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EDITORIAL

Does She or Doesn't She?

Readers of a certain age will no doubt remember the Clairol hair coloring advertisement that seemed quite risqué when it first debuted more than 40 years ago. It had many different interpretations and caused quite a stir. I'm now going to ask, "*Will they or won't they*?" in a similar vein, as we ponder the Supreme Court of the United States and the looming June 2012 decision regarding the Affordable Care Act (ACA).

By now oceans of ink have been devoted to media coverage of the ACA, the three days of unprecedented legal hearings and speculation about the potential outcome. Democrats and Republicans have flooded the airways and the expert "talking heads" have impressed us with their punditry. By Thursday, March 29, 2012, major national newspapers like the *Wall Street Journal* and the *New York Times* had already lined up the faithful on their respective editorial pages.

The punchline of the hearings went something like this, "while so much time was devoted to an evaluation of the Act, it seemed as though the Justices were asking questions that everyday people wanted to know." For example, "Do you really want us to read all 2,700 pages?" and "Are we doing a wrecking project or a salvage project?" I'm sure most readers had their own view of this process. Some political commentators framed the arguments in terms of social class, maligning the "punditocracy" and calling ObamaCare, itself, a "masterpiece of Mandarin abstraction."[1]

I would like to quickly reframe some of the issues from this past spring, reflect on my own personal experience as a panelist on a recent National Public Radio program, and attempt to answer the rhetorical question, "*Will they or won't they*?"

As best as I can tell, the Supreme Court is going to address four questions.[2] First, the Court will determine whether an archaic law from the late-1800s, known as the Tax Anti-Injunction Act or AIA, precludes a review of the ACA until 2014. The AIA provides that the legality of a tax cannot be challenged until the tax itself has been assessed. Some experts contend that the individual mandate part of the ACA represents a financial penalty, and therefore, is a tax under the AIA. Since no penalty (tax) will be assessed until 2014, the whole conversation is premature.

The second question that the Court will review remains the "hot button" issue, and that is whether the Federal government can compel citizens to purchase health insurance (otherwise known as the "individual mandate") or pay a penalty. The government attorneys argued strenuously that the federal government has this authority under the Constitution's commerce clause; previously, the Supreme Court has interpreted the section as providing Congress with wide latitude in this arena. The challengers argued that the mandate to purchase a product from a private entity is unprecedented and an intrusion on individual liberty.

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The third question the Supreme Court will consider (if they rule the mandate unconstitutional), is whether the mandate is "severable" from the rest of the law. ACA opponents argue that the whole law must be overturned if the Court invalidates any part, because the mandate is "inextricably intertwined with the elements." On the other hand, the government argues that only one or two other portions of the law would fall if the mandate were struck down. These other conditions are the requirements that ensure coverage for people with pre-existing conditions ("guaranteed issue") while not charging them higher premiums (the "community rate").

The fourth and final question is whether the ACA's Medicaid expansion is constitutional and whether states must comply with it in order to remain eligible to receive any federal Medicaid funds.

I would submit that we all need to take a collective big step backward and re-examine the core issues that the bill is attempting to address. I think the easiest way to frame this argument is the recognition that the ACA is really like two laws in one. One aspect deals with insurance reform; in my view, most of the aforementioned questions to be considered by the Court fall into this category. The other aspect of the law deals with healthcare delivery reform.

I believe the healthcare industry--providers, insurers, employers, essentially all the key stakeholders, have been working diligently on healthcare delivery form for over two years. Faculty in our School of Population Health and others have been leaders in the conversation regarding delivery reform. For example, we embrace the now famous Triple Aim articulated by Dr. Don Berwick several years ago.[3] We recognize that we must improve the experience of care, the health of the population, and reduce cost by reducing waste.

We support the move from "volume to value" and understand that Medicare must transform from a simple purchaser of services to a savvy shopper attuned to getting the most value for the dollars spent. We certainly support integration via bundled payment and coordination of chronic care. These are the critical underpinnings of the definition of population health. I have attempted to summarize the entire delivery reform aspect of the bill in four words, "No outcome, no income."[4] In my view, the four questions being considered by the Court essentially ignore these central issues. They also ignore the fact that stakeholders within the healthcare system have made substantive progress toward these critically important delivery system goals in the last two years.

On the third and final day of the hearings, I was privileged to appear on *Radio Times with Marty Moss-Coane,* a popular National Public Radio program produced by WHYY, the Philadelphia, Pennsylvania public broadcasting station. This daily call-in program has a wide following and often tackles timely, controversial news events. I appeared on the program with two other guests: Mr. Ted Ruger, a constitutional law scholar and professor of law at the University of Pennsylvania and Mr. Dick Polman, a popular political commentator in our region. Marty Moss-Coane is a recognized, outstanding radio host, able to synthesize a great deal of information quickly and cut right to the heart of the matter. I thought I prepared well for this important opportunity to help clarify what I saw as some of the "missing issues" in the public debate about the ACA.

When the radio program started, Marty turned to Ted Ruger to help set the stage for the important constitutional questions that were in play. I tried hard to steer the conversation to population health and the progress we've made in reforming the delivery system over the last two years. I noted that, in Pennsylvania in particular, we were working hard to reduce unexplained clinical variation and reduce waste by tackling central line associated bloodstream infections, readmissions, and promoting evidence-based medicine. Of course, I sadly recognize that these complex concepts cannot be distilled into a 15-second sound bite on the radio. When the program was open to questions from our listeners, I was truly depressed by the questions, as they focused on a narrow interpretation of the individual mandate.

All the while, information from the Henry J. Kaiser Family Foundation[5] regarding their up-to-the-minute public opinion polls about the ACA troubled me. I knew, for example, that 70% of Americans had favorable opinions of "guaranteed issue" and "no cost-sharing for preventive services." I knew that 71% of Americans also like the expansion of Medicaid. I sadly remembered that a December 2011 tracking poll (also from the Kaiser Foundation) found support for the mandate varied from 17% to 61%, depending on which messages or information opponents or supporters of the mandate hear on the issue. Perhaps surprisingly, the most effective information on changing people's minds is the basic reminder that under the reform law, most Americans would still get coverage through their employers and so would automatically satisfy the requirement without having to buy any new insurance. After hearing that message, favorable reviews of the mandate went up 28 percentage points to 61%.

Though the one-hour *Radio Times* program flew by quickly, I was happy to have expert colleagues sitting on either side of me in the studio setting. I thought we handled the "live" phone-in portion of the program with relaxed camaraderie and ease. Later that same day most of my email and text messages were positive but, of course, a few persons took issue with my position in particular--that is, delivery reform is what we ought to be talking about, not these narrow constitutional issues.

So then, where does all of this public attention on the healthcare system over the last several months leave us? It is the question of the hour for our industry. Does the notion of the Triple Aim mean anything to our citizenry? Is the public so afraid of "government intervention" in their lives that they lose sight of the fact that the bill itself represents a colossal compromise, wherein most of the stakeholders, now three years ago, put future economic rewards aside so that a historic bill could be fashioned and approved? Walking back from the local NPR studios to my office, I asked myself these same questions and found no ready answers.

Will they or won't they? There's no future in predicting the future, but I'll add my voice to the cacophony attempting to answer this important health policy question. I believe the court will strike down the individual mandate and uphold its severability. The insurance industry will respond with a flurry of activity. No doubt premiums will continue their inexorable rise. But there is some good news—those much needed delivery system reforms will continue to transform. Cooler heads will prevail and we will make progress in our unique American journey to improve the health of the population and reduce waste in our system. Somehow we must find a way to achieve value for the $8,000 per person that we spend every year. ■

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Community Benefit and the New IRS Mandate

Historically, not-for-profit hospitals and academic medical centers have been exempt from federal income taxes because of their mission and commitment to provide health services and outreach activities designed to address and improve community health, particularly for people who are most in need, such as the poor and those without adequate access to health care. Examples of how hospitals fulfill their mission and community benefit commitment in return for tax-exempt status include: charity care (uncompensated care), cash/in-kind contributions to community groups, health professional education, community-building activities that improve health and quality of life, generalizable research funded by tax-exempt sources, and providing outreach services designed to improve specific population health needs.[1,4] However, there has been growing concern that some hospitals' community benefit contributions may not be sufficient to warrant their tax-exempt status.[2,3]

In 2009, the Internal Revenue Service (IRS) revised the IRS Tax Form 990, and now requires more rigorous formal financial documentation of community benefit contributions. Hospitals must detail community benefit processes and contributions annually and report these expenditures on the IRS Form 990 and supporting Schedule H. The final specifications for such reporting are pending. In addition, a new federal mandate, Section 9007 of the Patient Protection and Affordable Care Act of 2010, contains requirements that non-profit hospitals must meet as 501(c)(3) charitable organizations. Key new obligations for tax-exempt hospitals include:

- Completion of a community health needs assessment (CHNA) at least once every three years by an individual with special knowledge or expertise in public health.
- Development of a written community benefit plan that addresses identified needs.
- Formal adoption of the community benefit strategic and implementation plan by the hospital's governing body.
- Publication of the CHNA findings and community benefit plan so that it is widely available to the public.
- Demonstration of effectiveness of community benefit efforts.

The CHNA, a pivotal component of the new requirement, is a process to identify and prioritize a community's health needs by collecting and analyzing data, including input from community stakeholders who represent the broad interests for the community (public health professionals, government, academic experts, business, health insurers and community residents). The hospital must list the key individuals/organizations with whom they consulted, describe how and when this information was obtained, and document the analytical methods used to assess the community served and the qualifications of the individual conducting the survey. Information gained from a CHNA is essential to developing an implementation plan that prioritizes and addresses each of the identified needs, with the goal of contributing to improvements in the targeted community's health. If a hospital chooses not to address a given health need, an explanation for this decision is required. Finally, the new rules mandate that the hospital's governing body formally adopt the plan and, once adopted, the report and implementation plan must be made publicly available.

These requirements take effect for tax years beginning after March 23, 2012. Failure to comply will result in a $50,000 excise tax penalty that will be applied to each hospital facility in the organization that fails to satisfy the requirements.

That leaves us to ponder the questions of how hospitals can comply with the new IRS and Patient Protection and Affordable Care Act (PPACA) mandates, and how the new PPACA components will impact community benefit levels given the expected decrease in the number of uninsured and changes in payment reforms.[3]

Since improving the health of the community has always been an integral mission of most hospitals, the majority of the new requirements will most likely be compatible with their historical approaches, particularly for hospitals involved in active healthy community initiatives. However, CHNAs, grounded in health data and community input that meet the new requirements, are not always conducted by hospitals, nor are CHNA results and intervention plans developed based on identified needs formally written and made publicly available. This may be a challenge for hospitals where local data is not readily available and resources to conduct such a survey are costly and/or limited.

In anticipation of these new regulations, Thomas Jefferson University Hospital (TJUH) initiated a Community Benefit Task Force in 2008 that included senior leadership and interdisciplinary representation from across departments. The Task Force has been meeting to create a more formal and systematic approach to addressing community health needs. TJUH has considerable experience with CHNAs, having contracted for Public Health Management Corporation's (PHMC) bi-annual survey in southeastern Pennsylvania for more than 2 decades.[5] TJUH utilizes expertise in the Center for Urban Health (CUH) and the Health Services Planning Department, as well as Jefferson School of Population Health faculty and students to access, analyze, and present PHMC and related demographic data and hospital emergency department data. To supplement the quantitative data, TJUH identified employees who live in or work with target communities and held a series of focus groups to gain their input on key issues. Additionally, the CUH has in-depth experience

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and contacts in the community that further informs the community health assessment process.

Based on the findings from the first CHNA, the Task Force recommended focusing its community benefit activities on neighborhoods near the Jefferson campus, where 20% or more of families are below the poverty level and experience the greatest disparities in health status and access. A plan was created that focused efforts on two neighborhoods with greatest disparities in cardiovascular disease and diabetes. In addition to its traditional community outreach activities – such as health screenings and health promotion programs held predominantly on campus – TJUH works with multiple community partners to develop programs that reflect community need, voice and culture, build on the assets of the community, and are neighborhood-based rather than hospital-based. Projects are planned and evaluated individually based on established baselines set from existing data. The following are examples of TJUH's approach to addressing access to primary care and high rates of cardiovascular disease and diabetes in our communities:

- **Philadelphia Urban Food and Fitness Alliance**
  A community partnership funded by the WK Kellogg Foundation to improve access to healthy affordable food and safe places for physical activity through policy and systems changes. TJUH is conducting community assessments and evaluation of the initiative.

- **Jeff HOPE**
  Since 1992, support from TJUH laboratory, radiology, and pharmacy; 35,000 weekly visits at 5 care sites serving the homeless.[6]

- **Refugee Health**
  Partnership with Nationalities Services Center, and the Department of Family and Community Medicine. Screening and primary care for over 700 refugees from Burma, Iraq, and multiple African countries.

- **Federation of Community Centers**
  JOINED-UP Program (Job Opportunities Investment Network Education in Diabetes in Urban Populations). Diabetes prevention and self-management education for 60 participants in a green workforce development project.

- **Stroke Hypertension and Prostate Education Intervention Team (SHAPE-IT)** *Reached 7,500 African American men in various locations, including polling stations, auto repair shops and barbershops.*

- **Diabetes Self-Management Education**
  Free diabetes education classes and support groups held in churches and Senior Centers, reaching over 1,500 individuals.

- **Cardiovascular Health Literacy Training**
  Leading train-the-trainer programs to enhance health literacy in 15 regional hospitals.

- **Project HOME's Wellness Center**
  Since 1995, support of free primary care and pharmaceuticals for formerly homeless men, women and children, serving over 1,200 individuals annually.

To fulfill the obligations of the proposed new regulations, TJUH will need to make several enhancements, including incorporating information from individuals who represent the broad interests of the community by forming a community advisory group with representation of key community stakeholders, including existing collaborative partners.

While TJUH has developed a three-year community benefit plan, regulations now require that a formal report be written for each hospital entity in the organization that not only documents the interventions and resources that will be utilized, but also the describes the process and criteria used to prioritize community health concerns identified through the CHNA. TJUH's next version of the implementation plan will include the required descriptive information and will be formally presented to the Board of Trustees for their approval. TJUH will communicate the CHNA results and approved implementation plans to the public by posting the written report and other communications on the TJUH website. Finally, reporting requirements include evaluation of community benefit programs. Currently this is accomplished in two ways. First, outreach programs provided by CUH are evaluated on an ongoing basis and modified to increase their reach and effectiveness. Second, TJUH requires all Departments to document their community benefit and leadership activities using the Community Benefit Inventory for Social Accountability software (CBISA) software. Regardless of the final IRS reporting requirements, Jefferson will continue its commitment to improving the health of our communities by structuring programs that have measurable positive impact on the health and welfare of the communities served. If proposed changes in health insurance reduce hospital costs for uncompensated care, the saved community benefit funds could then be reinvested in sustaining or expanding preventive health care services to vulnerable populations beyond the walls of hospitals. ■

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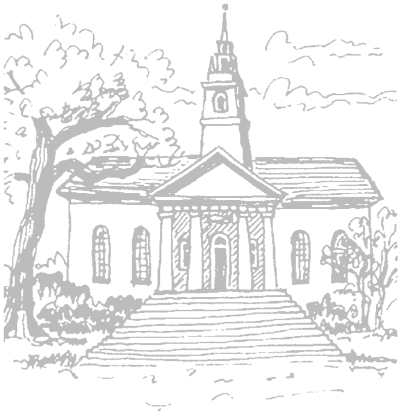

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TJUH Collaboration with The Joint Commission for Prevention of Wrong Site Surgery

Wrong site surgery (WSS) is such an egregious mistake that it has been labeled by one National Quality Forum (NQF) health safety expert as a "never event."[1] Never events are defined as occurences that are "of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable (and thus feasible to include in a reporting system); and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization."[2] The effects can be devastating for both the patient and the surgical team.[3] WSSs are widely considered to be preventable medical errors, easily derailed by a series of very basic verification steps.[1,3,4] Yet, according to estimates, the prevalence may be as high as 40 WSS events *per week* across the nation.[5]

When compared to the total number of U.S. operative cases performed annually, WSSs are still very rare.[1] However, in recent years the incidence of WSS reported to The Joint Commission has increased from 15 cases in 1998 to a total of 956 cases by late 2010 and, because reporting is voluntary, there is strong speculation that the official number of actual cases may be grossly underreported.[3,6] Regardless of the cause of the trend WSSs remain a devastating and potentially costly problem within the surgical setting.[1]

The issue of WSS errors is not new. Prior to the release of the Institute of Medicine's (IOM) report *To Err Is Human,* there was no process for recognizing, reporting and tracking injuries and near misses in the surgical setting.[3] As such, surgeons were largely unaware of the widespread nature of this issue.[3] Following the release of the IOM report, a 2003 Joint Commission summit brought together a multi-disciplinary team of health care professionals to examine and address the scope of WSS.[3,5] Their work led to the creation of a protocol, *The Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery*.[3,5]

Rooted in prevention theories derived in high-risk industries like aviation and nuclear weaponry, the Universal Protocol outlines three key elements for systems change to prevent WSS.[3]

1. Pre-operative verification
2. Marking the operative site
3. Taking a time-out

In 2009, The Joint Commission charged its newly formed Center for Transforming Healthcare with the task of addressing the problem of WSS.[5] Thomas Jefferson University and Hospitals (TJUH) was one of eight organizations that agreed to participate in a WSS project. The Jefferson organization has 57 operating rooms across all campuses, and performed over 38,000 surgical procedures last fiscal year.

The Wrong Site Surgery project is designed to address the problem using Robust Process Improvement (RPI) methods.[5] RPI is a fact-based, systematic, and data-driven problem-solving methodology that incorporates tools and methods from both the Lean Six Sigma and change management methodologies.[5] Lean Six Sigma is a business methodology that aims to eliminate variation in product by employing lessons learned the manufacturing setting. Using RPI, the project teams measure the magnitude of the problem (or in the case of WSS, the specific problems that increase the risk of this event), pinpoint the contributing causes, develop specific solutions that are targeted to each cause, and then thoroughly test the solutions in real life situations.[5]

The TJUH project focused on Orthopedic services. Because of the laterality that is inherent in these procedures, Orthopedics ranks nationally among the top five service lines in which WSSs most commonly occur.[3] At TJUH, every step in the process of scheduling and preparing a patient for surgery was reviewed to identify potential variations that could lead to errors.

After building a team and identifying key stakeholders, TJUH members set about initiating processes to measure inconsistencies and variations from policies, standards, and standard operating procedures. The team quickly discovered opportunities for improvement during the scheduling phase, including incomplete paperwork, illegible writing, and missing documentation. Within the actual operating room suites, the team observed that not all surgical team members were actively engaged in the time-out process. It was also noted that some site markings tended to fade after the application of the surgical scrub. In all of the areas, the team noted staff members appeared to be rushed to complete all tasks prior to the start of the surgical procedure. The findings at TJUH very closely mirrored the common contributions to errors found in a much larger 2007 state wide study performed by Clarke, Johnston and Finley.[7]

Following an examination of their findings, the TJUH team instituted several significant changes within the study areas. To improve the accuracy of the scheduling process, fax numbers were consolidated and a process was created to notify physician offices prior to the day of surgery when primary documents were missing. The team also redesigned the scheduling form to eliminate unnecessary or irrelevant fields. As a result of these changes, the proportion of variation in the scheduling area improved from 77% to 35%. The rates were calculated using data obtained from baseline audits compared to post solutions implementation. The data was submitted to the Center for Transforming Healthcare and entered into the electronic program.

In the pre-operative holding area, the surgical marker was changed to one that would not be removed by the operative site preparatory scrub. Education was provided to the staff to reinforce the importance of verifying the patient's identity and comparing their verbalized information against the signed surgical consent. Lastly, the team mandated that all regional blocks performed by anesthesia personnel have both a formal pre-procedure time-out and a standard site marking. As a result of these revised processes, the rate of variation was reduced from 73% to 12%.

Processes in the operating room suites were revised to include the implementation of a role-based time-out. The role-based time-out and the development of a surgical safety checklist (based on the WHO Surgical Safety Checklist) engages the entire surgical team and ensures their active participation in the time out process. The TJUH team also devised and implemented a modified staffing model for the orthopedic service, which included an increase from two to three staff members assigned for most rooms. This addition was a direct result of the findings of a pre-assessment nursing survey which identified that nurses felt rushed when setting up the cases. As a result of these process changes, the rate of variation was reduced from 68% to 48%.

Collaborating with the Joint Commission Center for Transforming Healthcare in the Wrong Site Surgery initiative was an excellent opportunity to learn from other health care organizations throughout the country. The engagement provided hospital leadership with tools to improve current processes and measure improvement. The project results were shared with the hospital community at large and support the TJUH mission of providing safe, quality healthcare to our patients. ■

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Population Health Preconferences Kick Off the 12th Population Health Colloquium

What is population health? What makes the field of population health important to all sectors of health care and business? What does it have to do with health care reform? These are just some of the questions discussed at the **12th Annual Population Health & Care Coordination Colloquium** preconference seminars. The sessions were taught by JSPH faculty at both an introductory and advanced level, offering health care professionals an in-depth examination of population health, its application in real-world settings, and an overview of the economic implications. Attendees included health care professionals representing a wide range of practice, administrative and industry settings.

Preconference I: Introduction to Population Health was designed for healthcare professionals seeking to increase their knowledge and understanding of the components of population health and how they apply to real-world settings. Dr. David Nash, Dean of the Jefferson School of Population Health, set the stage with an overview of how population health management strategies can provide a foundation for healthcare reform. The US ranks behind many other developed countries in terms of accessibility of health care, quality of care, and patient outcomes, an ironic finding since the US pays the most for care and derives little relative value for the dollars spent. He went on to describe the importance of evidence-based medicine as a way to improve care and decrease costs associated with care. Dr. Nash emphasized the need to prevent medical errors, avoid hospital admissions, re-admissions, and increase shared decision-making. He emphasized the role of population health in providing a conceptual framework for the reform of healthcare in order to provide safe, effective, patient-centered, timely, equitable and efficient care.

Building on the definition of population health as "the distribution of health outcomes within a population, the determinants that influence this distribution and the policies and interventions that impact these determinants," Dr. Tamar Klaiman provided an overview of the characteristics of population health and the factors that influence health. She emphasized that medical care, individual behavior, social and physical environment, and genetics are some of the main determinants of health. Dr. Klaiman also discussed the role of health education in improving health and reviewed the different approaches to health promotion. She concluded her presentation with a review of the strategies for population health management emphasizing demand management, disability management, disease management and catastrophic care management.

Dr. Kathryn Kash's presentation covered the impact of lifestyle behavior change management for chronic disease prevention. Chronic illnesses are on the rise in the US and elsewhere, accounting for the vast majority of all health care spending; we must find ways to increase primary prevention strategies in order to have a positive impact on the cost and the quality of care. The Expanded Chronic Care Model for disease prevention integrates health promotion into the prevention and management of chronic disease. Chronic care will be less costly and more effective if clinical prevention and management of chronic disease use similar strategies for improvement. Dr. Kash concluded by discussing how the patient-centered medical home aligns with the chronic care model by incorporating quality measures, patient self-management, lifestyle change theory, health information technology, and organization of the practice for efficiency .

Dr. Joseph Couto finished the preconference by discussing the role of patient engagement. This is an important component in helping patients manage their chronic care needs, and a critical component in healthcare reform. He noted that health literacy is a better predictor of a patient's health than gender, race, age, income level and

Continued on page 8

employment status. Engaging patients in their health care requires providers to both understand its importance and be able to implement appropriate strategies that will motivate patients to act. Clinicians must improve upon their communication skills, using decision aids to assist patients and providing culturally appropriate educational materials. The outcomes of interest are: patient knowledge of condition; care and ability to self-manage their diseases; the experience and satisfaction of the patient with their care, and the cost of services. Dr. Couto concluded by stating that significant improvements in patient outcomes for patients suffering from chronic diseases are unlikely without improvements in patients' activation and engagement levels.

Preconference II: Advanced Applications in Population Health detailed current and timely topics for experienced healthcare professionals interested in building upon their knowledge to apply the tenets of population health in their work settings. Dr. Rob Lieberthal opened this session by discussing the economics of personalized medicine and genomics. He explained the differences between genetics and genomics and described how genomics is offering new treatments for complex diseases. Personalized medicine means using one or more therapies based on what is most appropriate for the patient. Genomic tests can help identify which patients will benefit from treatment. Using a diagnostic genomic approach helps to categorize people and define targeted therapies. However, Dr. Lieberthal pointed out that what works for one patient does not necessarily work for the greater population. Some issues involved are the regulation of tests, determining evidence-based medicine for therapies, billing codes, and the economics of testing and therapies.

Dr. Mark Legnini, Director of the Center for Value in Healthcare, discussed the myth of consumer choice and what will take its place in the future. The consumer choice model was designed to improve quality and safety of care and increase cost-effectiveness through the use of publicly available information, helping patients decide where to seek care. This should have resulted in better provider performance and better health for the consumer. It simply hasn't worked because patients have an asymmetry of knowledge, limited choices for care, and they are uncomfortable in challenging their physicians' recommendations. Dr. Legnini talked about the need to shift the focus to managed competition between payers and providers with guaranteed access, no exclusions and community ratings. Value-based purchasing and pay-for performance are two models that include managed competition. He explained that consumers have difficulty making decisions about their healthcare because they don't understand the risks involved. Dr. Legnini offered suggestions for separating out purchasers and payers making sure that all patients in the population get evidence-based care.

Dr. James Pelegano, Program Director for the Master of Science in Healthcare Quality and Safety, discussed systems engineering for population health. He first described a basic system approach, identifying the key elements and how they are operationalized, and discussing their impact on the clinical setting. Early attempts to monitor physician quality were done at daily or weekly conferences to determine whether the standard of care was met and if the physician did what most physicians would do in the situation. It then became clear that standards were poorly defined and it was not clear who "most" physicians were. Competition is increasing and payers are using population statistics to better understand the relationship between quality and outcomes. For example, CMS has a pay-for-performance plan for patients on Medicaid and Medicare that has added value for patients in those populations. He discussed the four components of Six Sigma (measure, analyze, improve, and control) and how to use them with a well-defined population. Dr. Pelegano explained that helping to redefine and re-engineer systems in healthcare has been useful in solving problems and using best practice guidelines.

Dr. Nash provided closure to this seminar by discussing how to successfully implement healthcare reform. He described how the payment system needs to be restructured, by re-aligning incentives and creating rewards for collaborative and coordinated care. Throughout the preconference, Dr. Nash succinctly summarized the important elements of reform including: a focus on all risks; clinical providers able to work as part of a team; emphasis on education and coaching; evidence-based decisions; electronic sharing of information; and care customized to match the needs and values of patients. He also described ways to reduce the cost of care: tying payment to evidence and outcomes; bundling payments by episodes or condition; coordinated care in the medical home; and accountability for results. He concluded by emphasizing three major themes: "accountability, transparency, and understanding the concept of 'no outcome, no income.'" ■

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Jefferson Hosts *Discover Public Health Day*

April 3, 2012

In honor of National Public Health Week (April 2-8, 2012), the Jefferson School of Population Health (JSPH) collaborated with Jefferson's Career Development Center, Office of Admissions, and Jeff SAPHE (Student Activities for Public Health Education) to offer a student-driven, student-focused program designed to showcase the myriad public health initiatives in the region and provide opportunities for career networking. The idea was to reach students throughout the Delaware Valley, both undergraduate and graduate, from a variety of disciplines to expose them to a range of topics, programs, and career possibilities within the fascinating world of public health.

The afternoon began with a series of panel presentations featuring public health leaders from the Nationalities Service Center; the US Department of Health and Human Services – Region III office; Albert Schweitzer Fellowship Program; The Food Trust; Jefferson Center for Urban Health; and the Philadelphia Department of Public Health. The panelists described their organizations, highlighted current initiatives and briefly discussed their own career paths. Rob Simmons, DrPH, MPH, MCHES, CPH, Director of JSPH's Public Health Program, moderated the panel and facilitated the discussion. This was a unique opportunity for the student audience to see the diversity of programs that exist within the public health arena.

The second part of the afternoon, "Public Health Speed Networking" was hosted by Leonarda Parente and Katie Cranston of Jeff SAPHE. Organized in a similar fashion to 'speed dating,' this was a fun and innovative way for students to interact directly with representatives from public health organizations. Students were provided descriptions of organizations and selected three organizations each for networking. They were given approximately 15 minutes with each representative where they could ask questions related to programs and career paths. In addition to the organizations represented during the panel, other participating programs and organizations included: Philadelphia Global Water Initiative; Philadelphia Coordinated Care; Philadelphia Medical Reserve Corps; Physicians for Social Responsibility; Planned Parenthood Southeast PA; and the United Nations Association of the United States of America, Greater Philadelphia Chapter. Not only was this an invaluable experience for the students, but the representatives felt engaged in the process and honored to participate. ■

Students at Public Health Speed Networking event meeting with Amna Rizvi, Health Communications Specialist, Tobacco Policy and Control, Philadelphia Department of Health.

Manisha Verma, MD, MPH, Schweitzer Fellow for Life speaks to students at Discover Public Health Day.

"As a student leader and an upcoming MPH graduate, the speed networking event was a great opportunity for me to not only assist in the event planning, but also to get to do some networking myself at the event. I enjoyed learning how other MPH grads secured jobs in their public health fields of interest and the skill sets that are valued by employers."

Katie Cranston, Jeff SAPHE Vice President

"This was an eclectic event which enabled many students to network with professionals and learn about their experiences. Students participated in round-table discussions and were able to identify clerkship, capstone, and potential job opportunities."

Leonarda Parente, Jeff SAPHE President

Resources:

National Public Health Week 2012
http://www.nphw.org/

Jefferson Career Development Center
http://www.jefferson.edu/jchp/studentlife/cdc.cfm

Public Health Program, Jefferson School of Population Health
http://www.jefferson.edu/population_health/public_health/

Participating Organizations:

Albert Schweitzer Fellowship Program, Greater Philadelphia
http://www.jefferson.edu/population_health/research/schweitzer_fellows.cfm

The Food Trust
http://www.thefoodtrust.org/

Jefferson Center for Urban Health
http://www.jeffersonhospital.org/departments-and-services/center-for-urban-health.aspx

Nationalities Service Center
http://www.nationalitiesservice.org/

Philadelphia Coordinated Health Care
http://www.pchc.org/

Philadelphia Department of Public Health Get Healthy Philly
http://www.phila.gov/health/commissioner/CPPW.html

Philadelphia Global Water Initiative
http://pgwi.org/

Philadelphia Medical Reserve Corps
http://www.phila.gov/health/MedResCorps.html

Physicians for Social Responsibility
http://www.psr.org/about/

Planned Parenthood Southeastern Pennsylvania
http://www.plannedparenthood.org/ppsp/

United Nations Association of Greater Philadelphia
http://www.una-gp.org/

U.S. Department of Health and Human Services, Region III
http://www.hhs.gov/iea/regional/region3/index.html

Health Policy Newsletter to become *Population Health Matters*

Starting with the Fall Issue, the newsletter name will officially change to ***Population Health Matters***. The new name better reflects the expanded scope of the topics we cover. You will continue to receive high-quality content reflecting the mission, goals, and work of the Jefferson School of Population Health.

Start the Conversation: National Healthcare Decisions Day

National Healthcare Decisions Day (NHDD) has become an annual event devoted to raising awareness about advance directives and about the importance of communicating one's wishes regarding care at the end of life. Since its inception in 2006, NHDD -- which began in Virginia -- has expanded to include hospitals, state organizations and other agencies across the country. This year ear, 110 national organizations and roughly 1200 state/local organizations participated in NHHD, including Einstein Healthare Network.

Einstein first participated in NHDDA in 2011. A multidisciplinary group was formed that designed and organized the event. The goal of the day was to raise awareness about the importance of having conversations with loved ones about end of life preferences without advocating a particular position about end of life or "pushing" completion of advance directive documents (i.e., living wills or durable power of attorneys for healthcare). Our audience was patients, visitors, and employees. We named our event, "Start the conversation." The marketing department created buttons and banners with this title and was essential in helping to advertise the event. Anonymous personal experience stories involving the communication of wishes related to end of life were solicited and printed up for discussion and distribution at the event.

Ninety-one volunteers, from many different departments and who typically did not have much work-related connection with end of life, participated in educational training sessions. They staffed informational tables set up across the Network. A resource list with names and contact numbers for individuals (chaplains, social workers, ethics consultants, and attorneys) was compiled and prepared for distribution, along with other written materials about advance directives and some moving, anonymous personal stories. Our CEO, Barry Freedman, sent out a letter to all employees supporting the importance of the event. An institutional program focused on the sharing of the experiences of professional caregivers (Schwartz Rounds) took on the topic of end-of-life care experiences for that month.

On the day of the event, employees and hospital visitors could be seen at the various tables. Anecdotal reports indicated that the conversations with individuals approaching the tables varied from information seeking to the sharing of personal experiences.

In order to evaluate the event, we surveyed the volunteers (hospital employees) about their experience; what they heard in their conversations; and whether participation in the event had any impact on their own interest in completing an advance directive document. We constructed a short, 6-item survey that could be completed anonymously using the SurveyMonkey^{TM} online program. The link to the survey was sent to all volunteers who staffed tables during this event.

The overall response to the event by the volunteers was very positive, with eighty individuals responding (88% response rate). Volunteers reported that they spoke with both employees and hospital visitors during the event. Questions, concerns, and issues voiced by people with whom the staffers spoke covered a broad range of topics. The most frequently mentioned questions had to do with legal concerns and instituting advance care planning documents in the hospital. Volunteers reported that those who approached them were appreciative of information, shared personal stories with them, and discussed the difficulty of having a conversation with family. Some revealed their own discomfort with the topic for themselves. A few mentioned the need for materials in other languages, and a few raised questions about the hospital's motive in having such an event. Many individuals approached the tables and took the materials but did not engage in conversation.

In order to gauge the impact of the event on the volunteer, we asked which actions the respondent felt (s)he would be likely to take related to advance care planning. Close to one-third (31%) said they were likely to do more thinking and / or reading about the topic. The majority (66%) noted that they were likely to talk to family members or close friends about this topic. Two respondents said they weren't planning to do anything related to advance directives. A little less than one-quarter of the volunteers reported that they already had an advance care planning document (either a living will or durable power of attorney).

As a result of the feedback received, we are working to educate our employees about the importance of "starting the conversation." We plan to make Einstein's participation in NHHD an annual event. ■

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For more information about National Healthcare Decisions Day visit: http://www.nhdd.org/

Canadian Medicine at a Crossroads

Interview with President of Canadian Medical Association

Canada's four decades old government-sponsored healthcare system serves a population of 34 million, takes up 11.9% of GDP and costs $191 billion a year, or roughly $5,614 per capita. The majority of the country's 70,000 physicians have practiced under no other form of healthcare delivery.

While the Canada Health Act (CHA) is federal legislation, delivery of healthcare services is under provincial jurisdiction. Under the original Act, payment was on a 50-50 sharing arrangement between the two arms of government. Today, the federal share has dwindled to 21%.

The CHA has five basic tenets: *Universality*: that services cover everyone; *Comprehensiveness*: that all necessary physician and hospital services be covered; *Portability*: that services remain in force when a resident moves from province to province; *Accessibility*: everyone should have reasonable access to services; and *Public Administration*: that all services be carried out by a public authority on a nonprofit basis.

That some of these tenets, such as accessibility and public administration, might not be upheld in practice is a matter of concern to the Canadian Medical Association's president, Dr John Haggie. Dr Haggie, a British surgeon who moved from the bustling UK city of Manchester to the remote tip of Labrador, notes

Continued on page 12

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David B. Mandell, JD, MBA

How Healthy is Your Portfolio? Traditional and Alternative Investment Strategies for Physicians
Jason M. O'Dell, MS, CWM

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Daniel Z. Sands, MD, MPH

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Bettina Berman, RN, BS, CPHQ, CNOR

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that accessing services there often means expensive and not always reliable trips by air . . . and the range of services is limited, with primary care mostly provided by nurse practitioners.

There's some evidence that the public administration pillar may be showing some cracks, too. In 2005, Dr Jacques Chaoulli, a Montreal general practitioner challenged the nation's supreme court on behalf of a patient who learned that it would take a year or more to replace a painful, arthritic hip and wanted access to private care. The Court ruled 4 to 3 that "access to a waiting list is not access to healthcare." Dr Haggie notes that while that decision still holds, the result has been some improvement in wait times for treatment of cataracts and cancer, and for imaging and joint replacement.

In a recent interview with *Health Policy Newsletter*, Dr Haggie said that Canada's physicians "stand at a crossroads." Traditionally, he said, they have tried to effect change in an insular, ad hoc fashion. But system change is now possible, he said, because governments are scared by the rapid growth in healthcare expenditures, particularly with the rise in the baby boomer population. Haggie acknowledges, though, that 'we don't measure outcomes well; and there are still inordinate waiting times for some services. Moreover, he says, much of the infrastructure of Canadian healthcare facilities needs updating, and the growing emphasis on chronic care has left acute care "creaking." The country's medical profession, he says, is concerned that government is spending more and more dollars on healthcare at the expense of other programs.

Dr Haggie said that the Canadian Medical Association, in conjunction with the Canadian Nurses Association, developed a series of "Principles to guide healthcare transformation in Canada." They include patient-centered care; quality services that are appropriate for patient needs; health promotion and illness prevention; equitable access; adequate resources; and timely and cost-effective delivery. They also call for timely, transparent reporting at the system level on both processes and outcomes that can be used and understood by stakeholders and the public.

These principles were endorsed by some 75 healthcare organizations. The CMA and the CNA feel that these principles should now be part of the next Health Accord that is to be revisited later this year.

Last year, the CMA conducted a series of countrywide Town Hall meetings called *Voices into Action*. Among the observations: The need for a new system that puts doctors and patients in charge of making healthcare decisions rather than bureaucrats and politicians; that families and communities are not just the recipients of healthcare services but also the co-producers of health and need to be at the table; that the CHA be retained and expanded to include such services as pharmaceutical care, home care and complementary medicine."

Dr Haggie is also concerned about accountability in Canada's healthcare system. This means making it more patient-centered, and making sure it provides good value for dollars spent. A crossroads indeed, and one that the new president will need all of his powers of persuasion and diplomacy to take his adopted country's healthcare system into the coming year. ■

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Health Policy Forums

Reconsidering Law and Policy Debates: A Public Health Perspective

John Culhane, JD
Professor of Law, Widener University School of Law
Director, Health Law Institute
Lecturer, Yale University School of Public Health

December 14, 2011

Culhane's Forum presentation was primarily based on content from the book, *Reconsidering Law and Policy Debates: A Public Health Perspective,* which he edited and co-authored. Though the book is a compilation of a variety of topics (i.e., end-of-life care, gun violence, tort litigation, racial disparities), reproductive rights, marriage equality, and domestic violence were the main focus of his presentation. These controversial, hot-button topics are not always viewed as public health issues. Culhane likes to delve into these debates and examine broader approaches to public health and law.

He first discussed the benefits of a public health perspective, which he described as having a "jolt effect" – meaning it gives context to a "rights" talk. He also tackled the perceived risks of a public health perspective – the argument being that public health should only focus on narrowly defined topics such as disease control.

Culhane discussed the highly charged example of reproductive rights. Specifically, both pro-life and pro-choice advocates used a public health argument to support their cause. The pro-life side had gained some momentum by promoting the controversial breast cancer-abortion link. Wendy Parmet, JD of Northwestern University School of Law and contributing author of the book, challenges the public to use science responsibly and develop a population perspective that encompasses the complex, multi-factorial causality of illness.

Culhane went on to explore the issue of domestic violence, pointing out that the standard definition and legal interpretation of domestic violence is narrow and is typically characterized by a blatant form of violence. What is often neglected from this definition is the action of coercive control. Coercion, the act of controlling the environment or some aspect of a person's daily life, is not always taken seriously, and yet it can lead to intimidation and violence. Under the "abuse" model coercive control is not validated or acknowledged within the legal system. The public health model, however, defines health holistically and in this example, Culhane urges that there should be concern with prevalence rather than incidence.

The Forum concluded with a brief overview of marriage equality and the current climate surrounding same-sex marriage. Culhane explained that it can be difficult for marriage equality to be seen from a public health perspective. Though on the surface it can be seen as a basic "rights" issue, what is the context for the right to marry? Would same-sex marriage have a negative effect on opposite-sex marriages and how would that be proved? What are the costs and benefits of placing so much value on the privilege of being married? These engaging and provocative questions are not easily answered but, using a public health approach, Culhane finds no justification for excluding same-sex couples from marrying. Culhane summarized his presentation by explaining the differences between laws: laws that support existing marriages; laws that benefit the children of married couples; and laws that protect the interests and expectations of the parties upon dissolution.

Center for Value in Healthcare: Translating Research Into Policy and Practice

January 11, 2012

The winter Forum season opened with an opportunity for attendees to become acquainted with the programs of the Center for Value in Healthcare, a new research entity within the School of Population Health. The Center focuses on research designed to examine performance measurement and improvement strategies that will increase the capacity of the US healthcare system to deliver higher quality, and more cost-effective care.

Hosted and moderated by the Center's director, Mark Legnini, DrPH, this Forum featured innovative projects, presented by a panel of the Center's faculty and staff:

Evaluating the Impact of Pennsylvania's Medicaid Aging Waiver Reform
Albert Crawford, PhD, MBA, MSIS

Tobacco Use in Philadelphia: Philadelphia's Clean Indoor Air Worker Protection Law and Trends in Inpatient Admission
Robert Simmons, DrPH, MPH, CHES, CPH
Albert Crawford, PhD, MBA, MSIS

National Quality Measure Development and Implementation
Valerie Pracilio, MPH
Bettina Berman, RN, BS, CNOR, CPHQ

Physician Profiling in Emilia-Romagna Italy: A Tool for Quality Improvement
Vittorio Maio, PharmD, MS, MPH

Sponsor Involvement in Quality Improvement: How, Why, and When
Robert Lieberthal, PhD

Using a Novel Statewide Health Data System to Improve Care
Joseph Couto, PharmD, MBA

The projects discussed revealed a diverse range of content areas, with collaborations that spanned from local and state governments to physician practices abroad. The Center for Value in Healthcare has the capacity to expand its reach and foster the development of important quality initiatives affecting meaningful change.

If you are interested in collaborating with the Center, or you would like more information about a specific project, contact Mark Legnini, DrPH, at 215-955-0427 or mark.legnini@jefferson.edu.

Achieving Population Health: What Evidence Will We Need?

Lisa Simpson, MB, BCh, MPH, FAAP
President and CEO
AcademyHealth

February 8, 2012

This Forum presentation focused on the growing importance of adopting a population health approach to national health policy. Lisa Simpson, President and CEO of AcademyHealth, reviewed current federal policies promoting population health and described the national research agenda.

Dr. Simpson began her presentation by offering a detailed overview of the mission and programs of AcademyHealth, a non-partisan organization that represents a broad community of people committed to using health services research to improve care. It supports the development and use of rigorous, relevant, and timely evidence to: increase the quality, accessibility and value of health care; reduce disparities; and improve health. It has over 4,000 member organizations and a number of interest groups. AcademyHealth's new strategic priority areas include: delivery system transformation; public and population health; and value and health care costs.

Critical to the field of population health is the formation the Patient-Centered Outcomes Research Institute (PCORI). Initially established by the Affordable Care Act (ACA), it is now an independent organization. Simpson explained that PCORI provides a new emphasis on the patient's voice in research and it helps people become more informed about health decisions.

Simpson explained the relevancy of some key provisions in ACA related to population health. For example, the ACA addresses the need for systematic approaches to definition, funding, evidence base, communication and the need for cooperation.[1] It also encourages the development and use of common metrics to measure effectiveness. Other programmatic provisions include the National Prevention Strategy, Prevention Fund, Benefit Designs to Promote Wellness, and Employer Wellness Programs. Simpson emphasized the use of the population health "lens" for implementing health reform.

The field of public health services research was eloquently summarized by Dr. Simpson. She defined it as a field of inquiry examining the influence of the organization, financing, and performance of the public health system on population health outcomes. She also discussed public health services research needs assessment and the importance of filling the evidence gaps. Simpson concluded by raising the questions: *How can policy and systems change improve outcomes*? *How do we measure these improvements in population health?* Clearly, more evidence and more funding are needed to answer these questions.

For more information on AcademyHealth visit: http://www.academyhealth.org/

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1. Bovbjerg et al. What directions for public health under the Affordable Care Act? The Urban Institute Health Policy Center. November 2011. http://www.urban.org/UploadedPDF/412441-Directions-for-Public-Health-Under-the-Affordable-Care-Act.pdf. Accessed March 31, 2012.

Changing Patient and Physician Behavior: Moving Toward Informed and Shared Decision-Making

Ronald E. Myers, PhD, DSW
Director, Division of Population Science
Professor, Department of Medical Oncology
Thomas Jefferson University

March 21, 2012

Dr. Myers spoke to a standing room only audience at a recent Health Policy Forum where he discussed the impact of decision aids and decision support interventions used to facilitate informed decision-making in cancer care. Dr. Myers has dedicated much of his career to cancer control and prevention. He is currently Director of the Division of Population Science in the Department of Medical Oncology at Thomas Jefferson University.

Myers started with an explanation of the basic elements and definitions of patient-centered care and decision support interventions. Decision support interventions are designed to help people think about choices and why a choice exists; they can be used for a one way-delivery of information to patients (non-mediated) or in a context of a two-way interaction between a patient and provider. Decision support interventions may include print materials, audiovisual recordings, computer-based applications, oral or scripted presentations, and decision counseling.

Myers went on to highlight criteria described in the International Patient Decision Aids Standards (IPDAS). For example, patient decision aids should: provide information about options in sufficient detail; present probabilities in an unbiased understandable way; include structured guidance in deliberation and communication; use up-to-date scientific information; disclose conflict of interest; and use plain language. Although many clinicians are aware of patient decision aids, few currently use them. The main barriers identified are lack of awareness and resources.

In order to help the audience understand current research and implementation of patient decision aids, Myers used the example of informed decision-making in prostate cancer screening. In general, most primary care physicians do not engage in a discussion with patients when recommending or performing screening for prostate cancer; therefore, many men do not make an informed or shared decision. A recent study revealed that men who received informed decision counseling in primary care settings increased their knowledge about prostate cancer and screening; increased the completeness of informed decision-making in physician-patient encounters; and lowered screening use. This intervention however, had no effect on patient decisional conflict.

In summary, Myers shared his thoughts on the implications for the future, which include the development of new support methods and clarification of appropriate measures of success, along with research related to patient-centered outcomes. He stressed that health care reform legislation may facilitate decision support research, implementation and dissemination.

For information on the Center for Health Decisions visit: http://www.jefferson.edu/jmc/medical_oncology/divisions/population_science/chd/index.cfm

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

Upcoming Health Policy Forums – Spring/Summer 2012

Pennsylvania's Aging Initiatives: Planning for the Future

May 9, 2012

Brian Duke, MBE
Secretary of Aging
Pennsylvania Department of Aging

Public Reporting of Cardiac Surgery Outcomes in Pennsylvania: A 20-Year Personal Perspective

June 13, 2012

Raymond L. Singer, MD, MMM, CPE, FACS, FACC, FCCP
Vice Chair, Quality, Patient Safety, and Outreach
Chief, Division of Cardiothoracic Surgery
Lehigh Valley Health Network

Location:
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Time: 8:30 am – 9:30 am

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JSPH Presentations

Ai J, **Lieberthal RD.** The how, why, and when of PRIDIT: Examples from hospital quality and fraud detection. Presented at: The Casualty Actuarial Society's RPM Seminar; March 20, 2012; Philadelphia, PA.

Barber E, **Chernett NL,** Mc Coy M. Beat the blues: An integrated approach to depression identification and treatment in urban seniors. Workshop presented at: Annual Conference of the American Society of Aging; March 28-31, 2012; Washington, DC.

Chernett NL, McCoy M, Gitlin LN, Harris LF. Beat the blues: A collaborative home-based depression intervention-successful recruitment and enrollment strategies. Poster presented at: Collaborative Family Healthcare Association 13th Annual Conference; October 27-29; Philadelphia, PA.

Jackson JD. Understanding to whom CER results apply. Presented at: Q1 Productions, Integrating Comparative Effectiveness Research Conference; December 6, 2011; Philadelphia, PA.

Jackson JD. Atrial fibrillation. Presented at: Division of Pharmacoepidemiology and Pharmaceonomics, Harvard Medical School; November 29, 2011, Boston, MA.

Lieberthal RD. Population health management for casualty actuaries. Roundtable session discussion at: Casualty Actuarial Society's RPM Seminar; March 20, 2012; Philadelphia, PA.

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Simmons R. Raising the ante to improve health: Looking beyond health indicators. Presented at: Drexel University, Interdisciplinary Education program; January 26, 2012; Philadelphia, PA.

Simmons R. Global health promotion framework, competencies, and graduate education in global health. Presented at: Global Health Symposium of the Delaware Health Sciences Alliance; Feb. 4, 2012, Wilmington, DE.

Simmons R. Incorporating policy and advocacy into our teaching and practices. Presented at: 15th Annual Health Education Advocacy Summit; March 3, 2012, Washington, DC.

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Simmons R. Competencies and certification for public health education and promotion: The US experience. Presented at: Interamerican Conference on Health Promotion and Health Education, Pan American Health Organization, International Union for Health Promotion and Health Education; April 12, 2012; Mexico City, Mexico.

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