

Health Policy NEWSLETTER

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FROM THE EDITOR

Hips and Knees

Pennsylvania has done it again! With modest fanfare, the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency charged with collecting, analyzing and reporting information (that can be used to make more informed decisions thereby improving the quality and restraining the cost of health care in Pennsylvania), has released the first ever publicly funded, statewide physician- and hospital-specific report on the outcomes of total hip and knee replacement surgery. If nothing else, this report is a tour de force of our data collection and dissemination capabilities. What does this report contain and what are its implications? What's missing and, as a result, what might be the final impact of said report?

The official report entitled, "Total Hip and Knee Replacements" for the Fiscal Year July 1, 2001 to June 30, 2002, was released earlier this past summer.¹ There are several key findings in this important report including the fact that total hip and knee replacements have steadily increased in Pennsylvania. Most notably, between 1993 and 2002 the number of knee replacements increased by more than 70 percent and the number of total hip replacements increased by nearly 50 percent. With this dramatic increase in surgery comes some untoward consequences including a readmission rate due to deep joint infection or device problems that resulted in nearly \$30 million in charges and more than 6,000 hospital days.

The report outlines, by individual hospital and surgeon, the total number of cases in Pennsylvania at a staggering 29,710 with 9,769 total hip cases and 19,941 total knee cases. In a press release accompanying the report, Marc P. Volavka, the executive director of PHC4 noted, "This report demonstrates that most hospitals and orthopaedic surgeons in Pennsylvania are providing good to excellent care overall. However, variation in readmissions due to complications and infections continued to present major opportunities for quality improvement and cost containment."¹

Putting the hip and knee report into national perspective is a complex issue. Astute readers of the *Health Policy Newsletter* know that we have covered aspects of this territory previously in "Heart Attacks in Pennsylvania" (September 1996), "Report on Report Cards" (May 1998), and most recently, "The Vision for a National Quality Report" (September 2001). Space precludes my ability to review the literature on the impact of public reporting. One thing is for sure, Pennsylvania has made a unique contribution to the national conversation about accountability and outcomes in health care. Pennsylvanians now have an opportunity to ask far more detailed questions of their prospective orthopaedic physician including issues such as: "What is your deep joint infection or device problem rate?"; "How many blood clots in the lung or leg did your patients have in the last year?"; and, "What is the likelihood of my being readmitted to the hospital under your care?" We are now able to engage in a conversation with these provocative questions in a way that simply did not previously exist.

Yet, as in my previous columns on report cards and performance reports in medicine, I remain ambivalent about the overall impact of this report and its predecessor reports on coronary artery bypass graft surgery. Here's why. The literature on the public's ability to analyze this information certainly presents a rather dim view. Experts like Judith Hibbard from the University of Oregon in Eugene, and others, have been writing for nearly a decade about what the public really wants in a report card.² In a nutshell, the public has a difficult time discerning issues such as lower than expected or higher than expected rates of complications, readmission, or post-operative length of stay. It turns out, the public is interested, probably, in "Where will I be safer?" and "What is the likelihood of harm?" These are notoriously difficult issues to quantify. Also, we know that the public still, regrettably, chooses physicians largely based on the advice of family and friends without much regard to an internalization of the results of multiple public report cards available now online 24 hours a day.³

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There is another dark side to public reporting that has recently come to light. Some national experts contend that there are “unintended consequences of public reporting including causing physicians to avoid sick patients in an attempt to improve their quality ranking, encouraging physicians to achieve target rates for health care interventions even when it may be inappropriate among some patients, and discounting patient preferences in clinical judgment.⁴ Public reporting of quality information promotes a spirit of openness that may be valuable for enhancing trust of the health professions, but its ability to improve health remains undemonstrated and public reporting may inadvertently reduce rather than improve quality.”

The controversy surrounding the value of detailed public accountability for health care services remains unresolved. What else, then, is missing from this important new report? Of course, the report does not give us patient-specific information about their ability to return to productive work and to enjoy a renewed quality of life. Physician-specific reports on deep joint infection and blood clots are important as they may lead to work to improve the process of care. But, the report is only a jumping off point, a moment in time. It does not provide us, like all public reports, with a roadmap for improvement.

Some time ago, Marvin Bentley and I carefully studied the impact of public reporting for coronary artery bypass graft surgery in Pennsylvania.⁵ We found that, while individual referring physicians, patients, and managed care organizations may have given scant attention to CABG report cards, it was the hospitals who took the reports to heart and used them as quality filters to more carefully examine their own processes and systems of care. The fact remains, however, that as the data in the hip and knee report diffuses rapidly into the marketplace, we may regrettably see orthopaedic surgeons more carefully pre-selecting patients, turning away those who are obese with severe diabetes or with a history of multiple chronic medical problems.⁶

Is all lost, then, in the seeming morass of public accountability and our inability to effectively use the information? I think not! PHC4 has made, in my opinion, a major contribution to our understanding of the processes involved in providing such complex surgery as hip and knee replacement. The report has given hospitals a wake-up call to carefully self-evaluate and seek ways to improve the quality and safety of medical care. The report has given individual physicians ample reason to look in the mirror and ask difficult questions about their own performance. Careful readers of the report will note that some physicians do a handful of hip and knee cases on an annual basis, while others do more than 340! I know which doctor I would prefer to go to, and it's no secret that most referring physicians would want a high-volume surgeon operating on

them or a family member. As we move to a world of consumer directed health plans, the Pennsylvania report might come in very handy for individuals as they navigate the complex waters of hospital and physician selection.

I will go one step further. I challenge every other state to organize and disseminate a comparable report so that we can create a national benchmark regarding total hip and knee replacement surgery. In addition, I challenge the Center for Medicare and Medicaid Services to publicly endorse this report and begin a national dialogue regarding the possibility of linking outcomes to the payment process for total hip and knee replacement. Finally, I would urge every major employer in Pennsylvania to carefully study this report. As I noted in the Philadelphia Inquirer story that accompanied the debut of this report, “There is not a single doctor or hospital in the state whose performance is exemplary across all of the measures nor is there a single doctor or hospital whose performance is unacceptable.⁷ This report is only the beginning of the hard work necessary to improve the quality of hip and knee replacement surgery in the Commonwealth.” I am proud of our department's involvement in this work through my service as the chairman of the Technical Advisory Group of the PHC4. The report has made us all take a long look in the mirror. The question remains, are we happy with the images that we see? As usual I am interested in your views, and you may contact me at my e-mail address, which is david.nash@jefferson.edu.

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Letters to the Editor

David,

Even though we all have too much to do and read, each time I receive the Health Policy Newsletter I keep it in my briefcase until a moment arises, then read at the very least your editor's piece. It is always insightful, forward looking and interesting. The June 2005 editorial, "Trilogy of Woe" was one of the best! Thanks for keeping us well versed in these important topics.

Mark Linzer MD

Professor and Chief

Section of General Internal Medicine

University of Wisconsin School of Medicine

David,

I read your "Trilogy of Woe" editor's comment in the June 2005 Health Policy Newsletter. It commented on three books: 1) Critical Conditions: How Health Care in America Become Big Business and Bad Medicine, 2) On the Take: How Medicine's Complicity With Big Business Can Endanger Your Health, and 3) The Truth About the Drug Companies: How They Deceive Us and What to Do About It.

Your remarks were on point.

A few years back, I had the honor of being asked to provide ongoing expert counsel over the course of a couple of years to a federal court judge in one of the nation's most high profile school desegregation cases. During one of our many meetings, I asked the judge how he was able to come to decisions in cases such as this when, in my view, all sides in the dispute advocated only for funding of their own narrow self-interest without regard for, or sufficient financial analysis of, the impact of such rulings on the entire system. He said it didn't always work, but that simply investigating the inequities in a system sometimes was sufficient to reduce them.

We all know examples of "legalized corruption" and harmful secrecy in the U.S. healthcare delivery system today that create waste and increase suffering. Similarly, we all recognize that healthcare budgets are under fire due to the impact of an increasingly conservative public policy view whose leaders suggests that the less fortunate should fend for themselves – even in basic health care services.

It may be that in the U.S. healthcare debate, there is no middle ground, and that each special interest will continue to pursue their narrow funding concerns indefinitely without

regard for the sustainability of the system as a whole. Moreover, it may be that the rest of the modern world is right in their conclusion that the only workable solution lies in some form of global budgeting for healthcare delivery.

Whatever system we use to fund health care in the U.S. must have three characteristics in order to work:

1) Rich and poor citizens alike must recognize that they will share use of the same healthcare delivery system. A sense of shared destiny will ensure adoption of a more equitable and more thoughtful healthcare policy.

2) Healthcare delivery system quality and cost must become more transparent. Removing the veil of secrecy that surrounds healthcare delivery will highlight delivery system inequities thereby impeding the growth of separate and unequal delivery systems for the rich and poor classes.

3) Government's healthcare funding mechanisms must be honest, and must not rely on debt or budgeting gimmicks that disguise debt. U.S. debt growth, if it remains unbridled, will bind our children's and grandchildren's future to the whims of the world's current lender nations such as Saudi Arabia and China, and may make peace less likely.

Through debt, all things are possible – except a bright future.

Warm regards,

Bruce A. Boissonault

President

Niagara Health Quality Coalition

Dr. Nash,

Thanks for continuing to send me your Health Policy Newsletter. I always find the articles interesting as they apply to the improving quality in health care. The article concerning health literacy does support the idea that all of the quality initiatives will not be effective unless the patient can understand what to do. If I was leading a project to improve health literacy, I would find six people who have to communicate with the marginally literate daily and form a team with the objective of developing effective communication techniques for these marginally literate patients. The key to this project is finding the right six people who work daily under difficult conditions in trying to communicate with the marginally literate.

Bob Marquis

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Promoting Research in Cognitive Neuroscience and Cognitive Rehabilitation

Stroke, traumatic brain injury (TBI), and a variety of other diseases and injuries can impair cognitive function, with resulting impacts on personal, social, and vocational realms. Indeed, it is the cognitive and behavioral results of these central nervous system (CNS) insults that lead to the most serious long-term disability. Despite the fact that cognitive impairments are common and disabling, and that those who suffer from them are frequently the recipients of inpatient and outpatient rehabilitation services, current practice of cognitive rehabilitation rests on a very sparse evidence base.

There are several reasons for the paucity of rigorous efficacy research in cognitive rehabilitation. Only controlled research can sort out the impact of treatment from ongoing spontaneous recovery and natural learning processes. Yet this research is extremely complex and costly to undertake. Whereas pharmacological treatment trials can often be embedded in an ongoing treatment process that is paid for by clinical dollars, experimental treatments delivered by therapists in a teaching/learning context are much more costly. A recent example studied in a multicenter trial was partial body weight supported treadmill training to improve ambulation in spinal cord injury, as compared to “usual physical therapy”. It is also much more challenging to define the active ingredients of an interactive therapy provided by a clinician, than a drug or surgical procedure, and to determine the most appropriate control or comparison condition. Research is further complicated in this area by remaining controversies about the structure and neural control of normal cognitive processes, as well as the most appropriate methods for measuring those processes. Finally, there is the matter of assembling a sufficient number of patients with similar cognitive characteristics.

In the absence of rigorous evidence on the efficacy and cost-effectiveness of cognitive rehabilitation interventions, such as various approaches to speech and language therapy stroke-related aphasia, current healthcare financing mechanisms are typically reluctant to pay for these services. However, the financial and emotional toll of cognitive impairments is enormous. The absence of firm efficacy data is not, of course, evidence of the ineffectiveness of cognitive rehabilitation. Thus, at present, there may be many individuals who could benefit from cognitive rehabilitation services who are denied them because of the current state of the evidence. Only a sustained program of research in this area, informed by recent developments in cognitive neuroscience, can effectively surmount the obstacles noted above.

Researchers at Moss Rehabilitation Research Institute (MRRI), in collaboration with colleagues at a number of other institutions, are working to advance the state of research in this area, in the hopes of identifying specific cognitive rehabilitation techniques that can have a meaningful impact of real-world function. Among these efforts is the Northeast Cognitive

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Rehabilitation Research Network (NCRRN), funded by a grant from the National Institutes of Health (NCMRR/NICHHD), to serve as a center of excellence for research of this type. With this and other support, MRRI investigators have developed a consent-based patient registry of individuals with stroke and TBI who are interested in participating in studies on cognition. This registry can be searched for individuals with specific clinical characteristics who might be appropriate for

individual studies. A description of this registry, and its utility in large-scale programmatic research, has been published as a model for others to adopt.¹ MRRI investigators along with their external colleagues, have collaborative investigations underway related to attention, language, praxis (the ability to plan and execute skilled movements) and action planning, and executive function (a set of overarching functions that modulate lower level cognitive functions in the service of behavioral goals).

These studies range from basic cognitive neuroscience research, seeking to better define the normal cognitive process or how it is disrupted by disease or injury, to applied treatment studies that seek to improve cognitive function through drug treatment, retraining methods, or the provision of assistive technologies. This program of research has led to the development and publication of new assessment tools, including the Moss Attention Rating Scale, the Naturalistic Action Test, and quantitative methods for understanding the state of consciousness in vegetative and minimally conscious brain injured patients. It has also led to new therapeutic approaches for TBI-related attention deficits, through medication treatment, and language deficits, through the use of computer-supported treatment and compensation methods. Many of the outcomes of this research program are disseminated through the project website www.ncrrn.org. A grant to build further infrastructure to support cognitive rehabilitation research is currently under review. If funded, it will allow MRRI investigators and their colleagues to provide additional training and support to outside investigators conducting cognitive rehabilitation studies.

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Demonstrating the Value of Data Warehouses

The Department of Health Policy hosted a Professional Collaboration Day on June 14, 2005. The following is a summary of the morning session, hosted by GE Healthcare, which focused on Demonstrating the Value of Data Warehouses.

Two speakers offered their perspectives on the value of data collected via electronic medical records (EMRs) and managed through data warehouses. Both speakers conduct outcomes research using an office-based patient and data management EMR product designed by General Electric (GE) with the ability to interface with their laboratory and imaging systems. Approximately 5,000 providers (treating over 5 million patients) make up the GE Medical Quality Improvement Consortium (MQIC); whose data feed into the Centricity Data Warehouse. The comprehensiveness of the data coupled with the volume of patients with specific diagnoses adds power to most data analyses.

Diana Brixner, RPh, PhD is Associate Professor and Chair of the Pharmacy Practice Department in the College of Pharmacy at University of Utah. She also serves as Executive Director of the Pharmacotherapy Outcomes Research Center.

Dr. Brixner introduced the topic by stressing the importance of EMR in outcomes research. She pointed out that although data is abundant, there are barriers that impede its translation into practical knowledge. Information may not be easily accessible by outcomes researchers and is often incomplete or unavailable at the time of decision making.

The array of available data sources includes randomized control trials (RCTs), multi-site RCTs, patient-reported outcomes, observational studies, EMRs, public health data sources, and retrospective claims and pharmacy data. Each type of collection method and design has benefits and drawbacks, but EMRs have a unique advantage in that they facilitate real-time collection and analysis of data from real-world settings. For instance, an EMR is updated daily with clinical and laboratory data necessary for diagnosis and treatment, whereas a traditional claims data source contains limited subsets of clinical and laboratory data and has an update lag time of 3-6 months.

EMRs are clinically rich and provide longitudinal data for each patient. They can be shared and/or merged with other data sources to create even richer repositories of data. But EMRs' promise of improved quality of care and better information for outcomes studies comes with a price tag. It also comes with a set of unresolved problems – legal issues (HIPAA compliance), provider resistance, and interoperability between platforms among them.

Among the studies conducted by Dr. Brixner's team at the Pharmacotherapy Outcomes Research Center (PORC) in Salt Lake City, UT, was *Evaluation of Impact of Second Generation of Antipsychotics (SGAs) Treatment of Weight Gain in Primary Care*. (presented at 2005 ADA meeting in San Diego). Using Centricity

Data Warehouse data, over 50,000 patients met initial inclusion criteria of having a prescription for any of the antipsychotic drugs being studied, of which 9,000 were included in the final analysis. These patients had at least one body mass index (BMI) measurement in their EMR. Analyses demonstrated several of the SGAs were significantly more likely to cause weight gain than conventional antipsychotic drugs.

James M. Gill, MD, MPH is a member of the Family and Community Medicine Department at Christiana Care Health System, and is affiliated with the Family Medicine and Health Policy Departments at Jefferson Medical College.

In addition to being an advocate of HIT (healthcare information technology), Dr. Gill is a primary care physician who exemplifies the benefits of implementing an EMR in the clinical setting. Dr. Gill echoed Dr. Brixner's praise for Centricity/MQIC, emphasizing the volume of records, the increased acceptance and use by physicians, and the powerful capability to facilitate improvement in clinical care.

Dr. Gill described several unfunded EMR studies he and his colleagues have conducted, noting that EMR makes outcomes studies relatively inexpensive to perform. For example, a simple study on the *Quality of Care for Osteoporosis in Primary Care* was conducted using Centricity data from two family practice offices and three OB/GYN offices. The researchers looked at prescriptions for appropriate osteoporosis-related medications and documentation of bone mineral density (BMD) testing. Findings indicated that physicians were not following guidelines for prevention and treatment of osteoporosis. This gave rise to quality improvement interventions, including provider education and a reminder system built into the EMR.

There is always room for improvement, and Dr. Gill noted that improving the system's ability to capture more demographic variables for both the patient (race/ethnicity) and the provider (specialty) would permit even greater depth in outcomes research, particularly in the area of reducing disparities.

Because physicians who are willing and financially able to incorporate EMR into their practices may differ significantly from those who are not, the findings from studies using such data warehouses may be limited in their generalizability. The value of data warehouses will increase as office-based EMR use becomes more widespread.

For more information about Centricity Clinical Information Systems, please visit: www.gehealthcare.com/usen/cis/index.html

New Publications from the Department of Health Policy

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The 2005 Disease Management Colloquium a Success

The 2005 Disease Management Colloquium was held at Jefferson Medical College in Philadelphia on June 21-24, 2005. The Colloquium's goal is to better educate government agencies, the healthcare industry, employers, and the general public about the important role disease management programs play in improving healthcare quality and outcomes for persons subject to chronic conditions. The following are highlights from a number of the morning keynote presentations.

Is There Long-term Value in Disease Management Programs? Reflection on the 2004 CBO Report

Paul Wallace, MD

Executive Director, Care Management Institute, Kaiser Permanente

In 2004, the Congressional Budget Office (CBO) was charged with assessing whether disease management programs could “pay for themselves.” The CBO concluded, “There is insufficient evidence to conclude that disease management programs can generally reduce overall health spending,” but also noted “such programs could be worthwhile even if they did not reduce costs.”¹

How does one define the value of disease management programs? The answer will vary from stakeholder to stakeholder. “Value” is relative and subjective. Purchasers may define value by disease management’s affordability, consumers by the care experience, and clinicians by the clinical quality; all will assess programs in terms of return on investment and cost-effectiveness.

Will disease management’s goal of “mass customization” be met with a return on investment? Increasing numbers of consumers are diagnosed with chronic conditions, and simply “harvesting” the returns may lead to price relief or shareholder return in the short run. But only with the re-investment of these savings can disease management companies and each stakeholder group reap the rewards and recognize the “value” of these programs.

Is there long-term value in disease management programs? “Unequivocally: Yes.”

1. CBO. An Analysis of the Literature on Disease Management Programs. October 13, 2004. Available at: www.cbo.gov/showdoc

The Impact of Information Technology on Disease Management

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Information technology (IT) has a major role to play not only in health care, but in disease management (DM). Traditional DM programs have created communication “silos,” preventing optimal integration of care across stakeholders - DM companies, providers, payers, and consumers. Existing DM programs are faced with other barriers to delivering services, including standardized care vs. customized care (mass customization), person-to-person connectivity without IT (distance and time factors), and the high tech vs. high touch conflict.

Emerging healthcare IT has already begun to erode existing barriers and promote improved quality of care through such means as Web-based personal health records (PHR), home-based biometric devices (e.g., blood pressure cuffs that can send results directly to the PHR or the provider’s electronic medical record system), and constant (24/7) connectivity to the care team. These advances promise to improve the exchange of key health information between patients, DM organizations, and providers. They can identify intervention opportunities that may have been missed without “real-time” feedback and communication. In the evolving world of healthcare consumerism, these technologies encourage more involvement by patients in their care.

Most Web-based health IT companies recognize that seamless transition to these tools and services has not and will not occur.

Factors that may impede full implementation include consumer receptivity, interoperability of various data sources, provider adoption and utilization, and return on investment. Yet, there is great optimism that IT can flourish in health care and further DM’s quest for improved health outcomes.

Disease Management National Policy Issues

Christobel E. Selecky

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Many policy issues impact the implementation of disease management (DM) within the current healthcare system. Cost concerns, demographic factors, societal changes and delivery systems, are key obstacles for all involved. Of particular interest to the DM industry is the underuse of evidence-based therapies for chronic conditions.

The major goals of DM are to close the gaps in access to chronic care and to support the control of rising healthcare costs associated with those chronic diseases. The Disease Management Association of America proposes to achieve this by introducing individual interventions at a population level through the use of evidence-based care plans and continuous patient monitoring.

Looking ahead, the DM industry must confront the challenge of using DM as a platform to reduce underuse or misuse of medical services, and address the issue of how DM can work in a consumer-directed healthcare system. The mandate is clear - to avoid the fate of previous medical management efforts by ensuring that, “when we grow, we grow responsibly.”

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Harvest Health: Chronic Disease Self-Management Program for Older African-Americans

Chronic health conditions are the major causes of illness, disability and death in the United States, with African Americans bearing a greater burden compared to Whites. In Philadelphia, this disparity is particularly evident. According to research conducted by the Philadelphia Health Management Corporation (PHMC) in 2004, older African Americans in Philadelphia were more likely than Whites to rate their health as fair or poor (47.5% versus 34.1%); have a chronic health condition (43.4% versus 38.6%); have diabetes (30.5% versus 13.1%) and high blood pressure (71% versus 51.6%).¹ While recent research shows that with appropriate training and support, persons with chronic disease can learn to effectively manage their own diseases, few studies have focused on what works best with underserved populations.^{2,3}

One successful program, the Chronic Disease Self-Management Program (CDSMP), a patient education program developed by Dr. Kate Lorig at the Stanford Patient Education Research Center, has been found to improve health status and self-efficacy, and reduce healthcare utilization in White, middle income elders using randomized trials.⁴ Philadelphia's *Harvest Health* project is one of 13, three-year projects funded in 2003 by the U.S. Administration on Aging Evidence-based Disease Prevention Program.⁵ *Harvest Health* aims to extend the CDSMP to an urban, African American, older adult population through a collaborative efforts of four organizations: 1) The Philadelphia Corporation for Aging, functioning as the project administrators; 2) Center in the Park, an urban senior center, responsible for recruiting participants and implementing the CDSMP with 500 African American older adults; 3) Albert Einstein Healthcare Network (AEHN), a healthcare organization, charged with educating and seeking referrals from primary physicians; and 4) The Center for Applied Research on Aging and Health (CARAH) at Thomas Jefferson University, which is evaluating both the program's effectiveness and the collaborative process.

The CDSMP, a 6-week, 15-hour, peer-led education program is based on the premise that people with different chronic conditions present common issues and needs—dealing with symptoms, complex medication regimens, behavioral lifestyle adjustments and obtaining helpful medical care. The program is designed to empower patients to assume an active role in their health by managing symptoms. . The mechanisms that underlie the program's effectiveness include: 1) participant development of weekly action plans based on individualized goals, 2) instruction in multiple approaches to symptom management, and 3) group dynamics that provide opportunities for problem solving, peer modeling, and social persuasion.

A key issue in translating evidence-based programs to community groups is balancing intervention fidelity (i.e. is the program being delivered as it is intended) with program modifications deemed necessary to ensure acceptance by the target population and community.^{6,7} *Harvest Health* replicates the essential elements of CDSMP, but also implements cultural modifications to maximize the program's acceptability. One important adaptation was the name choice, "Harvest Health". Developed by Center in the Park, the partners endorsed this name based upon the historical and biblical associations many African Americans have with the word "harvest". The program's name is a welcoming and warm, non-medical symbol signifying the concept that one reaps what one sows (e.g., taking care of yourself results in an abundance of health).

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As of July 1, 2005, 322 persons (mean age of 72 years, 78 percent female) have participated in *Harvest Health*, with a retention rate of 87 percent (those attending at least 4 of 6 weekly classes). Preliminary results indicate a high level of satisfaction among participants. Through a pre- and post-intervention evaluation design, Year One outcomes for the 94 participants who completed both a baseline and a 4-month follow-up questionnaire indicate significant increases in stretching and strengthening activities ($p=.000$), a trend towards increases in aerobic physical activity ($p=.076$), and a significant reduction in health distress ($p=.000$). At 4 months, 95 percent reported continued use of strategies to increase physical activity, improve their diet, and increase symptom management.

The project's collaborative process evaluation includes both quantitative and qualitative measures using periodic surveys and structured interviews of each team member to identify the mechanisms by which the partnering organizations can work together more successfully, as well as barriers that may impede effective teamwork. Key factors for trust-building and cohesive partnerships have been the establishment and refinement of systems for ongoing communication, providing strong project leadership, and creating a safe environment to voice opinions. These data highlight the importance of each organization's having an ongoing commitment to the project goals, and developing processes for continually assessing and negotiating each partner's role.

The *Harvest Health* project thus far demonstrates the utility of the CDSMP patient self-management program with a traditionally underserved population, African American older adults. It also shows the value and importance of partnerships to ensure the success of translating and implementing evidence-based programs to enhance the health of a targeted community. This collaborative approach, linking community service organizations with healthcare organizations, is an important, replicable model that can be used in the implementation of additional evidence-based programs (e.g., fall prevention) with other target populations.

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Department of Health Policy Offers Physician Fellowship in OUTCOMES RESEARCH

For over a decade, the Department of Health Policy (DHP) has offered outcomes research fellowships for Doctor of Pharmacy (PharmD) graduates. Through the program, fellows learn to design, implement, and communicate the results of outcomes research studies and develop an understanding of policy implications.

In 2004, DHP partnered with GlaxoSmithKline to offer a physician outcomes research fellowship. The program consists of two years of post-graduate training. During the first year, the fellow will work under the mentorship of Dr. Nash at our office in Center City, Philadelphia. The fellow's primary role will be to serve as a member of the DHP Research Group. The fellow will also be encouraged to take classes in epidemiology, biostatistics, research design, and health policy and will have the opportunity to attend and present at DHP's short courses, research meetings, journal clubs, health policy forums, and sponsored educational programs. Writing skills will be developed through publication of the fellow's research projects and authorship of articles for the peer-reviewed journals. During the second year, the fellow will work as a researcher within the Global Health Outcomes department of GlaxoSmithKline, located in the Philadelphia area. A competitive stipend is provided.

Recruitment is underway for the 2006-2008 fellow, who will begin in June 2006. Applicants must be U.S. board eligible or already have U.S. medical licensure. Experience in health services research and/or health policy is preferred.

To apply, please contact Laura Pizzi, PharmD, MPH, Associate Director of Research, at 215-955-1159 or laura.pizzi@jefferson.edu.

Department of Health Policy Seeks ASSOCIATE DIRECTOR OF RESEARCH

The Associate Director will assist the Program Director in coordinating the planning, implementation, management and presentation of the Department of Health Policy's (DHP) research program. The Associate Director will represent DHP in meetings with clients, potential clients and research colleagues. In addition, the Associate Director will provide supervisory support to the research staff and develop and direct selected projects.

Position Requirements: Applicants must possess doctoral degree, or equivalent, in a clinical, or health-related field. Must have significant experience in the conduct of health services, research and outcomes research. In addition, applicants must have a thorough understanding of the US health care system, medical and pharmaceutical care, study design and statistics. Experience with proposal development, research project implementation and reporting is required. Knowledge and experience within the pharmaceutical industry, new product development, managed care, outcomes research, marketing strategy and disease management is beneficial. Computer proficiency, including MS office products required. SAS computer programming experience a plus.

For more information please contact Neil Goldfarb, Program Director, Research at neil.goldfarb@jefferson.edu, or mail or fax your resume to: Office of Employee Selection and Placement, Thomas Jefferson University, 201 South 11th Street - Martin Building, Philadelphia, PA, 19107. Fax: 215-503-4329.

Senior Scholars Program:

Building Connections with the Department of Health Policy

The Department of Health Policy of Jefferson Medical College is pleased to announce the launching of its Senior Scholars program. Created as an alternative to traditional faculty affiliations (i.e., adjunct or secondary status), the Senior Scholars program provides the opportunity for individuals to benefit from an association with the Department while contributing meaningfully to current Department research, mentoring, teaching, funding, and/or publication activities. Professionals from government, industry, business, marketing, academia, and medicine are encouraged to apply. For further information, visit the Department website at www.jefferson.edu/dhp or call 215-955-6969.

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Montreal GP Successfully Challenges Canada's Ban on Parallel Private Healthcare Insurance

Dr. Jacques Chaoulli, a Montreal general practitioner, has cracked open Canada's prohibition of private payment for services covered by the nation's 30-year-old single payer healthcare delivery system.

On behalf of a patient who had learned that it would take a year or more to replace his painful, arthritic hip, Dr. Chaoulli challenged the nation's Supreme Court, which, in a 4-3 ruling, decided, "Access to a waiting list is not access to health care."

In a press briefing in Washington, Dr. Chaoulli, who had taken courses in law to prepare for his unique and quixotic battle, said that the ruling is like the fall of a second Berlin Wall... and that the other nine provinces will also likely make way for a private stratum of healthcare insurance.

Asked how his physician colleagues felt about his quest, Dr. Chaoulli said that the Canadian Medical Association (CMA) was at first skeptical, but once the Supreme Court's ruling came down, CMA president Dr. Albert Schumacher called it a historic one that could change the foundations of Medicare. Dr. Chaoulli added that individual physicians' reactions were twofold. Those who had known no other form of healthcare delivery "could be scared by my victory because it might introduce competition and performance assessment." A second group is more open to entrepreneurial solutions to a system that, Chaoulli averred, has

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no one leading its evolution. The CMA is basically a union monopoly, he said, and the single payer system came about in part due to union pressure.

"I saw patients suffering and dying," he said and nobody was talking about the infringement of their rights. "After Chaoulli," he said, the doors are open to a stratum of care that will run parallel to a "compulsory, socialized program." He warned that those who urge a single payer system in the United States should be aware that it would inevitably lead to lengthy waiting lists and unnecessary morbidity and mortality. He also suggested that Americans should be allowed to opt out of Medicare, if they wish.

Speaking for the majority on the Supreme Court, Justice Marie Deschamps said: "Courts should base their decisions on legal principles and not on sociopolitical discourse."

Dr. Chaoulli, 53, who was born in France and emigrated to Quebec in 1978, says he wants to work with US entrepreneurs to bring about a parallel system of private healthcare in Canada. He wants to stir a cultural revolution in the minds of Canadians who, he believes, have for too long bought in to a Scandinavian type of egalitarianism and statism. But, he says, "I'm not running for political office."

David B. Nash, MD, MBA
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Motorcycle Helmets are Good Medicine

Eighty-one percent of Americans, as well as every major medical association, traffic safety group and insurance company support mandatory helmet use. Despite this support, in September 2003, the Pennsylvania Legislature repealed the 35-year-old state law mandating helmet use for all motorcyclists. Now only those riders under age 21 are required to wear a helmet. Though another repeal effort failed years earlier, the Pennsylvania Legislature voted for repeal after extensive lobbying by a small but effective group.

Studies show that motorcyclists are 21 times more likely to die in a crash than are car passengers.¹ According to the National Highway Traffic Safety Administration (NHTSA), motorcycles are only 2 percent of the registered vehicles nationally, but motorcyclist deaths are 5 percent of traffic fatalities annually. NHTSA also found that helmets reduce the risk of death by 29 percent and are 67 percent effective in preventing brain injury. While motorcycle enthusiasts disagree with what has been published on the issue, there is compelling evidence that helmet use reduces injury and death. Helmeted riders are less likely to require hospitalization, less likely to die and less likely to suffer head and neck injuries.^{2,3} Maryland repealed its helmet law in 1979; deaths and injuries climbed, leading to reinstatement of the law in 1992. The American Journal of Public Health, reports motorcyclist death rates were cut by almost 57 percent in the 33 months after the law was reinstated.⁴ Helmet use decreases dramatically when states repeal their helmet laws. Subsequently, an increase in fatalities has been observed in every state that repealed its law. After Arkansas repealed its mandatory helmet law in 1997, non-helmeted deaths at the scene of the crash increased from 39 percent to 75 percent.⁵ Florida estimates that the motorcycle occupant death rate increased by nearly 49 percent in the year following the repeal of their helmet law.⁶ The same expected to happen in Pennsylvania.

Advocates of helmet repeal point to loose science to propagate motorcycle helmet myths. They argue that peripheral vision is impaired — yet approved helmets must allow visibility that exceeds normal human peripheral vision. They argue that helmets impair hearing — yet no study has demonstrated that helmets reduce a driver's ability to distinguish between sounds. They argue that helmets increase the risk of head and neck injuries — yet no scientifically valid study has supported this assertion. They argue that the chinstrap may act like a hangman's noose in certain crashes, injuring the rider even more — yet no studies substantiate this claim. Even if true, this would be like arguing that because a seatbelt might keep a driver from exiting a burning vehicle, a mandatory seat-belt law is bad. One study has found no difference between helmet type (full or partial helmet) and fastening status (loose or firmly fastened) and cervical spine injury.⁷

Some bikers may argue, "It's my head, I'll take the risk and I have the right to refuse to wear a helmet." But the state has clearly infringed on all of our "rights" by making it illegal to drive without a license, to operate a vehicle while drunk, to

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transport a child without a safety seat or to exceed the speed limit. You can be ticketed in Pennsylvania if you exercise your "right" to drive without a seatbelt when you are stopped for another violation.

The government is obligated to provide for safe travel on the highway; this law is no different. Repeal of Pennsylvania's helmet law will probably cost millions in medical care, long-term rehabilitation, nursing-home care, lost productivity, and the loss of a productive taxpaying citizen. Data analyzed from the National Trauma Data Bank has shown that non-helmeted riders who are injured accrue greater hospital charges and are significantly less likely to have health insurance.⁸ The NHTSA estimates that mandatory helmet use saved \$13.2 billion between 1984 and 1999, and an additional \$11.1 billion could have been saved if all motorcyclists wore helmets. Already overburdened emergency departments, hospitals, and taxpayers will absorb the cost for uninsured motorcyclists. If the cyclist has insurance, each policyholder will assume some of the cost of allowing bikers to exercise their "right" to ride without a helmet.

In my opinion, while this may look like a public policy issue with clear and common sense answers, it is actually a civics lesson in the legislative process. It's about advocacy. Why was helmet law repealed? It was not repealed because to do so was a good idea. It was repealed because the motorcycle lobby advocated to their legislators better than physicians did. While a small group of advocates were successful at bringing around the repeal of the helmet law, these same tactics can work to reinstate the law. Let your voice be heard.

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College for Advanced Management of Employee Benefits

As reported in the December 2004 issue of the Health Policy Newsletter, this four-day training program is designed to improve employers' skills in obtaining value (improved quality and/or lower cost) when purchasing health benefits. Upcoming programs are scheduled for:

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For more information on any of these programs please contact **David B. Nash, MD, MBA** at (215) 955-6969 or david.nash@jefferson.edu

The Health Policy Forum: Upcoming Speakers Fall 2005

We are pleased to announce our September – December 2005 schedule for the Health Policy Forum. The Forum meets on the second Wednesday of each month from 8:30 a.m. to 9:30 a.m. in Conference Room 218, Curtis Building, 1015 Walnut Street, Philadelphia, PA. A light breakfast will be served.

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