

# Population Health Matters

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EDITORIAL

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## Raising All Boats

While our College of Population Health will always have the distinction of being the nation's first such college, we recognize that both undergraduate and graduate education in population health is a burgeoning field. In fact, we were very fortunate to host a panel that highlighted the growth in such educational programs at the 2017 Annual Research Meeting of [AcademyHealth](#) in New Orleans, LA. I would like to summarize aspects of our presentation, and put the work of our college into a broader national context.

AcademyHealth is probably the most prestigious membership organization focused on linking health services research to policy implementation. The organization's 50-year commitment to the field was recounted in a recent editorial in their journal, [Health Services Research](#). In it, Executive Director Dr. Lisa Simpson states that, "... *what endures is our field's thirst for relevant knowledge that will improve health in the performance of the health system. What is even more prominent today, however, is the imperative to translate our research into policy and practice impact for our field to continue to be supported by taxpayer investments.*"<sup>1</sup> I believe that the expansion of educational programs in population health may serve as the bridge between the public health and health services research communities for the betterment of our presently dysfunctional healthcare system.

Additional research and commentary by other national leaders supports my thesis, including Dr. Robert H. Brook, of [RAND Health](#) and University of California, Los Angeles. In a comprehensive review article, Brook notes that there have been essentially a dozen key facts that have emerged from the aforementioned 50 years of health services

research.<sup>2</sup> Among those key facts, central to our definition of population health are: 1) the U.S. healthcare system is wasteful, but one person's waste is another's income; 2) the most powerful determinants of health are socio-economic; 3) quality of care varies dramatically by where one lives, by socio-economic status, and in some cases, by hospital or doctor; and 4) geography is a powerful predictor of health service use. The research and curriculum that emanates from our college would support all of these emerging truths noted by Dr. Brook.

In a recent *New England Journal of Medicine* article, Lieu and Platt call for a bridge or a frameshift from health services research to applied research that can make a difference in the healthcare system.<sup>3</sup> While these more contemporary "call to arms" are nothing new, they are increasing in intensity and number. Again, our own survey research<sup>4</sup> supports this bridge concept and, with it, the creation of new leadership roles such as the Chief Population Health Officer.

These recent publications were top of mind as I prepared to moderate the special panel discussion in New Orleans. In my opening comments, I noted that the [ASPPH](#) (American Society of Programs and Schools of Public Health) has spent nearly a year trying to define the differences between *public health* and *population health*. I connected the work noted above by leaders such as Simpson, Brook, and Platt. I also explicitly emphasized that while our panel focused on freestanding colleges and schools, there is a broad national movement in academic medicine to create Divisions of Population Health within Departments of Medicine across the country.

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After my comments, I introduced each of the three key guest panelists in turn. The first was [Dr. Debra Helitzer](#), the former Dean at the [University of New Mexico \(UNM\), College of Population Health](#). Her research has focused on interventions in communities and clinical settings in collaboration with clinician experts. She described UNM's unique program, which is focused on undergraduate education in population health. She explained the idea of "working backwards" to create cross-cutting competencies for undergraduates, with a special focus on prevention and the social determinants of health. The students in this program are obligated to put together an undergraduate portfolio of their experiences and to commit to a summer experience working in the community. Dr. Helitzer explained that New Mexico is only one of four majority/minority states in our country at this time. As such, the UNM bears a special responsibility for improving rural health across the state.

The panel second speaker was [Dr. James Carlson](#), Dean of the College of Health Professions, and Associate Vice-President for Clinical Simulation at the [Rosalind Franklin University of Medicine and Science](#) in Chicago, IL. He described their nascent certificate programs in Population Health Strategies and Population Health Analytics (four courses each) that, at this moment in time, carry graduate-level transcriptable credit. He explained that their Provost is considering approval of a Master's degree that they hope to implement by the fall of this year. Their programs have a heavy emphasis on inter-professional education. Dr. Carlson noted that the evolution of their population health graduate certificate arose from a campus-wide "new program task force" that issued a report in 2014 noting the need for such graduate education in Illinois.

The third panel speaker was [Dr. Bettina Beech](#), the founding Dean of the [John D. Bower School of Population Health](#) on the campus of the University of Mississippi Medical Center in Jackson, MS. Like New Mexico, Mississippi bears the burden of being among the poorest states in the nation, and has ranked dead last for most health outcome-related measures since 1991. For example, it has the highest rates of obesity, hypertension, and the like. As the founding Dean, Dr. Beech described the four departments that make up her school, including population health, data science, preventive medicine, and health economics. I believe they are the only school of population health with an imbedded preventive medicine residency program, whereby physician trainees in preventive medicine will obtain a Master's degree in Population Health by the conclusion of their clinical training.

The final speaker of our distinguished panel was our very own [Dr. Billy Oglesby](#), Associate Dean for Academic and Student Affairs at JCPH. Billy did an outstanding job outlining all four of our exclusively online Master's degrees with a special focus, of course, on our programs in population health. These programs include our one-week, 40-contact hour (continuing education) Population Health Academy, our 6-course, 18-credit transcriptable Certificate in Population Health, and our leading Master's degree in Population Health. Billy also publicly unveiled for the first time our plans to launch a new Master's degree program in Population Health Intelligence. The program curriculum is built upon three foundational themes—*data, insight, and action*. Population Health Intelligence combines the knowledge of population health with the skills to collect, harmonize, analyze and disseminate data,

and then lead organizations to act on those insights.

Following the four presentations, I moderated a robust question and answer period among the panelists, and from members of the audience. I was particularly impressed by questions from other educational leaders at organizations like the University of Rochester School of Medicine and Dentistry, and leaders from several state hospital associations anxious to hire graduates of all four programs!

In the near term, we are likely to see many additional certificate and graduate programs in population health. It is our intent to catalog and survey these programs in the very near future. While I am extremely proud and privileged to be the founding Dean of the nation's first such college, I recognize, as do my colleagues, that the entrance of many other distinguished educational centers into the field of population health "raises all boats." That is, as our field matures, there is plenty of room for diversity in our approach to the myriad challenges that our health system faces. I welcome the detailed discussion within the "House of Academic Public Health," best represented by ASPPH, as we come to terms with this paradigm shift. We believe that population health is the bridge to the future, and it represents the best chance for creating leaders who can fix this delivery system mess. Jefferson's leadership role in population health will serve the delivery system well and will continue to contribute to improving the health of our citizens.

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# Thomas Jefferson University Commencement Address

Graduates, congratulations on your chosen fields. Promoting health and helping others is the highest human calling. You have heard the call. You have acted on it, and my heart is with you.

The great educator Horace Mann once said, “Be ashamed to die until you have won some victory for humanity.” And today’s commencement gives you the opportunity to uphold his ideals.

Today I want to speak to you with stories, not conventional commencement platitudes. Stories that can help you achieve success for yourself and advance forward the causes you care about. They are simply stories — some painful, some uplifting, all with lessons for you. They confirm fundamental human virtues that you can nurture to achieve a future that you desire. Equally as important, I have learned with time that the power of a personal story, honestly told, builds trust. And that trust can be built at the personal and professional levels.

My first story — a true story — is about my beautiful sister-in-law Rosemary who helped me through a trying time in my childhood. In July of 1972, she went into the hospital to deliver her second child, and unfortunately, she lost her life during childbirth. The cause was a medication error. A preventable error.

For the last 37 years, I have been working to make sure what happened to Rosemary never happens to anyone ever again. Improving the healthcare delivery system became my focus. It became my passion. It became my professional “why.”

That and other adverse life experiences have and continue to drive a business and personal worldview that has changed the arc of my life and has helped many others. My view is anchored in the reality that life can be hard, but successful personally and professionally.

It will take a strong sense of knowing your “why,” the ability to work together, and a willingness to open yourself to others.

Graduates — share your stories, big and small. And hear the stories of those you care for. For a world of opportunity can open. The great human rights activist Maya Angelou put it more poetically, “There is no greater agony than bearing an untold story inside you.”

Last year, I was fortunate to publish a book titled: *Life’s Bulldozer Moments. How Adversity Can Lead to Success in Life and Business*. Events, like the loss of my sister-in-law Rosemary, can knock you to your knees. The book proposes what you do when you get up. That’s what matters.

Having lost Rosemary to a preventable medication error, I founded several successful healthcare companies to address this very issue of medication errors and other human health challenges, including better data sharing, better integration and improving healthy aging.

And today, I am proud to be the CEO of Tivity Health, a publicly traded company that helps to improve health outcomes for older people, empowering them to live their lives with dignity and vitality. We enable healthy aging.

Just last month, I joined the 103rd birthday celebration of one of our oldest members. She started our physical gym fitness program at 89. I was touched when she asked me for a dinner date. She had the wisdom to know that it’s never too late to begin a new project. The good news for you today is that all of you have time to accomplish many good projects.

Across my cumulative experience, I have learned that innovation without integration was not a path to success at levels that could have prevented my sister-in-law’s death.

That brings me to the first of three imperatives for success that I’d like to share with you today.

## 1. Develop a collaborative IQ

This term was coined by Mike Leavitt, who served as secretary of Health and Human Services under President George W. Bush. When I met with the secretary a few years ago, he shared my concerns around the absence of innovation of new concepts with the integration of existing ideas.

A collaborative IQ leverages the strengths of the many to achieve a common goal. Someone gifted with a collaborative IQ doesn’t seek to replicate the good work of others. She mixes people to create an entirely new result.



Donato Tramuto (center) with Stephen Klasko, MD, MBA, and David Nash, MD, MBA

Practicing this lesson, I founded in 2008 a company that combined multiple organizations providing medical professionals with information via digital platforms.

Today, more than 3 million physicians around the globe use this system, saving thousands and thousands of lives from medical errors. Innovation without integration will not yield immediate or sustainable results.

## 2. My second success driver is to practice transformational leadership.

This is not transactional leadership. A good transactional leader does many things right. A transformational leader does the right thing. A transformational leader sees beyond the immediate task to bigger, long-range issues. Senator Robert F. Kennedy was a transformational leader.

He has long been a hero of mine.

During my younger years when I was bullied, I entered the quietude of an intellectual curiosity that was fueled by the writings of Senator Kennedy. His example of perseverance and his writings of moral leadership helped fill those difficult years. I admired him for his own ability to transform his life and become one of our greatest national leaders despite great personal tragedy.

Five decades ago, doctors surveying the poorest regions of the American South found third-world conditions, including diseases long thought to have been eradicated, even among children. He awakened the nation’s conscience through hearings, media and moral outrage. He stated clearly — if one

wants change — they must be passionate enough to want it. Yet, he also brought hope.

He was transformative. He knew the right thing to do, and he knew why.

### 3. Graduates, that leads me to my last imperative: be sure to find your own personal “why”.

Nobody cares what you do — until they know *why* you do it.

Nothing brought that lesson home to me quite like the events of September 11, 2001. You see, I was scheduled to fly on United Flight 175 from Boston to Los Angeles on 9/11. Due to a toothache that brought me to my Boston dentist on September 10th, I left for LA later that day and never boarded the flight on September 11th.

Sadly, my two friends and their young son who had been visiting me in Maine did, and they lost their lives when the second plane hit the south tower. Even now, I grapple with the larger questions: Why was my life spared and not theirs? How could anyone murder a 3-year-old boy?

This bulldozer moment guided me to Tennyson who said, “We faintly trust the larger hope.” One survives. One finds new

purpose. One finds new causes driven by a renewed sense of why.

In the fall of 2001, we launched the [Tramuto Foundation](#). For 15 years, we have supported many global organizations and helped hundreds of young children with special challenges pursue their educational dreams.

But we did not stop there.

I have been haunted by the fact that in our lifetime, 1 billion people will go to their graves prematurely because they lack access to a healthcare worker. Six million are children who die each year because they are denied clean water, medication and medical attention.

To help address this, we created [Health eVillages](#), a global non-profit that provides medical information and decision support to caregivers via mobile devices.

The results have been astounding. For example, in Lwala, a small village in Kenya, we have reduced infant mortality from 100 deaths per 1,000 births to 30. Yes! Seventy more babies per 1,000 births are now alive because of Health eVillages.

Just because you are poor does not mean you deserve to be treated differently than

those whose fate has provided them with better means.

Passion — embracing your why — can and will change your corner of the world.

Two years before the great Irish playwright, George Bernard Shaw, died, he was asked by a reporter to name a famous person whom he missed the most. A poet? A teacher? Or a writer? He thought for a second and responded, “The person I miss the most is the person I could have become.”

My journey is well along. And I’ve concluded that power stems not from wealth, degrees or status. Rather, power is in knowing your why. Power is visualizing a world of change — not a world of rest. Power is knowing that in your hands lie the opportunities to score many victories for humanity.

Good luck and Godspeed.

*This is an abridged version of Mr. Tramuto’s commencement speech at Thomas Jefferson University, where he received an honorary degree.*

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**Donato Tramuto**  
CEO  
Tivity Health

## Provider Screening for Adolescent Alcohol and Other Drug Use at Jefferson Health: Why It’s Important and How We Can Improve

Alcohol and substance use is common among U.S. adolescents. Close to 70% of high school seniors have tried alcohol, approximately 50% have taken an illegal drug, and more than 20% have used a prescription drug for nonmedical purposes.<sup>1</sup> Not only are there significant morbidity and mortality costs associated with adolescent alcohol and drug use, alcohol and drug use at an early age is a significant predictor of substance use disorders in adulthood. Research has shown those who begin drinking before the age of 15 are *six times* more likely to have [alcohol dependence or abuse](#) in their later years, compared to those who start drinking at or after the age of 21.<sup>2</sup> In addition, young adults who use alcohol and marijuana are two to three times more likely to subsequently abuse prescription opioids.<sup>3</sup>

Preventing alcohol and other drug use and abuse during the adolescent years circumvents significant public health problems, such as deaths from motor vehicle accidents, alcohol poisonings and suicides, as well as public health problems in adulthood, such as adult alcohol use disorder, with an estimated 88,000 annual deaths.<sup>4</sup>

Pediatricians and family care providers have a number of opportunities to screen adolescents for substance use, including annual examinations, acute care visits, sports physicals, and health and behavioral problems that may be alcohol or drug related.<sup>5</sup> The [American Academy of Pediatrics](#) (AAP) recommends that pediatricians provide adolescents with substance abuse education and screening

for alcohol and other drug use during routine clinical care by incorporating the universal use of [Screening, Brief Intervention and/ or Referral to Treatment \(SBIRT\)](#) guidelines designed by the [U.S. Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#).<sup>6</sup> However, in national and state studies, the prevalence of adolescent alcohol and other drug use screening among providers is low, as is the use of validated tools during screening.<sup>7-10</sup>

At Thomas Jefferson University, all medical, physician assistant and pharmacy students are being trained in the use of SBIRT, as part of a three-year grant, with the goal of reducing the impact of substance abuse in families and communities both local and afar.<sup>11</sup> Despite this initiative, there are no administrative policies to foster or promote

the use of SBIRT in current Jefferson practices. The number of Jefferson providers conducting screenings and the frequency in which they are conducting them is unknown.

To study adolescent screening (the first step in SBIRT) for alcohol and other drug use among Jefferson providers, an online survey was administered to a convenience sample of 44 Jefferson pediatric and family care providers in the fall of 2016. The goal of this survey was to identify what proportion of Jefferson providers currently screen their adolescent patients for alcohol and other drug use, as well as what screening tools they use and what screening barriers they encounter.

### **Frequency of Screening Adolescents for Alcohol and Other Drug Use**

Providers were asked if they screened adolescents for alcohol and other drug use “always,” “usually,” “about half the time,” “sometimes” or “never” during a routine visit. All providers reported some level of screening for both alcohol and drug use. Forty-one percent of providers “always” screened adolescents for alcohol use during a routine visit; 38.6% “usually” screened; 11.4% screened “about half the time;” 9.1% screened “sometimes;” and zero respondents “never” screened. Drug screening followed a similar trajectory.

The majority of respondents (70%) reported they did not use a specific tool when screening their adolescent patients. They simply asked questions regarding: 1) the type and frequency of alcohol and drug consumption, 2) the drug and alcohol use among their peers and at school and 3) whether they had been offered alcohol/drugs. Only two providers reported use of a validated screening tool, such as the CRAFFT,<sup>12</sup> the only validated screening tool

created specifically for adolescents. Seventy-three percent of providers had neither heard of nor used the CRAFFT.

### **Barriers and Facilitators to Screening Adolescents for Alcohol and Other Drug Use**

The top three barriers to screening were “insufficient time” (70.5%), followed by the “need to triage competing medical problems” (52.3%) and “lack of treatment resources” (18.2%).

Qualitative responses to facilitators that would assist providers in improving universal screening at Jefferson included: 1) increasing time for well-child visits to 30 minutes as opposed to 15 minutes, 2) making resources available for positive screens, 3) involving support staff, and 4) building tools into Epic (Jefferson’s electronic health record system) to support screening. Forty-three percent of providers would prefer screening be conducted by other staff in the practice prior to seeing the patient.

Providers seemed receptive to a day-long SBIRT training; 34% of providers noted they “would attend” and 50% said they “might attend.” A half-day training would be less time consuming and likely to produce more favorable results.

### **Author Recommendations to Increase Screening among Jefferson Providers**

1. Computerized pre-visit screenings are recommended to increase the proportion of providers currently screening for alcohol and other drug use and to facilitate standardization among Jefferson practices. Studies have shown a computer-assisted screening instrument can improve detection of at-risk alcohol drinking behavior and has higher compliance from both health care providers and patients.<sup>13</sup>

Eighty-four percent of surveyed providers would consider adding electronic screening to their practices depending upon cost and how it could be integrated into their workflow. Delivering screening electronically would also assist with time management, the number one barrier noted by physicians to screening patients.

2. Pediatric providers should form an SBIRT Change Team to organize efforts to standardize and strengthen clinical SBIRT processes by: 1) making recommendations to maximize screening rates, 2) incorporating the use of a validated screening tool, 3) advocating for screening tools and/or reminders to be included in Epic (Jefferson’s EHR system), and 4) supporting training for current providers and support staff.
3. Focus groups should be conducted to gain a deeper understanding of the current screening practices taking place in the Jefferson Health system and how SBIRT can be implemented into Jefferson providers’ current workflow.

The results of this study showed a significant gap between the AAP’s guidelines and current Jefferson practices. Incorporating clinical guidelines for adolescent alcohol and other drugs use into the Jefferson Health system that included validated screening tools, techniques and resources, would lead to more optimal physician screening practices.

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## A Vanguard in Montreal

On May 30th I traveled to Montreal, Quebec in Canada to participate in a conference unlike any I have ever attended. The three-day Vanguard Conference, sponsored by [Next City](#), is an experiential leadership assembly of 40 leaders whose work is dedicated to improving the quality of life in urban areas. The conference rotates locations each year; the 2017 host was [Concordia University](#) and the theme was "accessibility." Next City selected this topic because "21st century urbanism demands that all people enjoy access to the places, tools, and decision-making power necessary to fully participate in urban life and effect change in their community."

When I originally applied to become a Vanguard, I was working at [Philadelphia Corporation for Aging](#) (PCA), the Area Agency on Aging for the city and county, whose mission is to help older adults remain in their homes and communities for as long as possible. For 8 years I helped our city to become more supportive of people as they age, through influencing policies, plans and programs that increase access to safe and affordable housing, fresh foods, public transportation, and accessible public spaces. Upon transitioning to the Jefferson College of Population Health (JPCH) in January 2017, access was also central to my role, yet in a different way. Access to reliable, safe, and affordable health care that

is attuned to the social and environmental determinants of health is a key component of population health.

Participants in the Montreal conference came from urban planning, community development, entrepreneurship, government, transportation, sustainability, design, and art. I felt honored to have been selected to participate in the conference, given that there were over 700 applicants from all over the world, and a special sense of responsibility because I was the only person representing the healthcare sector.

The event organizers carefully curated the three-day schedule to allow the Vanguards to be exposed to intimate situations and places within the city of Montreal. We met community leaders fighting displacement; artists creating safe spaces for at-risk youth; social entrepreneurs who created co-working spaces in vacant churches; and public artists explaining their work. We went on an informal public art tour, ate lunch at a soup kitchen, and visited a park created by community members – our learning took place every other way except sitting in a classroom! Within the past couple of years, Next City added an additional dimension to the experience: the [Big Idea Challenge](#). On the third and final day, the Vanguards were divided into five teams of eight to work with a community partner and solve

a real-life program related to the annual theme. The day then culminated with eight public presentations in a competition to determine which team would receive funds to implement the solution.

My team was composed of an architect, landscape architect, urban planner, government relations professional, transportation planner, two community organizers and myself; we were partnered with [The Montreal Urban Aboriginal Health Centre](#) (MUAHC). Montreal's Aboriginal (indigenous) population is growing rapidly, yet we quickly learned that the community lacks a culturally safe and holistic health service center that is accessible to all Aboriginal people.<sup>1</sup>

Aboriginal cultures have a different approach to wellness that involves unique rituals, from smudging (cleansing spaces through burning sage) to chanting and singing songs, playing sacred instruments, and having elders teach healing practices to those who are ill, all of which are integral to the healing process. Other barriers to care include a lack of understanding of Aboriginal social and family structure, language, and perceived discrimination. A health services mobile bus serves [The Native Friendship Centre of Montreal](#) twice a week (an Aboriginal community center). It is the only care that many have access to and it does not fulfill

their cultural needs. Our team's goal was to design a short-term solution that would be a step in the right direction towards MUAHC's need to build a fully functioning and independent health center dedicated to Montreal's Aboriginal population.

We began our collaborative process to design a Big Idea through participating in a "listening circle" at the Friendship Centre. MUAHC welcomed us into their culture through actively engaging us in several spiritual rituals, such as cleansing our hands with burnt sage smoke, which we did individually before we sat to discuss the project. Songs were sung and prayers were said. We then began to learn more about the challenges facing this community. We learned from firsthand accounts about historical traumatic events that led to economic and social inequities - unemployment, unsafe living conditions, social marginalization and poverty. We heard about the serious health disparities that led to unacceptable rates of suicide, infectious diseases, chronic conditions, mental health difficulties, and infant mortality.

On a more theoretical note, we learned about the essential components of a [medicine wheel](#), which is the Aboriginal framework for wellness that comprises physical, emotional, spiritual, and mental health. It was during this discussion, when we began to talk about the inpatient hospital setting in Montreal and the need for a culturally welcoming space in that arena as well. This conversation gave rise to our Big Idea, which was to transform an existing room within a hospital into a

Healing and Teaching Lodge, where Aboriginal patients and their family and friends could come together to focus on wellness. We chose nearby [McGill University Health Centre's Glen Site](#) as the proposed pilot site, which was undergoing construction and where our partners had very strong relationships with senior leadership. Not surprisingly, our designed room was retrofitted into the shape of a medicine wheel, decorated with Aboriginal art, a sound system, instruments, and more.

Luckily, the judges received an anonymous donation during their deliberation that allowed them to fund not one but three projects! We were one of the three who won money to implement our project after our [final presentation](#) (which can be accessed on Jefferson Digital Commons along with supporting documents, such as photos). The decision to fund this small project made a profound impact on future of the MUAHC project because it was the first funding the effort received, and it allowed the MOAHC to get some well-deserved press coverage.

One of the most outstanding outcomes of this experience for me was learning about the effectiveness and flexibility of interprofessional teams, an essential component of population health. Each person lent their expertise and asked the right questions to make this project a reality in the 4 hours that we were given



*Kate Clark presenting with her team at the Big Idea Challenge, Next City Vanguard Conference*

to brainstorm and design this idea, create a presentation, and then publicly present it. I learned the weight that a project's first funder can give to a fledgling effort which, as a board member of a small foundation that funds similar work in Philadelphia ([Union Benevolent Association](#)), was an invaluable insight. I also experienced the intense desire to have this community be heard, a result of the group experience and making a friend from the Aboriginal community in the listening circle, with whom I still communicate. Lastly, it has made me look into the disparities that our own indigenous population is facing, learn about their untold history, and seek out innovative models, such as the Alaskan [Nuka System of Care](#), that are being implemented to address health disparities through a population health lens.

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## The Changing Landscape of Primary Care: Infection Prevention and Control Implications

The vast majority of health care is delivered in primary care settings yet, until recently, most of the attention regarding patient safety and quality outcomes has focused on acute, inpatient care.<sup>1,2</sup> However, several factors -- the growth of an aging population, increase in number of individuals with chronic health conditions, and millions of previously uninsured adults gaining health insurance under the Patient Protection and Affordable Care Act -- shift the focus of health care from an acute-care hospital-based model to a preventive care model focused on population health.<sup>2,3</sup> As a result, there has

been substantial growth in the volume, complexity, and acuity of patients receiving services in primary care, compelling regulatory and accrediting organizations to take notice of patient safety risks in settings where primary care is delivered, namely: private practices, hospital outpatient departments, community health centers, and integrated care systems.<sup>2-4</sup> Primary care is considered the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with

patients, and practicing within the context of family and community.<sup>5</sup>

All healthcare settings, regardless of the level of care provided, must make infection prevention and control a priority.<sup>2,6</sup> However, compared to inpatient acute care settings, primary care settings have traditionally lacked infrastructure and resources to support infection control and surveillance activities.<sup>2,6</sup> While data describing risks for healthcare-associated infections (HAIs) are lacking for most primary care settings, numerous outbreak reports have described transmission

of bacteria (e.g., invasive *Staphylococcus aureus*) and viruses (e.g., hepatitis C, hepatitis B, parainfluenza virus).<sup>7-11</sup> In many instances, outbreaks were associated with inadequate or inappropriate infection control procedures (e.g., unsafe injection practices). To date, there are no accurate estimates for the frequency of these problems, since disease transmission in outpatient health care settings is neither systematically monitored nor likely to be routinely detected by existing surveillance systems.<sup>2,12</sup>

For these reasons, regulators and accreditors have increased scrutiny on infection prevention and control policies and practices in outpatient settings, including primary care. For example, primary care settings that are licensed under a hospital's Centers for Medicare and Medicaid (CMS) Certification Number are subject to Joint Commission regulations and inspections.<sup>13</sup> Additionally, the Accreditation Association for Ambulatory Health Care (AAAHC), a voluntary accreditor of entities such as health care networks, workplace clinics, and urgent care centers, now requires facilities to have a written infection prevention and control program based on a formal, documented IPC (infection prevention and control) risk assessment.<sup>14</sup>

### Infection Prevention and Control Risk Assessment

Risk assessment is one of the cornerstones of IPC. Facility IPC risk assessments are conducted to: 1) provide a basis for infection surveillance, prevention and control activities; 2) identify at-risk populations/procedures at a facility; 3) assist in focusing surveillance efforts toward targeted goals; and 4) aid in meeting regulatory and other requirements.<sup>15</sup> Identified risks can be prioritized using criteria such as likelihood of occurrence or severity of impact. Facility risk will vary based on services provided and characteristics and behaviors of its population served.

The risk assessment should be conducted using a standardized tool by the institutional

infection prevention program in collaboration with facility staff. The schedule of review is determined after the initial assessment, but needs to be least annually.

Recognizing the potential infection threats to patients in outpatient care facilities, the Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) issued the *Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care* in 2011. Updated in 2016,<sup>16</sup> the document highlights existing CDC and HICPAC recommendations and provides basic infection prevention recommendations for outpatient (primary care) settings; reaffirms *Standard Precautions* as the foundation for preventing transmission of infectious agents during patient care in all healthcare settings and provides links to full guidelines and source documents. The guidance includes a companion checklist intended to assist in the risk assessment of infection control programs and practices. The checklist is used to ensure that the facility has appropriate infection prevention policies, procedures and supplies in place to allow healthcare personnel to provide safe care. It can also be used to systematically assess personnel adherence to correct infection prevention practices. Assessment of adherence requires direct observation of health care providers during performance of their duties. The checklist includes the basic tenets of infection prevention and control including: general infection prevention education and training, occupational health, surveillance and disease reporting, hand hygiene, personal protective equipment, injection safety, respiratory hygiene/cough etiquette, environmental cleaning, reprocessing of reusable medical devices, sterilization of reusable instruments and devices, and high-level disinfection of reusable instruments and devices.<sup>16</sup>

Based on the CDC checklist, we developed and launched a survey of the Delaware Valley/Philadelphia chapter of the *Association for Professionals in Infection*

*Control and Epidemiology* (APIC) to describe the implementation of infection prevention, control and surveillance policies in primary care.<sup>17</sup> Of the 109 responding infection preventionists (50% response rate), half worked in acute care settings and none were specifically employed in a primary care facility. Although half of hospital IPC departments were involved in providing services to primary care settings, resources in terms of time and staffing were limited. The majority (62%) of respondents who had primary care responsibilities reported spending 5% or less of their time on IPC activities in this setting. The top infection control issue identified was inappropriate sterilization and disinfection of medical equipment.

The basic elements of an IPC program are designed to prevent the spread of infection in healthcare settings. When these elements are present and practiced consistently, the risk of infection among patients and healthcare personnel is reduced. Our study identified important challenges in carrying out IPC activities in primary care including lack of staffing resources. According to IPC manager, Kelly Zabriskie, BS, CIC, of Thomas Jefferson University Hospital, a dedicated infection preventionist for the primary care and outpatient sites has been approved for hire, and will become an integral part of advancing evidence-based infection prevention and control practices at these sites.

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# From Clinic to Program: PRIDE and the evolution of LGBTQ+ Healthcare at Einstein Medical Center Philadelphia

In 2015, Dr. Michele Style, resident physician and co-founder of Einstein Health Network's Pride Clinic, treated a patient who presented with advanced-stage cervical cancer. Although the patient had health insurance and lived within walking distance of the hospital, she had avoided preventive care, including routine Pap smears. During the course of her treatment the woman disclosed that she identifies as a lesbian and feared she would be judged and unwelcome at the hospital due to her sexual orientation. As such, she had avoided pursuing life-saving screenings that could have prevented the progress of her cancer. Unfortunately, her story reflects a much larger trend in healthcare access and outcomes.

According to national research, individuals who identify as lesbian, gay, bisexual, transgender, and queer are more likely to experience discrimination in healthcare settings. In a 2010 survey conducted by [Lambda Legal](#), 70 percent of transgender respondents, and almost 56 percent

of lesbian, gay, and bisexual research participants, reported experiencing at least one instance of discrimination while trying to access health services.<sup>1</sup> In a similar analysis conducted by the [National Center for Transgender Equality](#), in partnership with the [National Gay and Lesbian Task Force](#), 19 percent of the trans-identified respondents described having been outright denied health care due to their gender identity. The same survey found that 28 percent of respondents reported being harassed, while an additional two percent experienced physical violence, all in the course of seeking medical care.<sup>2</sup>

Avoiding healthcare settings due to concerns regarding safety, comfort, and acceptance has left a large swath of our population without adequate care. Indeed, in the City of Philadelphia alone it is estimated that roughly 3.9% of the population,<sup>3</sup> a little over 60,000 people, identify as LGBTQ+. Yet despite the demand, LGBTQ+ competent services are limited. Aside from the [Mazzoni Center](#)

in center city Philadelphia, which provides medical services specifically targeting lesbian, gay, bisexual, and transgender-identified patients, LGBTQ+ competent care is sparse. At the time that Dr. Style first met with the aforementioned patient, there were no medical establishments in North Philadelphia or Montgomery County dedicated to the unique needs of our local LGBTQ+ communities. In 2015 the Einstein Healthcare Network sought to address this gap in coverage and set about establishing an OB/GYN clinic solely dedicated to caring for lesbian, gay, bisexual, transgender, and queer-identified patients.

Since its inception, the [Pride Clinic](#) has specialized in obstetrics, gynecology, and preventive care, for the LGBTQ+ community. In alignment with Einstein Healthcare Network's mission, the Pride Clinic provides LGBTQ+ identified patients with access to a safe, respectful, and confidential

*Continued on page 10*

environment that ensures clinical excellence and compassionate care. For two hours, once a month, a small team of competent, dedicated providers offers OB/GYN and wellness care to the LGBTQ+ community of North Philadelphia. To date, the Clinic has seen over 50 patients, many of whom reported they had previously not received OB/GYN care, or any healthcare services, in more than a decade, if ever. Surveys completed by all who have visited clearly show they would highly recommend the service to peers.

Thanks to the generous support of the [Albert Einstein Society](#), what started in 2015 as a once-a-month OB/GYN clinic has expanded into the central hub for LGBTQ+ care throughout the Einstein Healthcare Network. In addition to Pride's monthly OB/GYN clinic, the Pride Program is now able to offer LGBTQ+ specific mental health and wellness care as well as endocrinology and surgical services for our trans-identified patients. As part of ensuring LGBTQ+ identified patients are receiving quality services throughout the Health Network, the Pride Program offers

comprehensive training and education to all interested employees, including department-specific training tailored to provider's needs. As part of this work, the Pride Program has been instrumental in advancing policies that support our LGBTQ+ identified patients and staff, including advocating for essential changes to our electronic medical records system and employment application paperwork.

When the then-Jewish Hospital (now Einstein Healthcare Network) was established in 1866, it offered compassionate care of the highest quality to those with the greatest needs and least access. The establishment of the Pride Clinic is yet another example of this commitment. As the Pride Program continues to grow, it helps realize Einstein Health Network's mission: "with humanity, humility and honor, to heal by providing exceptionally intelligent and responsive healthcare and education for as many as we can reach."

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# The "Accelerating Policies & Research on Food Access, Diet, and Obesity Prevention" Symposium and Its Public Health Significance

On April 28th, 2017 the [University of Pennsylvania Prevention Research Center](#) (UPenn PRC) hosted a Symposium called "Accelerating Policies and Research on Food Access, Diet, and Obesity Prevention." The UPENN PRC is one of 26 Prevention Research Centers across the nation, funded by Centers for Disease Control and Prevention (CDC) through a school of public health or a medical school that study how people and their communities can avoid or counter the risks for chronic illnesses, such as heart disease,

obesity, and cancer.<sup>1</sup> Each PRC has a specific prevention research focus. In Philadelphia, the UPenn PRC's research focus is a randomized control trial for incentives and environmental strategies for weight loss.<sup>2</sup>

The symposium featured a wide range of national, regional, and local distinguished scholars and leaders to bridge the gap between research and practice. After a welcoming address by Dr. Karen Glanz, UPenn PRC's Director, Dr. Margo Wooten

was introduced as the first keynote speaker. As Director of Nutrition Policy at the [Center for Science in the Public Interest](#), Dr. Wooten is a national expert in public health policy and advocacy initiatives, and has been instrumental in policy efforts to: require calorie labeling at fast-food and other chain restaurants; require labeling on packaged foods; improve the nutrition of school breakfast and lunch programs; reduce junk food marketing towards children; and expand the nutritional and physical activity

programs at the Centers for Disease Control and Prevention (CDC). She explained how many of people believe that they are in control of their food choices, but that external forces have a big influence (through food industry marketing) over everyday decisions. For example, the placement of food in supermarkets is strategically decided and paid for by manufacturers to help convince people to buy certain foods; the food industry typically pays for ideal spots, right at the consumer's eye level in food markets. It is possible to find soda in multiple places along the supermarket route, but moving beyond the vegetable aisle it is unlikely that fresh vegetables will be found again in other sections.<sup>3</sup> For a description of the strategic layout of supermarkets, click on this link: [www.cspinet.org/rigged](http://www.cspinet.org/rigged).<sup>3</sup> Dr. Wooten also addressed how policies like soda taxes are a great way to help change behavior and fund important programs, such as education and parks and recreation to enhance physical activity. She emphasized that nutrition education alone is not enough to improve the way people eat, but through policy and advocacy supported by public education, we can improve food quality and access.<sup>4</sup>

The second keynote speaker was Dr. Mariana Chilton from the Dornsife School of Public Health at Drexel University, the Director of the [Center for Hunger-Free Communities](#) and the Co-Principal Investigator of [Children's Health Watch](#), a national research network that investigates the impact of public assistance programs through data obtained from surveys given to caregivers. Dr. Chilton founded the [Witnesses to Hunger](#) initiative, a participatory action study to increase engagement among women in poverty in the national dialogue on hunger and poverty.<sup>5</sup> Dr. Chilton's presentation and the videos and photos she shared, of women and children living in poverty, was nothing

short of inspiring and motivational. She expressed the importance of dialogue that addresses how to improve the systems we have in place for those in poverty. Through [Witnesses to Hunger](#), mothers are able to tell their own stories of hunger and advocate for their own families and communities. While many of the speakers at the symposium expressed their concern about the impact of the current federal administration's policies on the future of food access and programs like the [Supplemental Nutrition Assistance Program](#) (SNAP), Dr. Chilton shared data that showed the relationship between food insecurity and poor cognitive, social, emotional development in children and how SNAP benefits improve the health of most needy populations.<sup>6</sup> In addition, those who have experienced very low food security have also experienced short-term violence. In light of this data, it is imperative that we advocate to our government representatives, on behalf of our communities, in order to ensure the security of essential programs like SNAP. The most powerful image presented was a picture one mother had taken of a broken phone. It represented that most people who are food insecure want to get help, but without methods of access, are unable to get the help they need. Dr. Chilton expressed how welfare and other government programs often keeps families in the chains of poverty due to that fact that earning a meager income in order to get out of poverty, can put them at risk of losing food stamps. She also emphasized that if we want to end hunger, we need to address racism as well. One can also support the Center for Hungry Free Communities by eating at EAT (Everyday at the Table) Cafe, Philadelphia's first pay-what-you-can restaurant where, regardless of your ability to pay, you can enjoy a three-course meal.<sup>7</sup>

In addition to the two plenary presentations, there were a wealth of panel presentations

and breakout sessions on a wide range of health and nutrition, food policy and research topics. Several directors from other CDC Prevention Research Centers presented their community-based research initiatives as did key national nutrition and health leaders such as Tracy Fox, MPH, RD, [Food, Nutrition & Policy Consultants](#); Jennifer Pomeranz, JD, MPH, [NYU College of Global Public Health](#); Amy Lazarus Yaroch, PhD, [Gretchen Swanson Center for Nutrition](#); Cheryl Bettigole, MD, MPH, [Philadelphia Department of Public Health](#); Allison Karpyn, PhD, [University of Delaware](#); Yael Lehmann, [The Food Trust](#); and Carolyn Cannuscio, ScD, ScM, University of Pennsylvania. They all discussed innovative and successful policies and strategies in the context of the uncertainty of funding support under the new administration to help our most needy populations.

Speakers at the symposium offered a plethora of information that can be used to continue to make a difference and improve communities across our nation. The main take-away was that it is extremely important that research, policy, and advocacy must be included as part of the agenda in order to see successful, sustained, community and environmental change to reduce poverty and increase food access and healthy nutrition.

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# A Look at Interdisciplinary MPH Student Projects

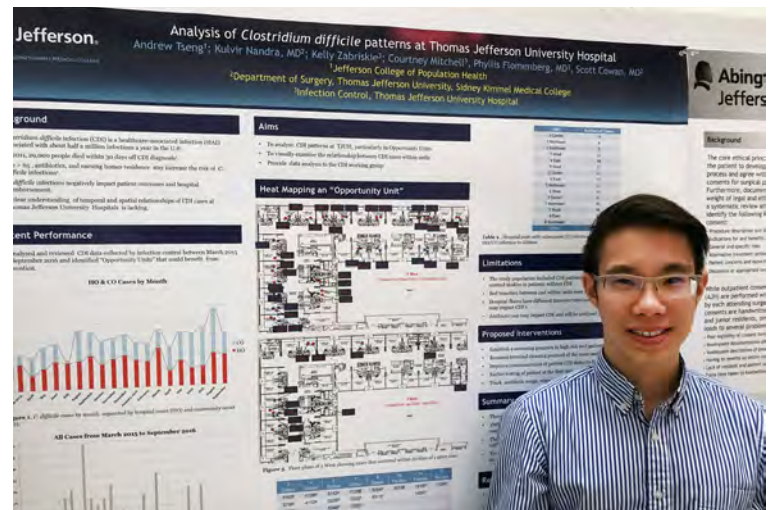
MPH graduate student Andrew Tseng (2017) completed two fascinating interdisciplinary projects as part of his workload at JCPH, which exemplifies the importance of collaborative work among professionals of diverse backgrounds to achieve population health goals.

The first project, which culminated in a poster entitled, *Clostridium Difficile (CDI) Patterns at Thomas Jefferson University Hospital*, was a quality improvement effort with the Surgery Department that looked at the infection's spatial patterns in TJU hospital units. CDI is a healthcare associated infection that affects half a million people a year in the U.S. and in 2011, 29,000 people died within 30 days of a CDI diagnosis. It negatively impacts patient outcomes as well as hospital reimbursement. Tseng identified the need for a clear understanding of temporal and spatial relationships cases in TJUH units and created a heat map to depict the CDI cases in the hospital between March 2015 and September 2016. The units with higher CDI rates, or "opportunity units," were highlighted to determine if there were any patterns between community onset and hospital onset CDI cases. In addition, the project examined same bed re-infections within 30 days in the hospital. The study combined the

usage of maps and health data to explore pattern and rates.

The second project that Tseng worked on was with the Department of Family and Community Medicine on a 5 year grant from Health Resources Service Administration (HRSA) called JeffAPCT

(Accelerating Primary Care Transformation). Among many of its goals, was to improve colorectal cancer (CRC) screening through quality improvement projects, as primary care physicians are often responsible for making the referral for a CRC screening. CRC is the third most diagnosed cancer in the United States and increasing screening rates for those aged 50 to 75 is paramount to preventing the disease. Despite the importance of primary care physicians in the referral process, there are significant



MPH Student Andrew Tseng

variations in this process, which often lead to lower screening rates. Tseng's MPH capstone focused on evaluating the trend of CRC screening rates in TJUH and determine which interventions made an impact in increasing the screening rate. CRC screening rates have been increasing in the U.S. and CRC rates have been decreasing as a result. The results will hopefully inform Jefferson of what interventions have been effective and if the rates are increasing. Currently, Tseng is applying to medical programs from his home town in Huntington Beach, California.

## JCPH at International Society for Pharmacoeconomics and Outcomes Research (ISPOR) 22nd Annual Meeting

### POSTER PRESENTATIONS

**Djatche L**, Alcusky M, **Singer D**, Hegarty S, Keith S, Lombardi M, **Maio V**. Does providing more services influence healthcare utilization rates and processes of care among medical homes?

**Djatche L**, Mitchell E, **Delgado D**. Age disparities in inflammatory breast cancer survival by race and hormonal receptor status: an analysis of 1990-2013 SEER data.

El-gendi S, Ziadeh M, **Djatche L**, Pickering M, Kim D, Le T, Perfetto E. Factors associated

with misdiagnosis an under-diagnosis of Alzheimer's disease: a systematic review.

Goble J, **Djatche L**, Chun G, **Varga S**. Evaluating value based framework in the US marketplace: challenges in real world application.

**Singer D**, **Crawford A**, Fortner G, Goldfarb N. Rates of prescriptions for high opioid daily doses across multiple employer group plans in Eastern Tennessee.

**Singer D**, Alcusky M, Hegarty S, et al. Do medical homes influence healthcare utilization rates and process of care measures?

**Singer D**, **Djatche L**, Payton C, **Maio V**, Scott K. Prevalence and factors associated with completing MMR vaccination series in a recently resettled refugee population.

**Singer D**, Alcusky M, Mitchell E, **Delgado D**. Early stage breast cancer treatment patterns by joint receptor subtype and insurance status.

### ORAL PRESENTATION

**Djatche L**, **Varga S**, Lieberthal R. Long-term cost effectiveness of adherence to aspirin for secondary prevention of cardiovascular events.

## IDEAS AND ARTICLES WELCOME FOR POPULATION HEALTH MATTERS

If you have been engaged with an interesting project, initiative or event, or if you have a passion for a particular topic that you would like to write about, we want to hear from you! Author guidelines can be accessed on [Jefferson Digital Commons](#). Inquiries and submissions can be emailed to: [jcphnewsletter@Jefferson.edu](mailto:jcphnewsletter@Jefferson.edu). The next submission deadline is **October 2, 2017**.

# Capitol Hill Days 2017

From March 25th-27th, we attended [Population Connection's](#) Capitol Hill Days to advocate for international family planning funding and repeal of the [Global Gag Rule](#). During the event, we learned the public health impacts of cuts to family planning funding and the reinstatement of the Global Gag Rule on global reproductive health, maternal and child health, and the environment. We spent three days developing our advocacy and lobbying skills. To open the event, we attended the 3rd annual "Empower Her, Empower Humanity" award ceremony, celebrating [Congresswoman Barbara Lee](#) and her advocacy and work on reproductive rights and family planning.

We attended a variety of workshops and discussions led by speakers including: Chloe Cooney, Director of Global Advocacy, [Planned Parenthood Federation of America](#) (PPFA); Jessica Marcella, Vice President for Advocacy and Communications at the [National Family Planning and Reproductive Health Association](#) (NFPRHA); Meaghan Parker, Senior Writer/Editor for the [Wilson Center, Environmental Change and Security Program](#); Dianah Wabwire, Program Manager for the

[Conservation through Public Health](#) (CTPH); and Teresa Omondi-Adeitan, Executive Director for the [International Federation of Women Lawyers](#) (FIDA-Kenya). The speakers engaged the audience on topics such as environmental health, domestic and global family planning issues. We left the sessions feeling empowered to lobby for women's rights globally, and were reminded by Chloe Cooney that, "You only get what you fight for. And we've got to fight every step of the way."

Our last sessions prepared us for Capitol Hill with grassroots organizing, lobbying and advocacy workshops that provided us with the tools to become activists on the hill and in our respective communities. We ended the event with a powerful keynote speech from [Jamila Perritt, MD, MPH, FACOG](#) an Obstetrician and Gynecologist, reproductive health and family planning specialist and passionate advocate for reproductive health and rights.

On Monday, we took our skills to Capitol Hill. We met with the offices of U.S. [Senator Bob Casey](#) (PA), U.S. [Senator Pat Toomey](#) (PA), U.S. [Congressman Dwight Evans](#) (2nd District

PA), and U.S. [Congressman Tom Marino](#) (10th District PA). We expressed the importance of funding for global family planning, and the harmful outcomes of the Global Gag Rule, particularly for underserved and impoverished communities. We reiterated to our state representatives that family planning is crucial for improving preventive healthcare and maternal health, as well as protecting our national security and the environment.

In all, Capitol Hill Days served as a great opportunity for sharpening our advocacy skills on a pertinent issue affecting all populations on a global scale, and putting skills learned from our MPH program into practice.

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## FALL 2017 JCPH FORUMS

### September 13

Population Health Informatics: Challenges, Opportunities and Case Studies

#### Hadi Kharrazi, MHI, MD, PhD

Assistant Professor  
Johns Hopkins School of Public Health  
Johns Hopkins School of Medicine

Bluemle Life Sciences Building, Room 101

### October 11 \*

Re-Envisioning Population Health for Vulnerable Older Adults: The LIFE Story Today and Tomorrow

#### Mary D. Naylor, PhD, RN, FAAN

Marian S. Ware Professor in Gerontology  
Director, NewCourtland Center for Transitions and Health  
University of Pennsylvania, School of Nursing

#### Pam Mammerella

Vice President of Marketing & Government Affairs  
NewCourtland Senior Services

#### Luz S. Ramos-Bonner, MD, FACP, AGSF, CMD

Medical Director for NewCourtland Primary Care Practice  
Jefferson Alumni Hall, Atrium

### November 8

Health Transformation: Preparing Population Health Leaders for the Future

#### Peter Fleischut, MD

Senior Vice President and Chief Transformation Officer  
New York – Presbyterian Hospital

Bluemle Life Sciences Building, Room 101

### December 6

A Value-Based Approach to Orthopedic Care

#### Christina Vannello, RN, BSN

Director of Quality  
Rothman Institute

#### Dave Janiec, MBA

Director of Contracting  
Rothman Institute

Bluemle Life Sciences Building, Room 101

\*This Forum will be followed by a special Grandon Society member-only interactive session from 9:45 am – 10:30 am.

Forums take place from 8:30am - 9:30am and are free of charge. Forums are designed for Jefferson students, faculty and staff; health care professionals, administrators, public policy analysts, advocates, and community health leaders.

For more information visit: [Jefferson.edu/PopHealthForum](http://Jefferson.edu/PopHealthForum)

# Meet the New JCPH Health Economics Outcomes Research Fellows



**Lauren Bartholomew, PharmD**  
*Novartis, AG*

Lauren grew up in Florida and received her PharmD from the University of Florida. During her time in pharmacy school, she sought out careers in the pharmaceutical industry because she was drawn to the impact a pharmacist can make on a population of patients. One of the most impactful experiences for her during pharmacy school that led her to Novartis/TJU Fellowship was an 8-week rotation in the HEOR group at Novartis. Lauren is excited to be part of this program to learn the skills necessary for a successful career in HEOR and how this field can shape the future of healthcare.



**Alberto Batista, PharmD**  
*Teva Pharmaceuticals*

Alberto received his PharmD from Florida A&M University, after having experience in managed care and healthcare consulting. Prior to pharmacy school, Alberto worked for the United Health Group where he participated in medication utilization evaluations and pharmacy cost containment strategies. During pharmacy school, Alberto gained valuable experiences at the State of Georgia Medicaid Program,

the Food and Drug Administration, and Pharmerit International. He now serves as a market access consultant at Pharmerit, where he provides evidence-based clinical opinions related to new drug and medical device launches in emerging markets. Alberto's ultimate goal is to apply his consulting and pharmacy knowledge to impact the evolving global healthcare landscape by identifying unique solutions for managing limited healthcare resources.



**Sonia Lee, MSPH**  
*Ethicon*

Sonia received her MSPH in Health Policy at Johns Hopkins Bloomberg School of Public Health. Her interest in health economics was sparked by a HEOR internship at Janssen, which inspired her to complete a health economics certificate at JHSPH. She diversified her background by working at CareFirst BlueCross BlueShield, the Center for Medical Technology Policy, and in vaccine economics research at the Johns Hopkins International Vaccine Access Center. Sonia served as a federal health policy analyst at The Lewin Group, where she supported its primary care model contract with CMS (CPC+). She also worked on an ONC contract about state health information exchanges and strategic planning for CMS's

cardiac bundled payment model. Sonia is generally interested in the interface between pharmaceutical policy and health economics and would like to learn more about the analytic methods that are used to determine the economic impact of healthcare technologies during the Fellowship.



**Jennifer Voelker, PharmD**  
*Janssen Scientific Affairs, LLC*

Jennifer received her PharmD from the University of North Carolina in May 2017, and is excited to start her career in HEOR. Jennifer's interest in HEOR began at Select Health, a regional managed care organization; during this internship, she had the opportunity to conduct a retrospective claims database study on the impact of the 2013 ACC/AHA cholesterol guidelines. The ability to use real-world evidence to observe trends in population health parameters prompted her interest in pursuing a career in HEOR. She also enjoyed learning more during her APPEs in the GHEOR department at Xcenda and the Value, Evidence, and Outcomes department at GSK. She hopes to utilize and expand upon her current skill set in HEOR to help improve the healthcare system by ensuring optimum patient outcomes while efficiently utilizing available resources.

## POPULATION HEALTH FORUMS

### Medicare at Fifty Years: Its Effect on Disparities

**Edith P. Mitchell, MD, FACP**

*Clinical Professor of Medicine and Medical Oncology*

*Department of Medical Oncology*

*Associate Director for Diversity Programs*

*Sidney Kimmel Cancer Center at Jefferson*

*April 12, 2017*

Edith Mitchell, MD, FACP, is a renowned researcher, clinician, leader, and advocate in cancer prevention, treatment, and disparities. She is member of the [Cancer Moonshot<sup>SM</sup> Blue Ribbon Panel](#) and is a decorated General in the Air Force. As Dr. Nash said when he introduced Dr. Mitchell, "She's been an important fixture at

Jefferson for a long time and is a national powerhouse...there is no better person to help us understand...not only the progress we've made...but identifying the challenges in making sure that we deliver care, we narrow the gap and decrease disparity."

"How many people in the audience have worked with a parent or a friend to sort through Medicare paperwork?" "And how many people are Medicare-wannabe -- in other words, someone who plans to live long enough to receive Medicare?" This how Dr. Mitchell opened the Forum, driving the point home that we are all impacted by Medicare in some way.

Dr. Mitchell first provided an overview of Medicare history, reminding the audience that the program was first administered by the U.S. federal government in 1966. July 1, 2016 marked 50 years since the birth of Medicare. It was initially set up for Americans aged 65 and older, who have worked and paid into the system, and younger people with disabilities. January 1, 1966 was when enrollment occurred. There has been a steady and significant increase Medicare enrollment since it was first implemented. By 2014, 15.6% of Americans were covered. She emphasized that, since then, the overall survival for Americans has increased -- which means we can expect the number of

Medicare enrollees to continue to increase.

Dr. Mitchell pointed out some of the key important historical markers of the Medicaid program:

- President Nixon signed the Social Security Amendments in 1972, which made more individuals eligible for Medicare.
- The establishment of the Health Care Financing Administration was created to administer both Medicare and Medicaid programs.
- President Clinton signed the Balanced Budget Act of 1997; this extended the financial solvency of the Hospital Insurance Trust fund to 2010.
- Creation of the Children's Health Insurance Program (CHIP).
- Clinton signed the Balanced Budget Refinement Act (BBRA) in 1999.
- Changing the name HCFA (Healthcare Financing Administration) to Centers for Medicare and Medicaid Services (CMS) in 2001.

Dr. Mitchell explained that additions to Medicare coverage over the years included benefits such as Medicare coverage to individuals with End Stage Renal Disease; hospice care, and coverage for younger people with ALS.

Dr. Mitchell's interest in Medicare was ignited by research she conducted on racial differences in cancer. She explained differences in how cancer care is covered by insurance, comparing white patients to black patients. For example, commercial insurance may be the dominant form of coverage for cancer treatment in white

younger patients (ages 40-64); whereas Medicaid and Medicare play a significant role in payments for black patients undergoing cancer treatment.

Medicare was a major force in racial desegregation of health facilities. As part of the Civil Rights Act, any institutions receiving federal funds were required to comply as a condition of their participation in the Medicare program. Hospitals integrated their staffs, waiting rooms and wards; admission rates for blacks rose; and disparities in access to hospital services for people of all ages began to narrow. Dr. Mitchell explained that the impact of the Civil Rights Act on hospitals became one of the major areas of integration, with little resistance.

Mitchell described current eligibility criteria for Medicare benefits. Persons 65 years of age and older, and legal residents of the U.S. for at least 5 years are eligible for Medicare. People with disabilities under 65 are eligible if they receive Social Security Disability Insurance, and specific medical conditions may afford eligibility. Medicare Part B is optional and may provide coverage for various outpatient services, tests, and medical equipment. Part C (Medicare Advantage) typically includes a monthly premium and may include prescription drugs, dental care, and vision care, etc. Part D covers prescription plans.

Mitchell went on to discuss MACRA (Medicare and CHIP Reauthorization Act), which was signed into law in 2015. She explained that MACRA streamlines and balances existing Medicare quality reporting programs into the Merit-Based Payment Incentive System (MIPS) and provides financial incentives for providers who

move into alternative payment models. It also helps to extend CHIP and funding for community health centers.

The future of the Affordable Care Act and Medicare is uncertain, explained Dr. Mitchell. Despite the number of adults that have gained coverage through the ACA and Medicare expansion, various proposals in Congress could impact some of the successful benefits of these programs.

Dr. Mitchell was then joined by Ronald Myers, DSW, PhD for the [Grandon Society](#) workshop. Dr. Myers is the Director of the [Division of Population Science](#) and [Center for Health Decisions](#) (CHD) at Thomas Jefferson University. His areas of expertise include patient adherence to cancer screening, physician follow-up of abnormal cancer screening test results, informed decision making in cancer susceptibility testing, and cancer disparities research.

Using the context of the current political and economic challenges of healthcare, Dr. Myers discussed the framework of the collective impact learning model which is actually used at Jefferson for cancer patients and overall can improve health and reduce disparities. He emphasized the importance of thinking about solutions beyond legislation, and to think about an institutional approach to improve care. Patient engagement is a big focus of Dr. Myers' work. Dr. Mitchell added to the exchange by examining the idea of incentivizing patients.

Both speakers provoked a lively audience discussion on Medicare, quality, and costs.

## New Developments in Genetic/Genomic Testing: Implications for Population Health

### Vivian H. Coates, MBA

*Vice President, Information Services and Health Technology Assessment  
ECRI Institute  
May 10, 2017*

Vivian Coates, MBA, is Vice President of Information Services and Health Technology Assessment at [ECRI Institute](#) where she develops and leads the evidence-based medicine and health technology assessment program, including the Evidence-based Practice Center (EPC)

and the Health Technology Assessment Information Service (HTAIS) for health plans, hospitals/health systems and health policymakers. Ms. Coates' most recent initiative is the development of ECRI's personalized medicine resource on genetic/genomic testing, [ECRIgene](#). This interactive database includes critical information on hundreds of genetic, genomic and proteomic tests meeting ECRI's criteria for inclusion.

ECRI Institute is a nonprofit health services

research organization with a history of over 47 years of laboratory-based medical device evaluations, and 25 years of conducting health technology assessment, forecasting and comparative-effectiveness research (CER). ECRI has a special relationship with the Agency for Healthcare Research and Quality (AHRQ), where they have maintained their role as an evidence-based practice center since 1997. ECRI has also created the National Guideline

*Continued on page 16*

Clearing House and National Quality Measures clearing house for AHRQ.

Ms. Coates' presentation focused on the human genome. A genetic test analyzes a single gene, while a genomic test analyzes an entire or large portion of the genome. These tests involve analysis of human chromosomes, DNA, RNA, genes and/or gene products predominately used to detect heritable or somatic mutations and genotypes related to disease and health. Ms. Coates explained that genetic/genomic tests are more widely available due to less expensive, quicker, and improved technologies, and advent of the [Human Genome Project](#).

Personalized medicine, explained Coates, is not a new concept. It's a way of customizing treatment for individual patients. It's an area that has evolved during the past few decades due to the advance in genetic science and technologies. Genetic testing can provide crucial information to accurately predict risk of developing disease, disease progression, and response to treatment. The effectiveness of personalized medicine really depends on how well clinicians understand each person's unique characteristics.

Coates described ways in which genetic

tests can pose challenges related to costs, practice, and policy. There are concerns regarding: the increasing complexity of multigene test panels and underlying platforms in the face of huge gaps in evidence; aggressive direct-to-consumer and provider marketing by the labs; ordering, interpretation, patient counseling, and a shortage of genetic counselors; and intensive time and resource requirements. Many tests serve different purposes, from carrier screening to monitoring to risk assessment.

Adding to the challenges are issues of regulation and reimbursement, with a plethora of federal and state certifications and pathways and varying levels of rigorous evaluation. Coates emphasized that the FDA is very concerned about genetic tests and may increase their oversight of Laboratory Developed Tests (LDTs). It has been found that some LDTs have high false negative and/or false positive results, inflated claims of accuracy, and weak clinical validity.

Coates went on to describe the challenges for payers. Lack of evidence showing clinical utility of a test creates a major barrier for insurance reimbursement. Sources for informing coverage decisions have limitations and are not available for

all genetic tests. Although payers such as Medicare may be influential, their decisions may not translate well to genetic tests for those under the age of 65.

The most important domains that ECRI examines to assess genetic tests include: analytic validity; clinical validity; and clinical utility. Coates explained that poor analytic validity will often compromise clinical validity and clinical utility, therefore efforts are focused on evidence for clinical validity and utility. She referred to a "chain of evidence," which includes some of the following issues: whether or not the test detects the genetic variant accurately and reliably; whether the test detects the disease accurately; and whether the treatment will lead to improved health outcomes.

Coates ended her presentation by discussing the impact of genetic testing on population health. She pointed out that, in many instances, precision medicine has caused a paradigm shift in treatment and helped to achieve superior health outcomes. There are, however, challenges in development of a comprehensive genetic/genomic testing approach for population-based care. Gaps in evidence do exist and the underlying science and data analytics must continue to improve.

## Improving Health Outcomes: Meeting the Basic Needs of Populations

### Ginger Zielinskie, MBA

President & CEO  
Benefits Data Trust  
June 14, 2017

Ginger Zielinskie is President and CEO of [Benefits Data Trust](#) (BDT), a national not-for-profit social change organization (active in 7 states) that is committed to transforming how individuals in need access public benefits and services. Ms. Zielinskie works with states, cities, community-based organizations, and the private sector to understand the true outcomes achieved when people are able to meet their basic needs (i.e. food, shelter, income, access to care, affordability of prescriptions etc.). BDT also seeks to push system change forward, thinking of ways to share data effectively across sectors.

Ms. Zielinskie began her presentation by providing an overview of some of the issues

of concern for BDT. She explained that 90% of national healthcare expenditures are spent on medical care, while 40% of overall health is attributed to socio-economic factors such as food insecurity and financial resource strain. Over 85% of physicians agree that unmet social needs lead to poor health outcomes for patients. Many physicians also agree that they do not have the resources to support patients' social needs. To further build upon this framework, she explained that it is known that increased prescription adherence reduces hospitalizations; food insecurity is significantly associated with diabetes and cardiovascular risks; and Low Income Home Energy Assistance Program ([LIHEAP](#)) enrollees are less likely to require acute care related to unsafe heating practices.

Zielinskie described a research study aimed at showing how access to food and energy

assistance improves health outcomes and reduces costs. BDT's partners included [Johns Hopkins School of Nursing](#), [The Hilltop Institute at UMBC](#), [Maryland Department of Health and Mental Hygiene](#), and the [Robert Wood Johnson Foundation](#). "I can't underscore enough...how critical good partnerships are," states Zielinskie. This group worked together on a weekly basis for two years. The study sought to show that access to food and energy assistance improves health outcomes and reduces costs. They looked at dually eligible adults 65 and older in Maryland and examined Medicare claims data, Supplemental Nutrition Assistance Program (SNAP) participation data, and LIHEAP benefits.

Zielinskie pointed out what she called a 'stunning finding' – the average annual income for almost 70,000 adults over the



age of 65 was \$5,800 and most of the population was female. She explained that this type of poverty is a both a rural and urban problem that can be found among all races. The findings also revealed that only half of this population was enrolled in SNAP. Zielinskie emphatically stated that this is a “huge failure.” Additionally, only 21% were enrolled in an energy assistance program. The study showed that 17% of this population ended up in nursing homes, at an average cost of \$28,091 per admission; and 28% of the population landed in the hospital at an average cost of \$25,091 per admission. Zielinskie discussed the irony regarding reluctance to spend a little to cover basic needs (\$339 annually for energy assistance and \$1404 annually for SNAP) versus the cost to cover hospital or nursing home care. SNAP participation significantly reduces odds of nursing home and hospital

admission and shorter stays, and odds of emergency department use and fewer visits.

Zielinskie then outlined the research implications for low-income seniors. Across the country, over 5.5 million eligible low-income seniors are not enrolled in SNAP. The estimated healthcare savings is \$2,300 per senior SNAP enrollee per year and \$6,900 over a three-year recertification period. Overall, closing the gap in senior SNAP participation can produce an estimated \$38 billion nationwide in healthcare savings.

Many programs exist to help meet the basic needs of food, shelter, income, education, and healthcare. Zielinski again emphasized that the problem is access and making sure that programs are well funded. One way in which to ensure the success of these

programs and overall well-being of the population is to connect the dots on social determinants of health – connect and strengthen our private and public health care partnerships, payers, providers, state agencies, and local health and human service agencies. It also means sharing data and looking at how we shape interventions across the continuum and through the ecosystem, explained Zielinskie.

“We need to partner in the right way, to continue to demonstrate the positive outcomes and the savings that can be generated,” stated Zielinskie. She encouraged us to re-examine about how we think of families on a continuum to better health and financial independence.

To view Forum slides and listen to audio recordings visit [Jefferson Digital Commons](http://Jefferson.Digital.Commons).

## CONGRATULATIONS TO JCPH GRADUATES!

Make sure to check out the impressive capstone presentations of JCPH students on Jefferson Digital Commons: [JDC.Jefferson.edu/jcph](http://JDC.Jefferson.edu/jcph)

## JCPH PRESENTATIONS

Cole JG, **Skoufalos A**, Collins L, Finley R. Building a community of educators: learning from each other. Presented at: Thomas Jefferson University 9th Annual Faculty Day, June 6, 2017.

Cunningham A, **Delgado D, Jackson J, Crawford A**, Jabbour S, Lieberthal RD, **LaNoue M**. Evaluation of an ongoing diabetes group medical visit: participant representativeness, attendance, and outcomes. Poster presented at: AcademyHealth 2017 Annual Research Meeting, June 25 -27, New Orleans, LA.

**LaNoue M**, Cunningham A, Kenny L, Helitzer D, Abatamarco D. Variations in the perceived impact of adverse childhood experiences. Poster Presented at: AcademyHealth 2017 Annual Research Meeting, June 25 -27, New Orleans, LA.

**LaNoue M**, Wlodarczyk J, George B. Keith S. An examination of the cumulative effects model of adverse childhood experiences (ACEs): are all events created equal? Podium presentation at: AcademyHealth, 2017 Annual Research Meeting, June 25-17, New Orleans, LA.

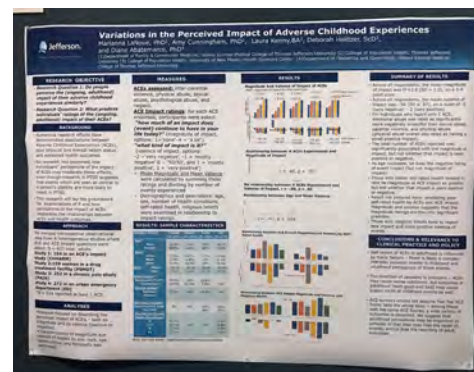
Mills G, Cunningham A, Silverio A, **Crawford A, LaNoue M**. Exploring non-clinical factors that contribute to clinical inertia in diabetes. Poster presented at: 2017 North American Primary Care Research (NAPCRG) Practice Based Research Network Conference, June 22-23, 2017, Bethesda, MD.

Sexauer W, Woodford M, **Crawford A**. Stiff-person syndrome. Presented at: Annual Meeting of the American Thoracic Society (ATS), May 23, 2017, Washington, DC.

**Simmons R**. The public health of our communities: what's science have to do with it? Presented at: Baruch S. Blumberg Institute, Hepatitis B Foundation, July 6, 2017, Doylestown, PA.

**Skoufalos A**, Cole JG, Collins L, Finley R. Tips for planning and Interprofessional continuing education activity. Presented at: Thomas Jefferson University 9th Annual Faculty Day, June 6, 2017, Philadelphia, PA.

**Skoufalos A**. Strategic opportunities for aging services. Presented at: Kendal Health System Leadership Forum, June 7, 2017, Kennett Square, PA.



Stoeckle J, Sigworth S, **Jacoby R, Crawford A**, Narzikul T. An interdisciplinary care coordination intervention to decrease pneumonia readmission rates in adult patients in an urban academic hospital system. Presented at: 2017 Society of General Internal Medicine Annual Meeting, April 19-22, 2017, Washington, DC.

Ziegler-Johnson CM, **McIntire, RK**, Keith S, **Leader**, Glanz, K. Characteristics of Philadelphia Census Tracts with High Prostate Cancer Risk. Presented at: North American Association of Central Cancer Registries 2017 Annual Conference, June 16-23, Albuquerque, NM.

# JCPH PUBLICATIONS

Boytsov NN, **Crawford AG**, Hazel-Fernandez LA, **McAna JF**, Nair R, Saundankar V, **Varga S**, Yang E. Patient and provider characteristics associated with passing the HEDIS Measure for post-fracture Osteoporosis Management. *Am J Med Qual*. First published online: February 1, 2017, DOI: <https://doi.org/10.1177/1062860617691123>

Harnish A, Dieter W, Shubert T, **Crawford AG**. Effects of evidence-based fall reduction programming on the functional wellness of older adults in a senior living community: a clinical case study. *Front Public Health*.

Published online December 22, 2016. <https://doi.org/10.3389/fpubh.2016.00262>

**Nash DB**. The dream of value-based care. *Am Health Drug Benefits*. February 2017; 10(1).

**Nash DB**. Reflections, predications, and admonitions. *Am Health Drug Benefits*. April 2017; 10(2).

**Nash DB**. Guru insights. *Am Health Drug Benefits*. May 2017;10(3).

**Nash DB**. 'Oh my aching back!' *MedPage Today*. Focus on Policy. May 31, 2017.

**Oglesby WH**, Birmingham L. Economic evaluation of substance abuse and prevention programs. In: Van Geest JB, Johnson P, Alemango SA, eds. *Research Methods in the Study of Substance Abuse*. New York City, NY: Springer; 2017.

**Simmons R**, Cosgrove S, Romney M, Plumb J, Brawer R, Gonzalez E, Fleisher L, Moore B. Health literacy: cancer prevention strategies for early adults. *Am J Prev Med*. 2017; Special Supplement on Cancer Prevention, DOI:10.1016, j.amepre.2017.03.016.

## RETIREMENT PARTY FOR MPH PROGRAM DIRECTOR, ROB SIMMONS



Rob and his wife Roselena



Rob and Dr. Nash



Rob with new MPH program director, Rosie Frasso



JCPH Alumni Brian Zepka



Left to right: Walter Tsou, Rob, Russ McIntire, and Rickie Brawer



Marty Romney (left), Mahak Lalvani (right)



Jefferson College of Population Health

# Save the Date: Grandon Society Fall Mixer

September 27, 2017 from 5:00-6:30pm | Jefferson College of Population Health | 901 Walnut Street, Lobby

Join us for an opportunity to network with like-minded professionals who are also committed to the field of population health. Enjoy hors d'oeuvres, and networking with new colleagues and special guest lecture.

For more information about the event or to join the [Grandon Society](#), contact [Kate.Clark@Jefferson.edu](mailto:Kate.Clark@Jefferson.edu).

## IN THE NEWS



Fellows Day with Vittorio Maio (center) and 2nd year Fellows David Singer, PharmD (Janssen Scientific Affairs), and Laurence Djatche, PharmD (Novartis AG)



Graduating HEOR Fellow Jacqueline McRae, PharmD (Janssen Scientific Affairs)



Graduating HEOR Fellow Po-Han (Brian) Chen, ScM (Ethicon)



Graduating HEOR Fellow Stefan Varga, PharmD (Novartis AG)



Dr. McIntire received the JCPH Faculty Achievement award (seen here with Dr. Oglesby)



College of Physicians Section On Public Health and Preventive Medicine 2017 Student Poster Section and Award Ceremony. Left to right: Dr. McIntire, Dr. Leader, Huma Qamar, Justine Brink and recipient of the Student Public Health Leadership Award, Alia Salam. Top row: Rob Simmons, recipient of Individual Recognition Award.



Left to right: Alexander Rowan, Huma Qamar, Kathleen Jarrell, and Shayan Waseh at College of Physicians Section on Public Health and Preventive Medicine 2017 Student Poster Section and Award Ceremony.



Sydney Shuster received the Distinguished Student Achievement Award at the MPH Student Awards Ceremony and Luncheon. [Click here](#) for Sydney's special message.



JeffSAPHE Members at the Philadelphia Science Festival. Left to right: Brandon Horvath, Madeline Brooks, Nishith Mehta, Brock Bakewell.



Alexis Skoufalos, EdD, JCPH Associate Dean & Executive Director of the Center for Population Health Innovation (CPHI), presenting on population health and aging for leaders of Kendal Corporation

# Population Health Matters

Jefferson College of Population Health  
Thomas Jefferson University  
901 Walnut Street, 10th Floor  
Philadelphia, PA 19107

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