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EDITORIAL

No Outcome, No Income CMS's "Meaningful Use" Initiative

Those of you who follow events involving health policy in this country have no doubt encountered the term "meaningful use." The term relates to criteria that hospitals and eligible providers must meet through their use of certified electronic health record (EHR) technology to qualify for incentive payments from the Centers for Medicare and Medicaid Services (CMS). Providers who fail to achieve meaningful use will receive decreased payments from CMS for clinical services beginning in 2015 and beyond.¹

The incentive payments, and the program which supports them, are part of a master plan to encourage the use of health information technology (HIT) in the US to improve the quality, safety, and efficiency of health care. The meaningful use initiative is part of the American Recovery and Reinvestment Act of 2009 (ARRA), specifically the Health Information Technology for Economic and Clinical Health (HITECH) Act, which appropriates an estimated \$27 billion to support the adoption and use of EHRs.² The Act defines criteria that must be met, such as electronic prescribing, electronic exchange of health information, and submission of clinical quality measures, in order to qualify for the financial incentives associated with achieving meaningful use.³ Because the implications of this program are so significant, we thought it

important to devote this month's editorial to a discussion of meaningful use.

For all involved, the embrace of meaningful use represents no less than a turning point in thinking about what we pay for in health care. Phrased in the language of quality, it can be summarized as "no outcome, no income." In other words, this program is not simply about purchasing hardware and computerizing medical records. Instead, policy makers view EHRs as the core of an emerging HIT infrastructure, which has the potential to improve the nation's health care system and the health of Americans.²

It is well known that fragmentation of the US healthcare system has led to numerous problems and inefficiencies. By increasing access to information, computerization has the potential to significantly improve this situation much as it has done for other major industries.⁴ Indeed, not only does healthcare IT adoption in the US lag behind other industries, but the US also lags behind other countries in the adoption of EHRs and HIT.⁵ In the US, only 4% of physicians in ambulatory practice and 1.5% of hospitals reported using a fully functional EHR.^{6,7} There are numerous criteria to be met by providers and hospitals to qualify for the incentive payments (up to \$44,000 for

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Medicare providers, \$63,750 for Medicaid providers, and millions for individual hospitals) for achieving meaningful use. To best understand the program itself and its goals and potential implications, it's useful to examine the program's three stages.

Stage 1 (years 2011-2013) criteria for meaningful use focus on the relatively basic elements of HIT and quality, such as electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

Stage 2 (years 2013-2015) expands upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

Stage 3 (years 2015 and beyond) criteria have not been officially published, but will focus on improvement in all areas of quality and safety

that can be facilitated by HIT, with the goal of improving population health outcomes.

In summary, the federal government and CMS have put forward a comprehensive program to bring providers and hospitals into the 21st century with regard to the use of information technology. However, due to the voluntary nature of this program, there is great uncertainty as to the extent that the vision of improved population health through the meaningful use of EHRs will be realized.

The Jefferson School of Population Health (JSPH) is actively involved in the meaningful use program in two specific ways, one internal to Jefferson and one external.

Internally, we provide input to the Jefferson University Physicians EHR implementation team on how to choose and meet the clinical quality measure criteria for meaningful use. This involves interaction with both the information technology (IT) team, who support the EHR software, and physician champions, who facilitate the implementation at the provider level. Specific recommendations to the IT team include discussions about data field layouts to optimize utilization by physicians and

staff. Suggestions to the physician champions include process and culture changes necessary to ensure the fulfillment of the meaningful use criteria.

Externally, we help providers in the community achieve meaningful use by participating in the Regional Extension Center Program (REC) for Eastern Pennsylvania.⁸ The REC program, another initiative funded under the HITECH Act, is designed to support primary care physicians in the adoption and implementation of EHRs on their quest towards meaningful use. As a participant in the REC initiative, JSPH faculty and staff collaborate with physician practices in the community as advisors and consultants on meaningful use. ■

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As always, we welcome your feedback. Please feel free to contact Dr. Nash with your questions or comments at david.nash@jefferson.edu.

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Project RED: A Transformational Approach to Post-Discharge Care

A recent study, showing 20% of Medicare patients are readmitted within 30 days and only 50% of those patients had a prior follow-up medical visit, has stimulated an increased focus on reducing hospital readmissions¹. Furthermore, new government legislation may affect financial

performance by eliminating reimbursement for 30-day readmissions starting in federal fiscal year 2013.² Riddle Hospital, a 200-bed acute care hospital in the Main Line Health System, is taking steps to reduce hospital readmissions by participating in the Project RED (reengineered

discharge) national pilot project with 39 other hospitals. First implemented at Boston University Medical Center, Project RED reduces readmissions by streamlining the patient discharge process through patient education and community follow-up. Evidence shows Project RED reduces

readmissions by approximately 30% and generates cost savings of \$412 per patient.³ The Agency for Healthcare Research and Quality (AHRQ) and Joint Commission Resources are providing funding, educational modules, networking, and technical support for the project until December 2012.

Project RED offers numerous benefits to patients and providers. Patients and caregivers experience improved communication and understanding of clinical outcomes, timely services, enhanced discharge preparation, and tools for transitioning to the community. Scheduling follow-up appointments improves patient and physician interaction while increasing primary care utilization.³

Riddle Hospital in Delaware County, PA, primarily serves an older population. A multidisciplinary team steers Project RED on a 34-bed medical-surgical unit. Two nurses designated as Discharge Advocates (DA) guide the eleven components of Project RED (Table 1).⁴ The components incorporate a comprehensive discharge plan using pictures and cues to support patients of varying health literacy levels. Project RED also includes a scripted pharmacy follow-up phone call to review specific medications and medical issues, assess patient satisfaction, and support the newly discharged patient.³

Eligibility criteria for Project RED include patients:

1. With a respiratory diagnosis
2. Admitted from home and not discharged to a long-term care facility (excluding assisted living)
3. Able to sign an informed consent and/or demonstrate knowledge of the discharge information, or have a caregiver who can demonstrate knowledge of the discharge information
4. Who have access to a phone

Table 1: Components of the Re-Engineered Discharge (RED)

1. Educate the patient about his or her discharge throughout the hospital stay
2. Make appointments for clinician follow-up and post-discharge testing
3. Discuss with patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up results
4. Organize post-discharge services
5. Confirm the medication plan
6. Reconcile the discharge plan
7. Review the appropriate steps for what to do if a problem arises
8. Expedite transmission of the discharge resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan
10. Give the patient a written discharge plan at the time of discharge
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge

The multidisciplinary team is engaged using a respiratory disease care plan to guide daily interventions and patient teaching. Upon discharge, patients receive the comprehensive discharge plan, including physician and emergency care contact information, a medication calendar, and disease-specific information. The discharge plan also includes information on follow-up appointments and tests, scheduled by case management according to patient availability. The pharmacist contacts the patient within 72 hours of discharge and resolves diagnosis-related medical issues.

Riddle Hospital's Project RED goals include:

- 100% of patients are discharged with a discharge plan
- 85% of patients complete the pharmacy follow-up phone call within 72 hours
- 75% of patients see a primary care physician within 30 days after discharge
- 30% reduction in readmissions
- 90th percentile for patient satisfaction in "readiness for discharge."⁵

Project RED offers process improvements through better resource utilization and reduced costs. Patient outcomes also improve due to stronger partnerships and communication with physicians, thereby facilitating the process for medication reconciliation and post-discharge appointment scheduling prior to discharge.³ Further investment in post-discharge care may offer significant benefits to healthcare organizations as health policy experts explore opportunities to enhance provider incentives and reimbursement. For example, accountable care organizations (ACOs) will provide a single payment for an episode of care, to be split among the hospital, physician, and other clinicians.⁶ Healthcare organizations can ease the transition to future compensation models, such as ACOs, by strengthening the continuum of care through improved post-discharge care as promoted by Project RED. ■

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Utilization of Palliative Care: Providers Still Hinder Access

Provision of compassionate, quality care for individuals with chronic illness is a challenge to today's health care system.¹ There is considerable evidence that patient suffering is not adequately addressed during treatment and that patient preferences are neglected at the end of life. The Jefferson Palliative Care Service investigated end-of-life care for hospitalized patients with lung cancer and found barriers to palliative care access typical of those reported elsewhere in the US.²

Confusion about the difference between palliative care and hospice is at the heart of the matter. These care delivery options are often misconstrued as synonyms for care in the final days of life. While both aim to prevent and treat suffering, provide clear communication about treatment options, and align patient wishes with health care decisions, *access* to care is different.³

Palliative care is considered an ongoing component of disease-modifying treatment intended to alleviate symptoms and manage pain at *any* stage of disease; hospice is holistic end-of-life care for individuals no longer receiving aggressive treatment and who are expected to die within 6 months. Palliative care can be provided by a hospital-based specialty team in more than 80% of US hospitals. Hospice care is usually provided by home-based health care providers, although inpatient hospice units are available in some acute care hospitals and skilled nursing facilities. Both palliative care and hospice rely on interdisciplinary collaboration among doctors, nurses, chaplains, social workers, physical and occupational therapists, and volunteers.

From the scientific side of the matter, findings from randomized controlled trials demonstrate that palliative care promotes pain and symptom

relief, improves patient/family satisfaction with care, facilitates earlier transitions to hospice, lowers health care costs without affecting mortality and lengthens survival.⁴⁻⁷ Despite the emerging evidence, health care providers typically wait to suggest palliative care when medical treatments are exhausted or death appears imminent.⁸ Exploring the reasons for underutilization of palliative care uncovers further barriers.

Health care providers are often unsure when patients with advanced illness are ready for palliative care or hospice and are reluctant to initiate end-of-life conversations.⁸ Both doctors and nurses acknowledge lack of training in end-of-life communication and when to suggest a transition to palliative care. Patients and their families share cultural attitudes about death and the role of health care which further hampers this communication.

Persons with advanced lung cancer can potentially benefit from palliative care involvement soon after diagnosis and during treatment due to their high symptom burden.⁶ During its first 3 years in operation, the Jefferson Palliative Care Service noticed that lung cancer topped its list of diagnoses referred for consultation and that referrals usually came when patients were close to death. The service was most often consulted to discuss end-of-life care options, but less frequently for pain and symptom management or emotional support. A median of 6 hospital days elapsed before a palliative care referral was made. Compared to usual care patients, the palliative care patients had a longer length of stay, higher mortality and greater percentage of hospice enrollment. These referral patterns reflect a delay in referral until late in the disease trajectory and underutilization of the service to

address symptoms and psychosocial concerns. Palliative care professionals were consulted for only 8% of all hospital admissions among this patient population.

The National Quality Forum has identified palliative care as a priority for action to improve care of individuals with chronic illness.¹ At Jefferson, the analysis of referral patterns for lung cancer was an impetus to employ strategies to overcome provider barriers and promote palliative care referrals earlier in the course of the disease. A planned initiative will include provider education on specific referral triggers for palliative care, such as repeated or lengthy hospitalization, decline in cognitive or functional status, unacceptable pain, symptoms or emotional distress. Outcomes will be assessed by analyzing changes in provider referral patterns such as frequency and reasons for referral, observation of timing of referrals within the hospital stay and the disease course, and type of post-hospital care. Improving our nation's health care will involve concerted education, communication and institutional commitment to patient access to compassionate, quality palliative care during all phases of chronic illness. ■

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Uganda and the Current HIV Treatment Crisis – A Perspective

According to UNAIDS (the Joint United Nations Programme on HIV/AIDS), 33.3 million people worldwide are infected with HIV. Of these, 10 million require treatment with anti-retroviral therapy (ART).¹ Currently, it is estimated that for every 100 people who receive treatment, there are 250 more people who become infected daily. This past October, the Global Fund to Fight AIDS, Tuberculosis and Malaria, an organization that provides treatment to roughly half of the world's poor population, failed to meet its minimum fundraising target of \$13 million, which is the minimum necessary to continue distributing anti-retroviral drugs to patients that have already started treatment.² This failure only serves to force us to recognize the reality that some HIV-positive individuals will be fortunate enough to be treated with life-extending medications and some will not.

Uganda provides a good example of the controversy surrounding global HIV/AIDS care and ART in resource-poor settings. During the 1990s, Uganda was viewed as a model for HIV/AIDS research, prevention, and public health education, and was one of the first countries in Africa to see a dramatic decrease in HIV prevalence. Now, Uganda is once again in the global spotlight, but as an example of one of the first countries in which clinics are routinely turning people away from care.³

In order to better understand the medical and public health principles of HIV/AIDS care and how treatment decisions are being made in resource-poor settings, I traveled to Uganda recently to complete a month-long medical student clinical elective. I visited Makerere University's Infectious Disease Institute (IDI) in Kampala, one of the country's state-of-the-art HIV research and treatment facilities. This was my ninth trip to Uganda; the first was during the mid-1990s, when

HIV prevalence was around 15% and coffin shops lined the roads out of the capital city. Today, the HIV prevalence in Uganda is 5.7% and Kampala has the chaotic, palpable energy inherent in all cities undergoing tremendous development and growth.⁴ According to 2009 data, the number of Ugandans living with HIV in was 1 million, with only 11% receiving anti-retroviral treatment.^{5,6}

A non-governmental organization (NGO), the IDI was established in 2004. It focuses on strengthening the care and treatment of HIV and related infectious diseases for people living with HIV across Africa by offering professional training for health workers, conducting research on best practices related to HIV in low resource settings, and advancing clinical services that support the development of new models of HIV/AIDS care. The IDI started at a time when ART was becoming more widely available in countries where there were not enough clinicians to implement treatment programs.⁷

Approximately 9,000 people currently receive care at the IDI clinic, and an additional 6,000 receive care through outreach activities.⁷ These patients, who often travel from great distances, wait for hours with hundreds of other patients, many of them quite sick, to be monitored during routine visits. Due to sheer volume, physicians and providers at the IDI see an average of 60 patients per day. Many patients that receive care at IDI do not qualify for treatment with ART based on their T-cell count. According to the World Health Organization's clinical guidelines, patients with T-cell counts below 350 should receive ART.⁸ However, in Uganda, like most resource-poor countries that cannot afford to treat patients based on this guideline, the T-cell count cut off is 250 for initiation of ART. Financial circumstances are forcing physicians to apply sub-optimal

criteria of care for patients, including denying medications to those who actually do clinically qualify for treatment. During my rotation, I watched clinicians turn away patients and make the sometimes impossible decisions regarding who should be treated and why. Importantly, these funding shortages also force patients to watch loved ones suffer and make the difficult decision to share or sell medications, which can ultimately lead to treatment resistance.

Although my clinical rotation at the IDI was, in part, about learning how to provide appropriate medical care to persons with HIV/AIDS in Uganda, it was also about re-examining a country that I care deeply about at this specific point in history. As always, I am inspired and impressed by Uganda's dedication to extraordinary research in the field of HIV/AIDS. It is a country that, through research and example, continues to provide the scientific foundation for HIV treatment in resource-poor settings. At the same time, I am angry and deeply saddened that the current level of global commitment to HIV/AIDS prevents clinicians from successfully translating this research into a model of clinical care that minimizes suffering and emphasizes principles of health equity. When I read about the Global Fund's fundraising failure, the faces of the many HIV-positive patients I saw in Uganda flashed through my mind. What will happen to them? The difficult reality is that, almost thirty years into the global HIV/AIDS pandemic, most of these patients with HIV, and those who will become infected, will die without ever accessing life-saving treatment. ■

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Innovatively Changing US Health Care From the Perspective of a Japanese Physician

This past summer I visited Thomas Jefferson University and with my host, Dr. Nash, Dean of the School of Population Health (JSPH), I was able to meet with executives throughout the university and hospital system. I also spent a great deal of time within JSPH, meeting with faculty, attending educational seminars, and developing an invaluable collegial exchange. I am very thankful for this amazing opportunity. I believe we can help each other to improve our respective health care systems, even though they are different. We share the goals of improving access to and quality of health care while maintaining proper cost control. I would like to briefly introduce the Japanese health care system, describe what we can learn from the United States, and comment on the Patient Protection and Affordable Care Act.

Japan has a universal health care system. Employers are required to provide health insurance for employees and their dependents. The rest of the population – those who are self-employed, farmers, unemployed, or retired – are covered by National Health Insurance. The central government in Japan maintains great control over all types of insurance by setting policies regarding minimum coverage, maximum out-of-pocket costs, and many other features. Thus, the Japanese health insurance system covers comprehensive and uniform services including inpatient, outpatient, dental care and prescription drugs. The reimbursement is based on a uniform national fee schedule, which is regulated by the central government with consideration of total health care spending. Japan spends 8% of GDP on health care, while the US spends 15.3%.¹ In addition, Japan

spends more on outpatient care (including home care services) than the US. This could lead to lower health care costs in Japan because of early detection and early treatment of diseases. Male life expectancy in Japan is 79.0 years and female life expectancy is 86 years,² while in the US, male life expectancy is 75 years and female life expectancy is 80 years.³

From my perspective, the US, has more freedom in healthcare markets than Japan, and the US government has created a system to control private sectors. The US has implemented a more innovative quality improvement system for health care than Japan. The US has public reporting systems on quality and safety indicators, such as the Healthcare Effectiveness Data and Information Set (HEDIS), that are linked to financial reimbursement through pay for performance. The electronic health record (EHR) system is more pervasive in the US than in Japan. It is a tool with potential to improve quality and reduce costs because it makes it possible to access precise information and conduct communication among health care professionals quickly. In the area of primary care, the concept of a patient-centered medical home may deliver comprehensive primary care with modern tools such as EHR, e-mail, and informed decision making. A patient-centered medical home allows patients to have effective and efficient coordinated health care because knowledgeable health care professionals support patients in a variety of ways, from clinical decision making to lifestyle modification.

My visit provided me with an abundance of information on the pros and cons of the provisions

of the Patient Protection and Affordable Care Act. Until now, the US has led innovation in health care with high technology and freedom of choice of health care for patients and professional freedom for physicians. However, this cannot be sustained because of the increasing numbers of uninsured people, escalating health care costs, and the increasing problems related to an aging society. The main causes of death in developed countries are chronic diseases related to lifestyle factors including diet, exercise and rest. Both preventative activities based on evidence-based medicine and continuous responsible care are essential for sustainable and effective health care with efficient use of high technology resources. In addition, primary health care will contribute to improving the quality of life of patients with chronic diseases by providing teamwork care. I hope that the Act improves health outcomes for Americans.

We have made progress in addressing the issues of improving healthcare quality and decreasing risk, at a reasonable cost. I believe that we can make additional progress by doing better at sharing and exchanging information to manage care. Making the best use of health care resources that are allocated is more important than how much is actually spent on health care. ■

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Diabetes: Seeking Patient Centered Solutions to a National Epidemic

Did you miss it?

To view slides and videos from this program visit:

http://jdc.jefferson.edu/diabetes_patient_centered_solutions/

Get Healthy Philly: Policy Change to Promote Healthy Eating, Active Living, and Tobacco Control

The City of Philadelphia has embarked on many groundbreaking initiatives to improve the health of its people and communities. Providing the health policy perspective at a recent Health Policy Forum was Giridhar Mallya, MD, MSHP, Director of Policy and Planning for the Philadelphia Department of Public Health. In this position, Dr. Mallya helps to define public health priorities for the City and coordinates the Department's research and data analysis activities. He is the primary Investigator for *Communities Putting Prevention to Work* (CPPW), a Philadelphia project funded by the Centers for Disease Control and Prevention (CDC). Dr. Mallya is a Jefferson alumnus, having completed his residency in Family Medicine at Jefferson before going on to serve as a Robert Wood Johnson Clinical Scholar.

Dr. Mallya provided an overview of the challenges Philadelphia faces with respect to the issues of obesity and tobacco use. In response to these pressing public health concerns, the city has launched *Get Healthy Philly* as part of the CPPW Initiative. CPPW is a federal program using funds from the American Recovery and Reinvestment Act (ARRA) to explore causal factors and develop solutions that take into account the complex contextual determinants that play a role in public health issues. Philadelphia was fortunate to be awarded two federal grants, totaling \$25.4 million over two years, to support both tobacco and obesity prevention efforts.

Obesity

Dr. Mallya noted that the key determinants of obesity include poor diet and lack of opportunities for sustained physical activity. In Philadelphia, obesity-related health issues are the second leading cause of death (22,000 related deaths in Philadelphia since 2000), and account for \$750 million in health care costs annually.

The combination of increased caloric intake, inadequate consumption of fruits and vegetables, and high consumption of fast food and soda has led to a surge in obesity rates. In 2008, 65% of adults citywide were obese, as were 46.9% of children. In addition to food consumption, a lack of regular physical activity among Philadelphians is another major

contributing factor; one-quarter of children do not get sustained physical activity (30 minutes) even once a week, and almost 50% of adults exercise less than 3 times per week.

Get Healthy Philly will address these issues by focusing on increasing access to healthy affordable foods, decreasing availability and consumption of unhealthy foods, and enhancing opportunities for safe activity in daily living.

Tobacco

Dr. Mallya also discussed tobacco use, a well-recognized public health concern. According to Dr. Mallya, tobacco use is the leading cause of death in Philadelphia; 1 in 3 smokers die of smoking-related illness. In Philadelphia, smoking caused approximately 3,000 deaths in 2006 and is estimated to cause \$800 million in lost productivity annually. In many communities, up to 4 of 10 adults smoke. Of the 10 largest US cities, Philadelphia has the highest adult smoking rate, at 27.3% in 2008. While national trends indicate that smoking is on the decline overall, the smoking rate appears to be on the rise in Philadelphia.

Dr. Mallya discussed the role of advertising in driving tobacco use. As he noted, tobacco advertisements are omnipresent, and tobacco manufacturers are adept at finding ways to circumvent limits on advertising. Smoking is a normative behavior in many Philadelphia communities, and advertisements take advantage of the trends, targeting those communities, often with a specific focus on communities of color.

In addition to advertising, Dr. Mallya also pointed out that pricing and tax policies are key. A pack of cigarettes currently costs only \$5 in Philadelphia, while the same pack is \$11 in New York City. The financial disincentive to consumers may help to drive the change in behavior to decrease their tobacco use or, ultimately, to quit smoking.

While 3 of 4 smokers want to quit, smoking is a notoriously challenging habit to break. Smoking cessation resources that have been shown to assist smokers with their efforts to quit can be

difficult to access, resulting in low utilization. Dr. Mallya emphasized that the city needs to work with insurers, employers, legislators, and other stakeholder groups to make cessation support widely available.

In summary, *Get Healthy Philly* is focused on changing the climate to promote quitting by increasing access to smoking cessation aids, and by decreasing initiation (reducing youth access to tobacco products).

How do we make healthy behaviors the default? *Get Healthy Philly* includes 5-7 year goals for both obesity and tobacco prevention, and healthy living is being incorporated into the City of Philadelphia's 2035 Comprehensive Plan which will increase opportunities for safe physical activities. In addition, the city will be conducting careful evaluations of the numerous initiatives included under *Get Healthy Philly*.

Finally, in order to advocate effectively for policy change, the city is taking a strategic approach to data analysis by using geospatial modeling to evaluate data by district, in addition to the more traditional analyses by zip code. The results, in turn, enable the City to make particularly compelling policy recommendations to legislators regarding the pressing public health policy concerns in their respective districts. Hopefully these combined efforts will lead to the changes in context necessary to promote healthy living for all Philadelphians. ■

Laura Kimberly, MSW, MBE

Director of Special Projects, JSPH

For more information on *Get Healthy Philly* visit: <http://www.phila.gov/health/Commissioner/CPPW.html>

Health Policy Forums

Addressing Population Health Through Interdisciplinary Collaborations

Tim Gibbs

Executive Director

Delaware Academy of Medicine

Sept. 8, 2010

The Fall season of the Health Policy Forum opened up with a presentation by Tim Gibbs, Executive Director of the Delaware Academy of Medicine, a private, non-profit organization that has been in existence for over 80 years. Mr. Gibbs has provided direct service delivery and technical assistance for Delaware nonprofits throughout his career.

The Delaware Academy of Medicine is an important partner in promoting professional and lay health education, and is the major resource for health information in Delaware. The Academy shares an extensive merged medical library with Christiana Care Health System, including consumer health libraries (the Gail P. Gill Consumer Health Library and Delaware Health Source) throughout the state. The consumer health library program is operated in collaboration with the Delaware Division of Libraries. The Academy also offers a number of professional and student educational activities. In addition to these initiatives, the Academy promotes a strong digital presence via *Go Local Delaware*, a free online database for consumers designed to provide numerous listings of health services and programs throughout Delaware.

Mr. Gibbs is particularly passionate about the Academy's various innovative multi-stakeholder initiatives. The "Delaware Mini Medical School" is a lecture series for high school students and students of all ages, with content that focuses on important trends in medicine and in health. Participants receive a certificate of achievement for attending the lecture series. Past topics have included: sleep; pain management; asthma; weight loss; and antibiotic resistance.

"Heart Truth Delaware" is another collaborative initiative of the Academy that targets primary care providers in an effort to improve clinical processes for the prevention, assessment, and treatment of cardiovascular disease for women in Delaware. Through education, training and communication regarding services and events, this program also aims to strengthen the referral process.

Mr. Gibbs discussed the "Top Ten Series," a monthly regional conference that educates physicians on evidence-based updates in a variety of specialty with the goal of improving the standard of practice for primary care physicians and specialists.

The Academy oversees the Hospice and Palliative Care Network of Delaware, a collaborative designed to improve access to quality end-of-life care by identifying barriers to care and working to overcome them. The network has a strong educational component for professionals and consumers.

Mr. Gibbs also described the Academy's financial aid program for physicians and dentists. In existence for almost 50 years, the program was established to promote the study of medicine and dentistry. Nearly 1200 students have received more than \$1.7 million in loans.

Mr. Gibbs emphasized the importance of real and effective partnerships as the avenue for achieving successful programs and improving services. Some of the organizations the Academy currently partners with include: Christiana Care Health System; The New York Academy of Medicine; Winterthur; The College of Physicians of Philadelphia; Nemours; Medical Society of Delaware; and the University of Delaware. ■

For more information on the programs of the Delaware Academy of Medicine visit: <http://www.delamed.org/index.shtm>

Breaking the Language Barrier: Health Care Quality, Efficiency and Saving Through Professional Medical Interpretation

Winnie Heh, MA

Vice President, Global Operations

Language Line Services

Nov. 10, 2010

Winnie Heh, Vice President of Global Operations for Language Line Services, recently addressed the Health Policy Forum to discuss the current state of professional medical interpretation. Ms. Heh made it a point to note early on that language barriers can compromise the quality of medical care, and this basic premise was a common thread throughout her presentation.

Ms. Heh began by describing demographic changes in the United States over the past

several decades that have transformed medical interpretation into an important health care quality and safety issue. As immigration has risen dramatically since the 1970s, the ensuing increase in the number of limited English proficient (LEP) populations has led to important policy changes regarding the provision of medical interpreter services. From 1990 to 2000 alone, the number of immigrants increased by 10 million people. Future projections continue to trend upward.

Current estimates place the number of US LEP populations over the age of five years at 24 million, and the percentage of LEP residents in Philadelphia (9.1%) is slightly higher than the national average (8.6%). However, the rate of growth for this population in Philadelphia is 10.3%, significantly higher than the national rate of 6.2%.

Given the demographic picture, and considering that language barriers and lower health literacy than the general population can lead to negative

health outcomes, (including serious adverse events and problems with adherence), and lower patient satisfaction, it is crucial to provide adequate professional medical interpretation in a culturally sensitive manner.

Ms. Heh described the various language assistance options which include in-house interpreters, third-party professional interpreters, and access through technology (over-the-phone and over-video interpreters). In selecting an option, she emphasized the following considerations: accuracy (language and culture), availability, speed of access, training, confidentiality, liability, cost and professionalism. Ms. Heh also cautioned that two common practices, the use of family members (children in particular) or untrained staff, can be detrimental and even traumatic; these practices should be avoided.

Service delivery models for professional medical interpretation continue to evolve in the face of budget constraints and service needs. For instance, some hospitals are providing in-house over-the-phone or over-video interpreters, rather than in-house face-to-face interpreters to allow for more

rapid access to services; this is particularly relevant for hospitals with large campuses.

Constraints also exist with regard to rare languages and dialects, including sign language. American Sign Language interpreters are available on a very limited basis for face-to-face interpretation; therefore over-video interpretation may provide an effective alternative for serving patients with this need.

In terms of training, Ms. Heh indicated that qualifications for medical interpreters are fairly well established in the industry. In fact, Language Line has created a Language Line University to provide education and training. However, fiscal barriers still pose a significant challenge as most hospitals do not have a budget line item for interpreter services. In addition, hospitals with high rates of staff turnover require continuous and active promotion of and education about the availability of language services across the hospital. Not surprisingly, support from senior hospital management is key to establishing and maintaining effective professional medical interpreter programs.

Finally, Ms. Heh discussed the legislative landscape, beginning with a mandate for provision of and access to interpreter services with the Title VI of the Civil Rights Act of 1964. Current standards issued by both the Joint Commission and the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) are rigorous and include demonstration of cultural competence in addition to language skills. Language Line and the International Medical Interpreter's Association (IMIA) IMIA have partnered and are working with the US Department of Health and Human Services and with Congress to advocate for better Medicare and Medicaid reimbursement and for greater overall awareness of the important role that professional medical interpreters play in improving health care quality and safety. ■

For more information on Language Line visit: <http://www.language.com/>

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

CEO of North Shore-Long Island Jewish Health System visits TJU

Do you ever wonder what it takes for a health system to win the National Quality Forum's (NQF) prestigious National Healthcare Quality Award? The 2010 award was given to North Shore-Long Island Jewish Health System (NS-LIJ) for its ongoing commitment to providing high-quality, transparent, patient-centered healthcare. NS-LIJ has the distinction of being the first health system in the New York metropolitan area to receive this award.

Recently, the Jefferson School of Population Health (JSPH) hosted a presentation by Michael Dowling, President and CEO of NS-LIJ. Mr. Dowling spoke at length about his personal and professional journey, and how it influenced his mindset and set the stage for his commitment to creating a culture of quality at NS-LIJ. Over the course of his talk, he shared numerous insights, including his perspective regarding the essence of the quality movement – “quality is a value, it is in the DNA of an organization, and every employee is a quality professional.”

During his tenure as CEO, Mr. Dowling has promoted the quality agenda through radical changes to the structure and organization of the primary hospitals, long-term care facilities,

community hospitals, and ambulatory sites that comprise the NS-LIJ Health System. The health system owns each entity, and all primary administrative and clinical functions are centralized for maximum efficiency, communication, and integration. In addition, the health system has a single board of directors, enabling effective decision-making with a constant focus on the big picture. There were enormous challenges to produce the massive systems changes required to create NS-LIJ. Despite the fact that nearly every entity within the health system was operating at a deficit at the time of purchase – it is now profitable, generating over \$6 billion in revenue and employing 42,000 people.

One example of Dowling's paradigm-shifting approach to leadership is his attendance at NS-LIJ's Monday morning new staff orientation sessions. He makes it a point to personally meet every new hire – on average, about 70-90 people each week. He is also committed to the concepts of integration, teamwork and transparency, and has established protected time on Fridays for all administrative and clinical staff to attend patient safety rounds. Dowling is interested in the feedback and experiences of all personnel and views the collective partnership as key to service excellence.

Some of the significant themes in his presentation included:

- *Employee Development and Engagement*
- *Teamwork and Collaboration*
- *Commitment to Transparency*
- *Commitment to Innovation and Continuous Improvement Focus on Accountability*
- *The Big Picture – Manage for the Short Term, Lead for the Long Term*

Regarding health care reform, Dowling believes that most future revenue will come from government payers instead of commercial payers. He is concerned about the high expectations for success of American Recovery and Reinvestment Act (ARRA) and its lack of emphasis on cost containment, and issues around caring for an aging population.

Dowling's approach to quality, organizational culture and leadership within the broader context of health care reform is to extend it beyond the framework of simply doing a job and regard it as a “responsibility and obligation.” ■

Bryn Mawr Rehab's Career Development Program for Individuals with Disabilities

Bryn Mawr Rehabilitation Hospital (BMRH), a member of the Main Line Health System, has become the first in the region – and second in the nation – to establish a Project SEARCH program that will target adults with disabilities. Project SEARCH was originally developed by the US Department of Labor and implemented by Cincinnati Children's Hospital in Ohio to provide internship experiences for high school-aged children with disabilities.^{1,2} The US Department of Labor recognizes that identifying alternate labor pools, which can include individuals with disabilities, can be a viable strategy to confront critical workforce shortages.³ BMRH recognizes the potential in a historically underutilized workforce.

The Americans with Disabilities Act defines the term "disability" in three parts. An individual with a disability "(1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment."⁴ According to a 2010 survey of Americans with disabilities, among all working-age (ages 18-64) people with disabilities, only 21% state they are employed.⁵ Among the disabled unemployed, 73% attribute their disability as being the primary reason of their unemployment.⁵ Regrettably, an overwhelming 43% of individuals with disabilities reported that they have encountered job discrimination.⁵

These statistics are staggering and clearly demonstrate the need for programs that provide opportunities for individuals with disabilities. BMRH has developed a unique Project SEARCH Program designed specifically for adults. Although creating a new program can be challenging, BMRH is proud to take a leadership position in this arena, both as a way to give back to the community, and to improve the quality of life for people with disabilities by helping them enter or re-enter the job force.

BMRH, in partnership with the Pennsylvania Office of Vocational Rehabilitation (OVR) and Main Line Health, will serve as a single conduit for delivering vocational training and employment services for adults with disabilities. At the conclusion of the program, BMRH anticipates hiring graduates of Project SEARCH within the Main Line Health System to improve performance in high-turnover, entry-level positions. For example, interns are currently placed in physical therapy, environmental services and materials management roles, to name a few.

The highlights of the program include:

- Three, 10-week job site rotations throughout Main Line Health hospitals
- Personalized training plan for each intern
- Support of a job coach, worksite supervisor, and peer mentor throughout the program
- Assessment for necessary adaptive equipment at work sites

- Functional curriculum that will provide travel training, and time and money management skills

The primary purpose of this program is to obtain competitive employment for adults with disabilities. The program's success will be measured based on indicators, which include: weekly hours worked, salary, benefits, and employee and employer satisfaction. Evaluation data will be obtained on an ongoing basis to allow for early identification of barriers to achieving success. In the first year, eight interns will participate in the program. If the BMRH project for adults is as successful as the high school model, we anticipate an 82% placement rate.

Looking to the future, BMRH hopes to expand the program to non-Main Line Health entities by forming partnerships with regional businesses to provide employment opportunities to qualified graduates of the program. This program will allow BMRH to further its mission to serve individuals and their families whose lives can be enhanced through physical or cognitive rehabilitation. ■

Teenice Nebblets

*ARAMARK Administrative Fellow
Main Line Health System*

Donna Phillips

*President, Bryn Mawr Rehabilitation Hospital
Main Line Health System*

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Patient Awareness of Practicing Hand Hygiene: An Intervention for Hospitalized Oncology Patients

Completion of a Capstone Project is the culminating experience for the Jefferson School of Population Health (JSPH) Master in Public Health Program. Due to the growing

concern over the impact of healthcare associated infections and the use of prevention techniques in health care settings, I decided to focus my capstone

project on this topic. In consultation with my advisor and several TJUH infection control clinicians, I developed a pilot study that aimed to assess patient awareness and compliance

regarding hand hygiene to reduce healthcare-associated infections.

The topic and purpose of the study were developed after in-depth research on the extent and impact of HAIs and the current efforts taken to prevent them. The Joint Commission reported in September of 2009 that HAIs are among the top 10 causes of death in the United States.¹ HAIs are defined by the Centers for Disease Control and Prevention (CDC) as “infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting.”¹ The CDC reports that 1 in 136 hospital patients become seriously ill as a result of acquiring an infection in the hospital.² This is equivalent to nearly 2 million unnecessary infections each year. It is estimated that 247 people in the US die every day from HAIs, which is approximately 90,000 deaths per year.³ The overall annual direct medical costs of HAIs to US hospitals range from \$28.4 to \$45 billion.²

HAIs primarily involve the urinary tract, lungs, blood and skin. The exact modes of transmission and areas of infection differ among the common HAIs and there are specific strategies designed to prevent them. However, all preventive measures include proper hand hygiene maintenance. Transmission of HAI pathogens is found to most often occur via contamination from unclean hands in the healthcare setting. There is a great deal of research regarding hand hygiene of healthcare providers. Hand washing is a primary preventive measure for HAIs, but often has very low compliance rates.⁴ The main reasons reported for low compliance include busy schedules, hands drying out from too much washing, lack of education about guidelines, and routine behavior habits.⁵

Patient compliance to hand hygiene protocol however, is an underdeveloped area of research. Like providers, patients are at risk of spreading infection. In most cases, they are either the original carriers of infection or are immune-

compromised, making them even more vulnerable to infection. Efforts to increase patient knowledge and awareness regarding hand hygiene, the effects of not washing, and the responsibility to protect one’s health while in the hospital, are crucial to prevent transmission of disease. The World Health Organization has launched a number of hand hygiene public awareness initiatives and campaigns, along with recently released guidelines. They recognize the importance of patient awareness, and work within the context of the patient’s cultural and religious beliefs in the effort to improve hand hygiene practices.⁶ This study was developed to better understand the patient perspective and increase patient awareness of HAIs, in the hope of changing behavior in ways to protect their health.

A hybrid survey was developed to evaluate the efficacy of the CDC’s “Hand Hygiene Saves Lives” video,⁷ a five-minute patient education tool emphasizing the importance of handwashing in the hospital. The study took place on the Thomas Jefferson University Hospital oncology unit, where the CDC video was available in all patient rooms.

The study received IRB approval prior to implementation. Patients who agreed to participate received an initial survey and were randomized to either view the video or not view the video. Twenty-four hours later, a second identical survey was completed by all participants. The sample was evaluated by age, gender, and responses to the 10 items on the survey that assessed knowledge of hand hygiene in the hospital, awareness of the environment, benefit of awareness education and comfort asking providers about hand washing. Information regarding age and gender was collected primarily to keep record of the demographic of patients who participated.

The premise was to compare pre and post surveys of those who viewed the video and those who did not view it. We hypothesized that the score would be higher on the post-survey than

on the pre-survey and the patients who watched the video would score higher on the post-survey than those who did not view the video. There were a total of 30 participants; 17 patients in the control group (12 female, 5 male) and 13 in the intervention group (9 female, 4 male). Ages ranged from 28 to 74 years with a Mean of 54.

In both groups, the overall mean scores increased between the pre- and post-surveys. There was also a greater difference in the total mean change score in the group that watched the video versus the group that did not watch the video. Finally, the short answer analysis allowed conclusions to be drawn with regard to the patients’ understanding of their condition and how to protect their health.

Although the results were not statistically significant, patients scored slightly better on the post-test than the pre-test indicates that the video enhanced patient awareness of hand hygiene. The only factor that did not show an increased score in the intervention group was level of comfort in asking providers about their hand hygiene. It was determined that with greater knowledge of the potential for infection and how to prevent it, patients will be more inclined to be more proactive in protecting their health.

There is great opportunity for further research to better understand patient awareness and compliance by increasing sample size, including more hospital units, collecting demographic information and comparing various sustainable methods of patient education. Encouraging discussion and educating patients about HAI prevention more frequently is likely to make patients more inclined to wash their hands and ask their providers to do so as well. ■

Brianna Germain, MPH

JSPH Master of Public Health Graduate 2010

Project Specialist

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interest in Health Economics and/or Outcomes Research. Completion of relevant graduate coursework is preferred. ■

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

To learn more about the fellowship program, visit http://www.jefferson.edu/population_health/research/fellowships.cfm.

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Upcoming Health Policy Forums - Winter/Spring 2010

Health in All Policies: (How) Can We Make it Work?

January 12, 2011

Shiriki Kumanyika, PhD, MPH

*Professor of Biostatistics and Epidemiology
University of Pennsylvania School of Medicine*

**Location: Jeff Alumni Hall-Solis Cohen Auditorium
1020 Locust Street**

Public Health Law Research: Making the Case for Laws to Improve Health

February 9, 2011

Scott Burris, JD

*Professor of Law
Director, Centers for Health Law, Policy and Practice
Temple University Beasley School of Law*

**Location: Bluemle Life Sciences Building-Room 101
233 South 10th Street**

The Role of Innovation in Value-Based Healthcare Delivery

March 9, 2011

Christopher McFadden

*Managing Director
Health Evolution Partners*

**Location: Bluemle Life Sciences Building – Room 101
233 South 10th Street**

Time: 8:30 am – 9:30 am

Betting on Bending the Cost Curve

April 13, 2011

Mark Pauly, PhD

*Bendheim Professor and Professor of Health Care Management,
Business and Policy, Insurance and Risk Management and Economics
University of Pennsylvania, The Wharton School*

**Location: Bluemle Life Sciences Building – Room 101
233 South 10th Street**

The Changing Landscape of Health Services Research and Policy

May 11, 2011

Erin Holve, PhD

Director, Academy Health

**Location: Curtis Building – Room 218
1015 Walnut Street**

Personalized Medicine: Transforming the Future of Healthcare

June 8, 2011

Edward Abrahams, PhD

President, Personalized Medicine Coalition

**Location: Bluemle Life Sciences Building – Room 101
233 South 10th Street**

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