, and bioscience technology. Health professionals and students identified the need for information about the roles and education of other health professions. In response, JCIPE developed posters/handouts regarding selected health professions accompanied by video descriptions by the Dean or Chair of the Jefferson program. These resources are available for use as teaching resources and can be accessed by anyone from JCIPE's website (http://jeffline.jefferson.edu/jcipe). Other projects of interest, initiated in collaboration with the Eastern Pennsylvania and Delaware Geriatric Education Center(EPaD), include: interprofessional geriatric care web-based self-study modules; Objective Structured Clinical Exam (OSCE) focused on clinical skills for an interprofessional discharge planning team; and an interprofessional falls assessment clinic.

JCIPE held its first IPE conference in October 2008 to share the activities of the Center with the larger University community. A second, more regional conference is being planned for March 12 and 13, 2010. Members of JCIPE facilitated two Jefferson interprofessional faculty groups to participate in the Association of Prevention, Teaching and Research seminar and projects. As part of a faculty development initiative, JCIPE conducted a Mini Grant Program and funded three interprofessional projects during the past academic year. Projects included orientation of health professionals working with immigrant/refugees, expansion of interdisciplinary care course, and cultural competency training for medical residents and nurse practitioners. Ongoing interprofessional education research and scholarly seminars on evaluation and faculty networking are currently in progress or development. Finally, the EPaD Geriatric Education Center, with JCIPE participation, recently implemented an interprofessional fellowship program.

Future plans by members of the JCIPE community are: continued refinement of the existing curricula; increasing the number of IPE programs; continued focus on evaluation of all programs; development of a model to assess patient outcomes related to IPE; and finally, to assess the long-term impact on patient care and practice choices by Jefferson graduates. ■

Kevin J. Lyons, PhD
Assistant Vice President for Program Evaluation and Student Faculty Surveys and Director, Center for Collaborative Research
Thomas Jefferson University

Christine Arenson, MD
Co-Director, Jefferson InterProfessional Education Center

Molly Rose, PhD, RN
Co-Director, Jefferson InterProfessional Education Center

Carolyn Giordano, MS
Senior Research Analyst, Center for Collaborative Research
Thomas Jefferson University

REFERENCES

1. Canadian Interprofessional Health Collaborative. Interprofessional education and core competencies: Literature review. 2007. http://www.cihc.ca/files/publications/CIHC_IPE-LitReview_May07.pdf. Accessed September 21, 2009.

Building a Coordinated Care Model for Diabetes Management

October 21, 2009

A significant public health issue with serious medical complications and substantial financial implications, diabetes is the quintessential "poster child" among chronic conditions. The complex nature of the condition presents challenges for patients and their physicians – challenges that are not amenable to single solutions or straightforward treatments. Emerging patient-centered, outcomes-driven, coordinated care models provide the framework for improved clinical quality and cost effective diabetes management.

On October 21, 2009, the Jefferson School of Population Health convened a one-day policy forum moderated by David B. Nash, Dean of the School. The forum focused on care coordination as an effective model for managing care and improving health outcomes for patients with

diabetes. Various organizations, programs, and initiatives that demonstrate quality and coordinated care were featured, and perspectives of key stakeholders (e.g., clinicians, administrators, policy experts) were discussed.

Keynote speaker Tom Valuck, MD, JD, Senior VP, Strategic Partners, National Quality Forum, pointed out that care coordination is critical to achieving each of the National Quality Forum's six National Priorities. He described an ongoing shift in orientation from provider-focused to longitudinal, patient-focused episodes of care and associated measures to monitor patient level outcomes, processes of care, and cost/resource use.

Richard Baron, MD, of Greenhouse Internists, PC, discussed the promise and pitfalls of implementing the Patient Centered Medical Home (PCMH). Although a Commonwealth Fund study found practices doing well with existing resources, the lack of reimbursement for efforts associated with positive change continues to be an issue for many. Edwina Rogers, Executive Director of the Patient-Centered Primary Care Collaborative (PCPCC) described the work of PCPCC, a broad based coalition (i.e., providers, purchasers, payers, and patients) dedicated to advancing the PCMH model, gathering information, and publishing guides on model types and effectiveness. To date, 27 multi-stakeholder PCMH pilots have been rolled out in 18 states. In addition, 8 State Medicare pilots are in the planning stages, and 44 states and the District of Columbia have either passed PCMH related legislation or engaged in PCMH activity.

Cyndy Nayer, MA, President and CEO, Center for Health Value Innovation observed that population health and the economy are intrinsically linked. The Center has published *Leveraging Health*, a book describing "levers and dividends" in value based design. It identifies 107 levers that cause change in consumer behavior.

John Miller, Executive Director, MidAtlantic Business Group on Health, discussed coordinated care from an employer/purchaser perspective, noting that the root of all discussion is return on investment. Attention to health care costs has shifted perceptibly from benefits administrators to CFOs, and value based purchasing has come to the forefront. A health plan assessment tool (eValue8) has been implemented to articulate employer expectations.

Carey Vinson, MD, VP for Quality and Medical Performance Management, Highmark, Inc. described Pennsylvania's Chronic Care Initiative and shared some early results. An important new parameter gauges the degree to which patients are involved in their care. There is some evidence that patients are beginning to take responsibility for their conditions.

The forum ended with expert panelists Carey Vinson, MD, Andrea Silvey, PhD, MSN, and Samuel Lin, MD, PhD, MBA, MPA, MS responding to questions. ■

Program materials and a video recording for this forum can be accessed at:
http://jdc.jefferson.edu/jsph_diabetes_management/2009/

Cultural Competency: A Growing Need to Better Serve Our Diverse Populations

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."
Rev. Martin Luther King, Jr., Chicago, March 25, 1966

Despite 40 years of social and environmental change that drove health improvements in the US, as we monitor key public health outcomes – infant and maternal mortality, teenage pregnancy, underinsurance and poor access to health care, and the increased prevalence of chronic disease – we see that health disparities and inequities continue to plague our nation. This contributes to our low ranking globally on many key health status indicators.

As the US healthcare system works to confront the disproportionate burden of chronic illness and improve access to quality health care, it is also coping with significant demographic and social changes that have greatly expanded the cultural diversity of the US population. Many factors have influenced the growth of our multi-cultural society, including immigration from Latin America, Africa and Asia, changing sexual norms, and population aging.[1] As a result, healthcare professionals are increasingly serving people with limited English proficiency (LEP) and those whose health beliefs differ from traditional Western culture.[1] This emerging multi-cultural environment can pose significant challenges to providing high quality, effective health services.

Cultural and linguistic competence must be infused in all sectors of healthcare training if we are to attain the Healthy People 2020 goals of achieving health equity and access to all groups.[2] Cultural competency refers to the health professional's ability to work effectively with individuals and communities from different cultural and ethnic backgrounds.[1] It has been described as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency or profession, enabling it to work effectively in cross-cultural situations".[1,3] Cultural competency also includes an awareness of one's own cultural influences, personal biases and prejudices.
"The acquisition of cultural competency is a process that requires humility, self-reflection and development of sensitivity and acceptance of individual differences to enhance communication between patients, providers, and community members."[4]

An increasing number of health professions have recognized the importance of cultural competency and have created specific educational programs for their constituents.[5] These programs include online educational tools for physicians; resources for practicing and academic nurses; standards for culturally relevant assessments; intervention tools for occupational therapists; and public health cultural competency guidelines for graduate education and professional practice.[6-9] The US Department of Health and Human Services

Continued on page 8

Office of Minority Health developed a set of recommended standards on culturally and linguistically appropriate services (CLAS) for health care organizations that have been used extensively for much of the decade.[10]

In 2007 and 2008, an interprofessional team of TJU faculty developed a pilot course entitled "Cultural Humility and Competence in Health Professions and Population Health."* The course was designed to provide students with an in-depth understanding of cultural diversity, health disparities and cultural competence; and facilitate students' ongoing development and application of cultural competence skills. Overarching topics included **diversity and health disparities,** which addressed unique stressors experienced by racial /ethnic minorities and other socio-economically disadvantaged groups, and their impact on public health and health outcomes; **students' self-reflection** on personal values, beliefs and behaviors; and **applications to practice,** which examined standards of culturally competent care, culturally sensitive health communication and health literacy, access to care, and patient-provider partnerships.

The course has been designed as an online course with three in-person Saturday sessions accessible to students across disciplines, schools and colleges. Ten graduate students, representing the health disciplines of Occupational Therapy, Public Health, and Physical Therapy completed the initial course during the fall 2008 semester. Students reported that the course added to their knowledge of cultural diversity and provided critical thinking and cross-disciplinary skills. Students also valued the opportunity to develop their own personal and organizational cultural competence plans. The course has been offered for the second time in the fall of 2009 with 13 students representing the disciplines of public health, occupational therapy, and medicine. Sessions were offered in person and online. The results of these two pilot courses will be shared throughout TJU. Ultimately, we hope to expand the course and integrate cultural humility and competence concepts and learning tools into the range of programs at Thomas Jefferson University.

Health and human service professions have clearly recognized the increasingly diverse populations we serve and have developed an expanding array of evidence-based cultural competency tools and resources for professional education. This next decade will provide evidence of whether these innovations in professional development lead to improvements in practice that affect the quality of care to individuals and the populations we serve. ■

Rob Simmons, DrPH, MPH, CHES, CPH
Associate Professor
MPH Program Director
Jefferson School of Population Health

Nancy L. Chernett, MPH
Project Director, Jefferson Center for Applied Research on Aging and Health (CARAH)
Research Instructor, Department of Occupational Therapy,
Jefferson School of Health Professions

Elaine Yuen, PhD
Associate Professor,
Jefferson School of Population Health

Susan Toth-Cohen, PhD, OTR/L
Associate Professor and Director, Occupational Therapy Doctoral Program,
Department of Occupational Therapy,
Jefferson School of Health Professions

REFERENCES

1. Carter-Pakras O, DeLisser H. Introduction: The Importance of Cultural Competency. In in Hark LA, DeLisser HM, eds. *Achieving Cultural Competency: A Case-Based Approach to Training Health Professionals*. Wiley Blackwell; 2009: xxi-xxxi.
2. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I Report. Healthy People. October 28, 2008. http://www.healthypeople.gov/hp2020/advisory/PhaseI/PhaseI.pdf. Accessed July 24, 2009.
3. Cross T, Bazron B, Dennis K, Issacs M. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed: Volume I*. Washington, DC: Georgetown University Child Development Center CASSP Technical Center;1998.
4. Tervalon M, Murray-Carcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Healthcare for the Poor & Underserved*. 1988; (9):117-125.
5. National Center for Cultural Competence Curricula Module Enhancement Series. Georgetown Center for Human and Child Development Web site. http://www.nccccurricula.info/. Accessed July 24, 2009.
6. Tool for Assessing Cultural Competence Training (TACCT). AAMC Web site. http://www.aamc.org/meded/tacct/start.htm. Accessed, July 2, 2009.
7. Giger J, Davidhizor R, Purnell L, Hardin JT, et al. American Academy of Nursing Expert Panel Report: Developing cultural competency to eliminate health disparities in ethnic minorities and other vulnerable populations. *J of Transcultural Nursing*. 2007; 18 (2): 95-102.
8. Accreditation Council for Occupational Therapy Education (ACOTE) Standards and Interpretative Guidelines. Rockville, MD., http://www.aota.org/Educate/Accredit/StandardsReview/guide/42369.aspx. April 2009:24-27.Accessed July 2, 2009.
9. Council on Linkages: Core Competencies for Public Health Professionals. Public Health Foundation Web site. www.phf.org/link/core-061109.htm. June 11, 2009. Accessed July 24, 2009.
10. US Department of Health and Human Services, Office of Minority Health. National Standard for Culturally and Linguistically Appropriate Services in Health Care. Final Report. http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf. March 2001. Accessed July 24, 2009.

* Course development was supported in part by "In Touch: Mind, Body & Spirit" (NIMH# R24 MH074779, LN Gitlin, PhD, principal investigator) Jefferson Center for Applied Research on Aging and Health, Jefferson School of Health Professions)

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JSPH Hosts *Healthy People 2020* Meeting

November 7, 2009

Since 1979, the US Department of Health and Human Services (HHS), Office of Health Promotion and Disease Prevention, has developed national preventive health goals and objectives for each decade. Known as *Healthy People*, these goals and objectives have been used as guides for health programs and policies as well as serving as benchmarks to assess overall health, risk factors, preventive health services, and public and private health systems to support the overall health of our nation.

Healthy People 2020 (HP 2020) is being developed. The framework for HP 2020 uses an ecological model including individual behavior, social, family, and community networks, living and working conditions, and broad social, economic, cultural, health and environmental conditions. It also incorporates determinants of health, program and policy interventions, outcomes, and assessment, monitoring, evaluation, and dissemination of preventive health and health promotion initiatives. The four overarching goals for Healthy People 2020 are:

- Elimination of preventable disease, disability, injury, and premature death
- Achievement of health equity, elimination of disparities, and improvement in the health of all groups
- Creation of social and physical environments that promote good health for all
- Promotion of healthy development and healthy behaviors across every stage of life

On November 7, 2009, the second of three national HP 2020 meetings was held on the Jefferson campus. Approximately 250 health professionals attended the meeting, which was hosted by Dalton Paxman, Regional Health Administrator for HHS Region III. JSPH Dean David B. Nash, MD, MBA welcomed attendees to Jefferson and linked the graduate education, research, and professional development work of the School to the nation's prevention agenda.

Highlights of the meeting included a presentation by Karyl T. Rattay, Director of Delaware's Division of Public Health, who discussed state initiatives from the past decade. The program also included a panel moderated by Michelle Davis, Deputy Regional Health Administrator for Region III. Panelists included: Shiriki Kumanyika, Vice Chair of the Secretary's Advisory Committee on HP 2020; Rear Admiral Penelope Slade-Sawyer, Deputy Assistant Secretary for Health; Carter Blakey, Senior Advisor for the Office of Disease Prevention and Health Promotion, HHS; and Richard Klein, Chief, Health Promotion Statistics Branch, National Center for Health Statistics, Centers for Disease Control and Prevention. A broadcast message was provided by HHS Assistant Secretary Dr. Howard Koh.

The meeting was enriched by the oral public comment segment from over 50 members of the audience. The comments addressed a diverse range of health issues presented by service providers, advocates, administrators, and researchers.

JSPH was pleased to host this important national health meeting and encourages students and health care professionals to read the HP 2020 objectives and submit public comments by visiting: http://healthypeople.gov/hp2020/Comments/default.asp. ■

JSPH Faculty Discusses Health Care in Italy

Vittorio Maio, PharmD, MSPH, associate professor at the Jefferson School of Population Health, was a guest on Kathleen Dunn's radio program on Wisconsin Public Radio on October 22, 2009. Maio, a native of Italy, was interviewed over the phone by Dunn for a live broadcast about the health care system in Italy. A report by the World Health Organization ranked Italy second in the world in health care system performance, while the United States is ranked 37th.

During the hour-long program, Maio discussed the evolution of the Italian health care system, its differences from American health care, his personal experiences with health care in Italy, and how the Italian system is funded. Maio also fielded questions from listeners.

"In Italy the concept of solidarity, the concept of sharing wealth, the concept of having general benefits coming from the development of society, is embedded in our culture," Maio, who joined the Jefferson Medical College faculty in 2004, explained. "That was what the Fathers wanted to emphasize in the Constitution."

Explaining that Italy is a very young democracy in relation to the US, Maio noted that the developers of the Italian Constitution chose to make universal health care one of the document's components, choosing a social insurance model similar to those in Germany, France and Switzerland.

Health care coverage for the whole population is a key characteristic of the Italian health care system. Mandatory health insurance was established in 1943. This system was replaced in 1978 by the institution of the Italian National Health Service (NHS). Similar to the British model, the Italian NHS provides single payer universal health care coverage throughout the Italian State.

In Italy, Maio explained, "health is a value for the country. I never thought not to have health care coverage in all my life in Italy. It's embedded in our culture, so the government will protect us toward any type of illness or any type of problem related to health." ■

To listen to this broadcast visit: http://www.wpr.org/regions/mke/healthcare.cfm.

Health Policy Forums

Innovative Approaches to Medical Education

Brownell Anderson, MEd
Senior Director, Educational Affairs
Association of American Medical Colleges

September 9, 2009

The fall season of Health Policy Forums opened up with a presentation by M. Brownell (Brownie) Anderson, the Senior Director for Educational Affairs at the Association of American Medical Colleges (AAMC). Ms. Anderson is responsible for curriculum and evaluation of medical student education programs throughout the US.

Ms. Anderson provided context to the topic by sharing a brief overview of the history of medical education in the US. Noting the 100th anniversary of the Flexner Report, Ms. Anderson described its remarkable influence and the subsequent theoretical and didactic changes in medical education practices. Flexner advocated a need for organizational change, shifting toward a more vigorous university model. One significant result of this report was the introduction of the notion of an admissions policy. Though he wrote his report for a single generation, Flexner's influence has served as the foundation for medical education for generations.

Ms. Anderson described changes in curriculum over the past 30 years. Today there is a shift toward a hybrid of problem/clinical case, systems, outcomes and competency-based education. Ms. Anderson discussed the emphasis on competency-based education and assessment. "Competency is the habitual and judicious use of communication, knowledge, skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served."[1]

She presented the Howard Hughes Medical Institute (HHMI)/AAMC report of the "Scientific Foundations for Future Physicians" and noted that competencies promote a shift away from required courses; competencies are measured through accomplishments. Schools are fostering interprofessional education and learning as well. Competencies will be updated on a regular basis.

Current popular topics and themes in medical education include global health, cultural competency, and business education. Due to considerable interest in global health, AAMC, in partnership with the Foundation for Advancement of International Medical Education and Research (FAIMER) of the Educational Commission for Foreign Medical Graduates (ECFMG), has created a website for students and faculty that identifies opportunities for international exchanges. The URL is: http://www.faimer.org/resources/opportunities/

Ms. Anderson predicted that globalization, competencies, and interprofessional education will continue to be key themes in policy and medical education for the foreseeable future. ■

For more information on AAMC, visit: www.aamc.org

REFERENCES

1. Epstein RM, Hundert EM. Defining and assessing professional competency. *JAMA.* 2002;287:226-235.

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

Donald Schwarz, MD, MPH
Deputy Mayor for Health and Opportunity
and Health Commissioner, City of Philadelphia

October 14, 2009

Dr. Schwarz, Deputy Mayor for Health and Opportunity and Health Commissioner for the City of Philadelphia, took time out of his demanding schedule to speak at the Health Policy Forum in October. Throughout his career, Dr. Schwarz has been a strong advocate in the public health arena as a clinician, researcher, administrator, and educator. Prior to his role in government, he was he was Vice Chairman of the Department of Pediatrics of the University of Pennsylvania School of Medicine, Deputy Physician-in-Chief and Craig-Dalsimer Division Chief for Adolescent Medicine at The Children's Hospital of Philadelphia, and Professor of Pediatrics in the University of Pennsylvania Schools of Medicine and Nursing at The Children's Hospital of Philadelphia.

Dr. Schwarz, within his first few sentences, emphasized education as the key to health of Philadelphians and the overall success of the city. Throughout his presentation he revealed the striking disparities in our city and the interplay between health and economics. He described the deeply profound educational deficits that exist, placing children and youth at risk for myriad economic and health consequences. He stated, "Education is central to the mission of public heath."

Using census data, Dr. Schwarz offered a historical overview of how Philadelphia and its neighborhoods have transformed by examining many factors such as: workforce/loss of manufacturing jobs; poverty rates; shifts in populations; immigration; mortality; infant

Continued on page 12

mortality and low birth weight; educational attainment and reading proficiency. He compared some of these issues to other larger cities and to national averages. Of particular concern are the following indicators:

- 35% of children in Philadelphia live in poverty
- 30% of children in Philadelphia are functionally illiterate in the 3rd grade – a serious predictor of future health
- A decline in the number of health care-related social assistance jobs. Health care has preserved core medical functions, but not support positions.
- Of the top 10 cities with the highest poverty rates, Philadelphia is substantially poorer
- 30% of adults in Philadelphia are obese
- HIV/AIDS rates in Philadelphia continue to remain higher than the national average, particularly among African Americans. Late identification and treatment among African American men is an enormous problem with devastating consequences.

Though these issues may sound bleak, Dr. Schwarz explains that many highly successful programs exist in Philadelphia including: early childhood immunization; lead poisoning prevention; and Chlamydia screening and treatment programs.

The focus of the future in Philadelphia, as explained by Dr. Schwarz, is in a few key areas such as expanding employment opportunities; investing in children and families; and shifting to population-based preventive primary care services.

Dr. Schwarz challenged the audience to think of public health in the broadest terms, and to partner with other universities and organizations to write proposals and work along side the health department to create programs that emphasize cost-effective best practices.

For more information on Philadelphia Department of Public Health programs and services visit: http://www.phila.gov/health/index.html. ■

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

Jeffrey Brenner, MD
Medical Director, Camden Coalition of Healthcare Providers

November 11, 2009

Returning for his second appearance at a JSPH Health Policy Forum, Jeffrey Brenner, MD continued to dazzle the audience with fascinating facts and pioneering projects capturing the state of health care in Camden, NJ. Dr. Brenner is a family physician who has worked in Camden for the past 11 years where he provided full-spectrum family health services to a largely Hispanic, Medicaid population. He is currently the Founder and Medical Director of the Camden Coalition of Healthcare Providers, a non-profit organization committed to improving the quality, capacity, and accessibility of the healthcare delivery system in Camden.

Dr. Brenner presented key facts on health care in Camden which provided context to the discussion. As part of a Citywide Care Management Project, the Coalition has tracked emergency room (ER) and hospital use data that have revealed a few concerning trends: 50% of the population use the ER or hospital in one year, exceeding rates of other cities in the US; most frequent ER and hospital utilizers tend to be insured or self-pay; and conditions most commonly treated in the ER were respiratory, ear, and viral infections, all of which could be treated in a primary care setting. Causes of high utilization may include lack of health insurance coverage; limited access to primary care; mental health issues, and dangerous living conditions. Dr. Brenner was also able to identify specific neighborhoods with high ER utilization, in other words, "high-cost hot spots." He effectively illustrated a strong case for reducing costs by funding more family physicians and nurse practitioners in these neighborhoods.

The Camden Coalition of Health Care Providers provides oversight for a number of initiatives including the Camden Citywide Diabetes Collaborative and the Camden Health Information Exchange. The Camden Diabetes Collaborative is designed to improve the capacity of community-based providers to provide comprehensive, pro-active care to diabetic patients; support self-management; increase the capacity of medical day programs to care for diabetic patients; and improve the coordination of care across the city of Camden. The Camden Health Information Exchange (HIE) is a new project that will assist community-based providers, labs, and the major health systems serving Camden by sharing electronic data of patients who give their permission. This will not only help reduce costs through unnecessary tests, it will promote coordination of care and improve patient management. This is particularly important in Camden where underserved, disenfranchised residents frequent emergency rooms at various hospitals.

In the future, Dr. Brenner hopes to see a shift toward an Accountable Care Organization (ACO) model which he defines as an integrated delivery system in a defined geographic region involving multiple primary care offices and at least one hospital. At the core of this model is the capacity to manage costs and improve quality through coordinated relationships. Dr. Brenner remains passionate and optimistic as he continues to advocate for healthcare improvements in Camden. ■

For more information on the Camden Coalition of Healthcare Providers visit: http://www.camdenhealth.org/index/index.cfm

Health Policy Forum podcasts can be downloaded by visiting: http://jdc.jefferson.edu/hpforum/

If you have topic ideas or speaker suggestions for future Health Policy Forums, please email: emily.frelick@jefferson.edu

Upcoming Health Policy Forums - Winter/Spring 2010

Health Care Reform: Future Implications and the Role of the Physician Advocate

January 13, 2010

Valerie Arkoosh, MD, MPH
President-elect, National Physicians Alliance
Professor of Clinical Anesthesiology and Critical Care
Professor of Clinical Obstetrics and Gynecology
University of Pennsylvania

Turning Dialogue Into Data: Leveraging Patient and Physician Insights for Behavioral Change

February 10, 2010

Carolyn Choh Fleming, MBA
Professor of Marketing
Department of Pharmaceutical Marketing
Saint Joseph's University

How Pennsylvania's Budget Shapes Service Delivery

March 10, 2010

Kenneth J. Braithwaite, II
Senior Vice President, Hospital and
Health System Association of Pennsylvania
Delaware Valley Healthcare Council

Laval Miller-Wilson
Executive Director
Pennsylvania Health Law Project

Consumer Health Informatics and Healthcare Disparities

April 14, 2010

Michael Christopher Gibbons, MD, MPH
Associate Professor
Johns Hopkins Urban Health Institute

Changing Social Environments to Promote Health: Evidence, Opportunity, and Challenges*

May 12, 2010

Karen Glanz, PhD, MPH
Penn Integrates Knowledge (PIK) Professor of Medicine and Nursing
University of Pennsylvania

*** Please note, this Forum will take place in Bluemle 105/107**

Physician Leadership and Medical Group Performance: A National Study

June 9, 2010

Louisa Baxter, MD, Msc, MRCP (UK)
Commonwealth Fund Harkness Fellow In
Health Care Policy and Practice
Jefferson School of Population Health

Location for Health Policy Forums:

Bluemle Life Science Building, Room 101
233 South 10th Street (10th and Locust Street)
Philadelphia, PA 19107

For more information contact: (215) 955-6969

Time: 8:30 am – 9:30 am

JSPH Publications

Almario CV, Moskowitz EJ, Koran J, **Berman B, Pracilio VP, Crawford A,** Baxter JK. Examining the effectiveness of an opt-in approach to prenatal human immunodeficiency virus screening. *Am J Obstet Gynecol.* 2009 Oct. 19. Epub ahead of print.

Hansen-Turton T, Ridgway C, Ryan SF, **Nash DB.** Convenient care clinics: The future of accessible health care-The Formation Years-2006-2008. *Popul Health Manage.* 2009; 12(5):231-240.

Kiviniemi MT, Hay JL, James AS, Lipkus IM, Meissner HI, Stefanek M, Studts JL, Bridges JFP, Close DR, Erwin DO, Jones RM, Kaiser K, **Kash KM,** Kelly KM, Lee SJC, Purnell JQ, Siminoff LA, Vadaparampil ST, Wang C. Decision making about cancer screening: An assessment of the state of the science and a suggested research agenda from the ASPO behavioral oncology and cancer communication special interest group. *Cancer Epidemiol Biomarkers Prev.* 2009;18: 3133-3137.

Leas BF, **Berman B, Kash KM, Crawford AG,** Toner RW, **Goldfarb NI, Nash DB.** Quality measurement in diabetes care. *Popul Health Manage.*2009;12(4):265-271.

Nash DB. Home sweet home. *P&T.* 2009; 34(9): 481.

Nash DB. My dad. *P&T.* 2009; 34(10):526.

Nash DB. Value-driven spine care. *Am J Med Qual.* 2009. Supplement to 24(6):3S.

Nash DB. Getting our priorities straight. *Biotechnol Healthcare.* 2009; 6(3):4.

Nash DB, Skoufalos A. Medical errors, malpractice and healthcare reform. *Medpage Today.* November 2, 2009. http://www.medpagetoday.com/Columns/16744. Accessed November 16, 2009.

Nash DB, Toner R. Social networking and healthcare. *Medpage Today.* September 9, 2009. http://www.medpagetoday.com/Columns/15891. Accessed November 16, 2009.

Nguyen GT, Hsu L, Kue KN, Nguyen T, **Yuen EJ.** Partnering to collect health services and public health data in hard-to-reach communications: A CBPR approach. Progress in Community Health Partnerships, in press.

Pracilio VP. The open school: A framework for innovation. *Am J Med Qual.* 2009;24:447-448.

JSPH Presentations

Bavousett T, Curtis S, del la Torre D, Maiga A, **Pracilio VP.** Narrowing the health education chasm. Presented at: The Institute for Healthcare Improvement 21st Annual National Forum on Quality Improvement in Health Care, Orlando, Florida, December 2009.

Czaja SJ, **Kash KM,** Griffen AA, Levy RL, Mann LS. Obtaining research funding in our current climate: A review of the NIH grant process. Workshop presentation at: 56th Annual Meeting, Quality of Care: Implications for Psychosomatic Medicine, Academy of Psychosomatic Medicine, Las Vegas, NV, November 11-14, 2009.

Goldfarb NI, Romney, M. Compliance in the era of value-based purchasing. Plenary presentation at: Health Care Compliance Association Quality Meeting, Philadelphia, PA, October 12, 2009.

Goldfarb NI. Effective grant-writing. Workshop presentation at: National Business Coalition on Health National Meeting, Scottsdale AZ, November 8, 2009.

Pracilio VP, Nash DB, DesHarnais S. Jefferson School of Population Health Chapter of the IHI Open School. Presented at: The Institute for Healthcare Improvement 21st Annual National Forum on Quality Improvement in Health Care, in Orlando, Florida, December 2009.

Yeo TP, Belcher A, Yeo C. Incivility in Healthcare Settings: Manifestations, root causes, and downstream effects on patient care and productivity. Presented at: 6th Annual National Patient Safety Conference. Promoting Professionalism: Managing Unmanageable Colleagues, University of Pennsylvania School of Nursing, Conshohocken PA, October 15, 2009.

Yeo TP, Burrell SA, Sauter PK, Delengowski A. Fatigue, physical functioning, and quality of life in patients with pancreatic and periampullary cancers following surgery, chemotherapy and/or radiation therapy. Interim results. Presented at: Advanced nursing: Developing excellence in evidence-based practice and research. University of Delaware, Newark, Delaware, November 6, 2009

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