

Health Policy

NEWSLETTER

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EDITORIAL

Looking Back and Forward: Reflections on 20 Years of the *Health Policy Newsletter*

For more than 20 years the *Health Policy Newsletter* has been among the intellectual products emanating from what was first the “Office of Health Policy and Clinical Outcomes,” then the “Department of Health Policy” (both at Jefferson Medical College) and what has become, over the course of the past few years, the Jefferson School of Population Health. This will be the last issue published under the *Health Policy Newsletter* masthead. Beginning in the fall, we’ll be publishing under a name that is more reflective of our mission and vision – *Population Health Matters*. As Editor in Chief, I think it’s important to reflect on our two-decade journey as we complete our conversion to a totally online publication.

Our newsletter has served to illuminate and inform our readers about the pressing issues of an important era in health care and documents some key aspects of our own journey from office, to department, to school. We covered many policy issues, political issues and even a few personal issues. It’s a journey we could not have undertaken without the help of many colleagues and friends – from inside and outside the Jefferson family of university, hospital and health system – who contributed articles or gave of their time to serve on the editorial board.

The newsletter started publication before the advent of the digital technology that rules our lives today. When I arrived at Jefferson in January

1990, there was no computer or even voicemail. We actually talked to one another, and there was nothing to distract from the topic at hand during a meeting. While it’s certainly hard to visualize a work environment without all of our modern tools, I think we were a lot less preoccupied and more “in the moment.”

During the first decade of publication of the newsletter, the Office of Health Policy was deeply involved in the early movement toward public accountability for patient outcomes. I began my tenure as chair of the statewide Technical Advisory Group (TAG) of the Pennsylvania Healthcare Cost Containment Council, headquartered in Harrisburg, PA. PHC4, as it came to be known, was one of the first state-based, tax supported, hospital outcomes purveyors in the United States. In the early 1990s, PHC4 was among the first organizations to create a report card on the outcomes of open heart surgery, myocardial infarction, and then the top 25 inpatient DRGs for every hospital.

Given my role on the TAG, several editorials in the 90s reflected on our work together. “*Report on Report Cards*” (May 1998) acknowledged the struggle of promoting public accountability and drew attention to the differences in outcomes of care. The political climate at that time was not widely supportive of releasing what had heretofore been

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private information. PHC4 and our Office of Health Policy continued to push forward on these issues.

The second decade (the Y2K era) could be characterized by the introduction of disruptive innovations and technology. We thoroughly examined burgeoning movements to transform care delivery (September 2007). In our early work as the Department of Health Policy (JMC), the faculty were deeply involved in helping to assess the quality of care delivered by nurse practitioners in clinics based largely in for-profit drugstore chains and “big box” retail stores. We had access to some of the emerging national leaders who helped to frame this innovative paradigm which evolved into what is now known as “retail medicine.” We allied ourselves with a new organization, the Convenient Care Association, headquartered right here in Philadelphia.

Hospital technology designed specifically for patient education and entertainment led to the introduction of the “hospital bed of the future” spearheaded by GetWell Network, a young company established in 1999 (December 2007). GetWell Network was among the first to use a bedside touchscreen monitor and other hand held devices that allowed in-patients to access the Internet and other educational communication and entertainment tools. They coined the phrase “interactive patient care or IPC” to describe this patient-centric point of view, which was endorsed by major national organizations, such as the American Hospital Association. In a relatively short period of time, this work has led to the establishment of the Institute for Interactive Patient Care (IIPC), a not-for-profit research organization closely affiliated with GetWell Network.

Another important milestone in this second decade was our early publication of the results from a now famous Pennsylvania-based study on hospital-acquired infections. The *Health Policy Newsletter* was among the first to describe this new lexicon of “hospital-acquired (later termed ‘hospital-associated’) infections” (HAI). This

work was based, again, on heretofore “confidential” data released by PHC4. “*Sunshine is the Best Disinfectant*” (March 2007) was fueled by a press conference at the National Press Club in November 2006 which resulted in a cover story in *Modern Healthcare* magazine. This was a watershed event for the newsletter as it documented how a local story could have national significance.

Sometimes our editorials had a distinct personal flavor. At the end of our second decade of publication I became introspective in three editorials of special significance to me. In the first, in December 2008, I reflected on the meaning of “mission.” At the time, I had concluded 10 years of service on the Board of Directors of Catholic Healthcare Partners, the nation’s 10th largest not-for-profit hospital system. CHP is a recognized national leader and I was privileged to work with both religious and lay leaders who taught me a great deal about the meaning of devotion to the mission of an organization.

Probably the most personal editorial came in June 2009, a few months after the death of my father, in a piece called “*Losing My Dad*.” I was humbled by the power of the newsletter to reach so many, as I received more than 200 personal letters, emails, and hand scribbled prayers of support. I was overwhelmed by the outpouring of emotion as many readers described similar stories of elderly parents or relatives who were victims of medical error and other untoward events.

Finally, in the summer of 2010, the newsletter editorial focused on the Arthur C. Bachmeyer Memorial Lecture, which I was privileged to deliver as the special honoree at the American College of Healthcare Executives annual meeting. I reflected on the passage of health reform as the lecture occurred exactly one day after the Senate passed the Affordable Care Act (ACA).

As we step squarely into the present decade, our content has been appropriately characterized by the launch of our new School of Population Health and it completes our journey from office,

to department, to school. Many faculty members have helped to sculpt the front page editorial, especially in this last era. Editorials have focused on “*One Book, One School*,” which was a detailed review of George Halverson’s critically acclaimed book, *Healthcare Will Not Reform Itself: A User’s Guide to Refocusing and Reforming American Health Care*. We also began to focus on the details of the ACA and published such issues as “*No Outcome, No Income*,” a deep dive into meaningful use and its impact on the healthcare system. We also took time to reflect more broadly about reform, asking whether it will actually improve our nation’s health. Guest editorialists focused on other pressing issues of the new decade, including, for example, the new program requirements from the Accreditation Council for Graduate Medical Education (ACGME).

As we move forward into the next phase of our journey, we will strive to bring our readers the best commentary, analysis and reporting possible. We hope you choose to join us as we refine our voice in the context of our new publication, *Population Health Matters*. Aside from choosing a new name befitting the broader goals and mission of the only school of Population Health in the United States, we have transformed our publication into a digital format, a cost-efficient and “green” effort. As we upgrade our technology and online publishing skills, we will work to incorporate more dynamic and interactive content to engage and inform you.

I hope you’ll join the conversation with our faculty and staff, and that you will attend our live programs and conferences (or access the online archives and podcasts), submit an article or commentary, become a member of the Grandon Society, or even take some courses with us in person or online. I am enthusiastically looking forward, with great pleasure, to the next decade of publication. ■

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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.

Developing a Resident Quality and Safety Curriculum

Inspired by attending the American Medical Student Association's Patient Safety and Quality Leadership Institute at Jefferson, I believed that my Physical Medicine & Rehabilitation (PM&R) residency program had many opportunities to improve its training of residents in how to improve safety culture and conduct quality improvement projects. Here we discuss how a curriculum was developed to leverage these opportunities.

The Accreditation Council for Graduate Medical Education (ACGME) released a new set of approved standards for residency education (effective July 1st, 2011)¹ that placed an increased emphasis on quality and safety education. They require that residents develop familiarity with the related vocabulary, concepts and implementation procedures through educational initiatives designed to fill the gaps in their knowledge base.

Initially, we developed a needs assessment survey to determine how prepared residents in our PM&R training program were to initiate continuous quality improvement and recognize safety culture. The Safety Attitudes Questionnaire (Ambulatory Version)² provided half of the survey items. The remaining survey items were adapted from the ACGME "Facilitator's Manual"³ and specific departmental program objectives. The survey was administered during protected didactic time to 17 psychiatry residents and assessed several domains, including safety attitudes and familiarity with stated program educational objectives. The data was presented as a poster at the National Physician's Alliance National Meeting in October, 2011. The majority of residents (94%) felt it was important to be a part of hospital safety initiatives, but only a few residents were confident in their ability to conduct a quality improvement initiative (24%)

or root cause analysis (18%). Just over half (59%) could identify a near-miss event, and less than half (47%) knew how to identify systems causes of error.

A concurrent Jefferson Hospital Patient Safety Champion project allowed residents to implement a quality improvement initiative. Safety Champions from various clinical areas were trained as facilitators to identify and address their respective department's areas of deficiency as assessed by Pascal Metrics' Safety Attitudes Questionnaire (SAQ). As the department Safety Champion, I recruited a team of eight PM&R residents who created "Safety Rounds," a thirty-minute session held during didactics once per two-month block, to discuss on-call issues encountered on our inpatient rehabilitation unit. Our aim was to improve our learning from the errors of others, which was the chosen area of deficiency that was identified from the SAQ. Since its inception six months ago, we have held three Safety Rounds. After the first session, we surveyed our residents to determine on-call concerns, and these were addressed at subsequent sessions. For example, to help residents facilitate the transfer of patients from our unit back to acute care, the process was reviewed, a real-time demonstration was given, and a senior resident created a pocket-size handout describing the step-by-step process to distribute to all residents and post on the unit as a reference tool.

There have been other attempts at augmenting resident education about quality improvement and safety culture. Two quality improvement articles were selected as an addition to required reading for one of our PGY-2 rotations. A quarterly lecture has been added into our didactic curriculum. Given that 94% of residents on our needs assessment survey agreed on the

importance of standardized communication while sharing information during handoffs of patient care, a Grand Rounds was presented reviewing the evidence of handoff communication.

Our needs assessment survey was re-administered one year after the initial survey to determine whether the interventions had been successful and identify further areas of possible curricular enhancement. Overall, there has been heightened awareness of safety culture among residents. The data quantified areas of improvement and identified opportunities to develop further educational programming during the upcoming year. During the next year, we will attempt to create additional curricular interventions and repeat our needs assessment survey as a tool to analyze the effects of our efforts. As ACGME accreditation requirements continue to evolve, it will be important for residents not only to understand quality improvement and safety culture, but also be able to demonstrate skills relating to systems-based practice.⁴ ■

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REFERENCES

1. Common Program Requirements. ACGME Web site. http://www.acgme.org/acwebsite/home/common_program_requirements_07012011.pdf. Effective July 21, 2011. Accessed January 17, 2011.
2. Sexton JB, Helmreich RL, Neilands TB, et al. Safety Attitudes Questionnaire (Ambulatory Version). The University of Texas- Memorial Hermann Center for Healthcare Quality and Safety Web site. http://www.uth.tmc.edu/schools/med/imed/patient_safety/documents/Survey-SAQ-Ambulatory.pdf. 2003. Accessed January 17, 2011.
3. Facilitator's Manual: Practical Implementation of the Competencies. ACGME Web site. http://216.92.22.76/discuss/messages/21/MODULE_2_Facilitator_Manual_module2-486.pdf April 2006. Accessed June 19, 2012.
4. Nasca TJ, Philibert I, Brigham T, Flynn T. The Next GME Accreditation System – Rationale and Benefits. *N Engl J Med*. 2012; 366(11):1051-1056.

Mark L. Tykocinski, MD

Commencement Address to the JMC Class of 2012

May 21, 2012

Verizon Hall at the Kimmel Center for the Performing Arts

Class of 2012 – you have been trained to be Jefferson’s ambassadors to the world. As such, my parting message to you speaks to your sense of empowerment. I draw lessons from a Nobel laureate, a moon-mission astronaut, and a world-class pianist.

Message #1: DREAM BIG. Supplement the day-to-day with ambitious goals and do not underestimate your own catalytic power. Recognize your inner agency – one that transcends self-imposed limits and empowers you to influence events even on the largest of stages. The story of my own mentor, Dr. Bernard Lown, speaks in particular to how a single physician’s agency can play out in a remarkably short timeframe.

Back in the 70s, I was a clueless Yale undergrad hunting for a summer job up in Boston, wandering the hallways of Harvard’s School of Public Health, literally just looking for an open door. I stumbled into Lown’s office. What followed was a life-changing Forrest Gump-like cascade – three intense summers with one of the world’s most remarkable physician-scientists and a close-up view of how a single physician with a clear goal can move mountains.

Many believe Lown should already have received the Nobel Prize for Medicine – after all, he discovered cardioversion with pulsed DC current, the ‘Lown waveform’, and pioneered the cardiac defibrillator. Yet, while the medicine prize has eluded him thus far, what has come his way is the Nobel Peace Prize. This he shared in 1985 with a Russian cardiologist in recognition of their co-founding the International Physicians for the Prevention of Nuclear War.

What stands out in Dr. Lown’s remarkable saga is just how quickly it all unfolded. It was a mere four years from the first International Physicians for the Prevention of Nuclear War (IPPNW) Congress to Lown’s standing on the podium in Stockholm with Nobel medal bestowed. A mere kernel of a thought in one physician’s mind: *why cure individual patients if we are all but a keystroke away from mass annihilation?* Any of us could have had this thought. Any of us could have acted on it. But we didn’t. Lown did. And a mere 4 years later, he flew from his

secluded perch in academia to a world podium – catalyzing a world-class movement of physicians, penetrating the Iron Curtain, and deploying citizen diplomacy to influence a superpower dialogue. And what makes this so tangible is realizing how close I was to these unfolding events – just 30 feet down the hall from Lown’s office, as the embryonic seeds for his Nobel journey were being sown.

So, Class of 2012, do not limit yourselves – dream big, take the first small steps, persist in a single-minded way, and know that big things can sometimes be achieved in remarkably short timeframes, seemingly in the blink of an eye. You too can shape – and even shake – the world. ‘Be realistic’ is a message you’ve had pounded into you like a drumbeat over the years. But I’m now urging you to titrate in a bit of unrealism. Open yourselves up to greater possibilities! Certainly have realism ground you, but don’t let it cage you.

My second message to you, Class of 2012, is a bit more sobering: Sometimes you can shake the *status quo* in lightning speed, like Lown, and be there to garner the glory, but at most times, you are simply laying cornerstones and foundational bricks for edifices that others will cap off. Often, we are initiators, enablers – fated to concede the limelight to others who finalize what we introduce. Understand that this enabling role, in projects and initiatives that reach beyond us in time and place, is no less noble and remains the most worthy of ambitions.

The metaphor of *‘the third astronaut’* capsulizes this thought. Some of my contemporaries in the audience may remember a song by the rock group Jethro Tull entitled, *For Michael Collins, Jeffrey and Me*. Released in 1970, one year after the first moon walk, this song was a tribute to Michael Collins, the Apollo 11 astronaut who stayed behind as command module pilot orbiting the moon and minding the mother ship Columbia as his two fellow astronauts, Neil Armstrong and Buzz Aldrin, descended in the L.E.M., the lunar module *Eagle*, and stepped into the limelight of history – the image of their feet touching the moon’s surface beamed to billions back on planet Earth and imprinted forever on mankind’s collective psyche. All eyes were on Armstrong and Aldrin; few, if

any thought about Collins – *the third forgotten astronaut* – who piloted Columbia almost a half-million miles round-trip and came close enough to almost touch the moon but never set foot on it. What a powerful metaphor for the enabler, for selflessness, for teamwork.

When interviewed later, Collins claimed that what preoccupied him the most was his concern that Aldrin and Armstrong would not make it back to the mother ship, leaving him in the unenviable position of returning to Earth alone. But the lyrics to the Jethro Tull song intimated a more complex psychology at work, projecting an ambivalent Collins:

*I’m with you L.E.M.
though it’s a shame that it had to be you.
The mother ship is just a blip
from your trip made for two.
I’m with you boys, so please employ just a little
extra care.
It’s on my mind I’m left behind
when I should have been there.
Walking with you.*

“I’m left behind when I should have been there” – a bittersweet lament, conveying the mixed emotions of a man forced to watch his two partners moon walk into history. And yet, Collins played his role dutifully.

So, sometimes as agents we are privileged to be like Lown – driving accomplishments that unfold quickly; recognized and rewarded as prime movers. But at other times, we are enablers like Collins – not privileged to carry the baton on the final leg of the race, but rather destined to yield the finish line snapshot to others.

A former colleague once shared with me a profound Greek saying: *“Do the good deed and throw it in the sea.”*

What is the implication? That one should never expect recognition or compensation for one’s good deeds. A wise saying, but is it entirely true? Is doing the good deed a matter of selfless giving, with no personal return?

I would opine ‘no’. There are personal returns even for the enabler. In enabling, you are growing yourself. Acts of selflessness provide a framework for, and become part and parcel, of your own self-development.

One final message to you, Class of 2012, about persistence and fearlessness in the face of challenges. Embrace challenges and eagerly seek out problems to be solved. No obstacle is too daunting! As you manifest your agency, whether or not recognition will be your fate, do so with relish for the difficult. Just take the first steps because, time and again, your sheer agency and initiative will somehow make the obstacles before you melt away. Paradoxically, the challenges are often the most empowering, pointing to imaginative solutions and driving innovation.

We all have our own favorite inspirational anecdotes of someone who has tackled seemingly insurmountable obstacles, triumphing through persistence. On my personal list is the pianist Leon Fleisher, one of the true giants of the 20th century keyboard. Fleisher made his public debut at age 8, and by age 16, played with the New York Philharmonic under Pierre Monteux, who labeled him “the pianistic find of the century.” Fleisher became one of the few child prodigies to be accepted for study with Artur Schnabel, linking him to a tradition that descended directly from Beethoven himself. And then, like the hero of a Greek tragedy, he was struck down in his prime: at 36, he suddenly and mysteriously became unable to use two fingers of his right hand.

Fleisher recalls the depression that engulfed him as his condition worsened, but even more powerfully the sheer love of music that rescued him from complete self-destruction. That love of music manifested itself in his starting to conduct, but far more compelling, in his continuing to *play*

– now with his left hand only – while searching for a cure for his condition. Miraculously, at the age of 66, his condition was diagnosed as focal dystonia, and cured by experimental Botox injections. Having regained the use of his right hand, he returned to Carnegie Hall in 2003 to give his first two-handed recital in over three decades, bringing down the house.

It is not so much Fleisher’s return with two hands that makes him a legend, as it is the 30 years he pressed forward with his weaker left hand, developing new strengths in the face of new obstacles. He inspired the American composer William Bolcom to compose *Concerto for Two Pianos, Left Hand*. And then there was Paul Hindemith’s *Klaviermusik* Piano Concerto for the Left Hand, written years earlier for the Austrian pianist Paul Wittgenstein, who lost his right arm in World War I. It was Fleisher who rescued this piece from the dustbin and who premiered the work in 2004 with the Berlin Philharmonic, and a year later with the San Francisco Symphony.

Fleisher’s left-handed piano saga didn’t end there. At age 82, he underwent surgery on his right hand, requiring him to rest it for a number of weeks. This did not deter him from proceeding with a scheduled concert at Muhlenberg College, once again performing left-handed works only, and concluding with Brahms’ arrangement for the left hand of the Chaconne from Bach’s *Violin Partita No. 2 in D Minor*.

So, Class of 2012, you are more empowered than you think – whether you see the fruits of your labors in a short period of time or you plant the seeds of success that only bloom later.

Problem-solving is our fate. It is what energizes each of us individually and collectively. As framed by David Deutsch in his recent book, *The Beginning of Infinity*, we are all together on a collective journey

of endless problem solving, with no end *per se* – life and mankind are about continuous, never-ending progress, improvement, and knowledge generation.

Drawing on a quote attributed to Will Eisner, my plea to you, Class of 2012: be the ones to find the “*impossible solutions for insoluble problems*.” Like Lown, start great things, even if you only can spare time to do it as a sideline. Like Collins, be enablers, confident that, even if the limelight eludes you, you will benefit in any case, as you are on an endless journey of self-creation that is powered by your giving of yourself. And, like Fleischer, no matter what hurdle is thrown in your face, even when your strong right hand falters and ingenuity demands that you reinvent your weaker left hand, keep pressing forward with a confidence that most hurdles can be overcome.

As you now take the sacred Oath of Hippocrates, hear the profession’s ancient call to service, heed its admonitions, and affirm your commitment to others in the most professional and altruistic ways and permit yourselves to look beyond yourselves. Think big, enable even if you won’t get full credit, and know that your agency is almost limitless if you simply plow through the obstacles before you.

We salute all those that brought you to this point in life – your parents and family who nurtured and supported your passion for service and inquiry. As you cross this stage, it is indeed the dreams of all of us here today that go with you. You enter a long tradition that dates from Hippocrates, to McClellan and Gross, through Gibbon, and now to you. It is your turn to join, to continue, and to enhance Jefferson’s legacy of service, and to perpetuate that desire to make a difference that brought you to Jefferson four years ago. ■

This is an abridged version of Dean Tykocinski’s speech.

Award for Excellence in Teaching Presented to Dan Z. Louis

May 15, 2012

I have the pleasure this evening of speaking to you about Daniel Z. Lewis, the 2012 recipient of the Jefferson School of Population Health (JSPH) Award for Excellence in Teaching. Professor Louis teaches our public health and health policy students about the organization and delivery of healthcare in the United States and other countries around the world. As his students will tell you, his knowledge of health

care systems, their strengths, weaknesses, cost and quality is exceptional.

At present, Professor Louis is Research Associate Professor of Family and Community Medicine and Managing Director of the Center for Research in Medical Education and Health Care at Jefferson Medical College, a relationship that began in 1985.

Prior to coming to Jefferson, he was Executive Vice President and Chief Operating Officer of SysMetrics/McGraw-Hill in Santa Barbara, CA, a firm he founded that specializes in health services research and the development of databases, models and software designed to provide information for health care management. Born in New York City

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(Brooklyn, I believe, at a time when the Dodgers still called Brooklyn their home), he holds a BA in mathematics from Alfred University in New York and earned his MS in Operations Research from the Wharton School of the University of Pennsylvania; all totaled he has more than 35 years of experience in health services research.

Along with his friend and mentor, Dr. Joseph Gonnella, former Dean of Jefferson Medical College (JMC), Professor Louis is one of the developers of the Disease Staging or classification system for evaluation of severity of illness that is now used in the United States and internationally to assess quality and costs of health care. Their seminal paper introducing the Disease Staging system, published in 1984 in *JAMA*, the *Journal of the American Medical Association*, is considered a major contribution to the field.

Currently, Professor Louis is Jefferson's principal investigator for a major series of projects, performed with his colleague Vittorio Maio, PharmD, MS, MSPH of JSPH, in collaboration with the Regional Health Care Agency of the Emilia-Romagna Region of Italy. These projects, which take him to Italy quite frequently (primarily to Rome and Bologna), include development of models to predict risk of hospitalization for patients with

chronic disease, assessments of the timeliness and appropriateness of acute hospitalization, analyses of patterns and quality of care for women with breast cancer, and studies of the integration of hospital and outpatient care, among others.

In addition to teaching in the School of Population Health's MPH and health policy programs, Professor Louis lectures to first-year medical students in JMC on the cost and financing of the US healthcare system, at the Università Cattolica del Sacro Cuore in Rome, Italy, as part of their Master's Program in Health Administration, and at the University of Pisa, Faculty of Economics, in their Master's Program in Management of Health Care Organizations.

In speaking to students and reviewing evaluations of his courses, several patterns emerge about Professor Louis' teaching. In addition to his incredible knowledge of the subject matter, students cite him for the superb organization, clarity and precision of his lectures and the vigorous nature of class discussions. The most frequent adjectives used to describe his teaching are "excellent," "engaging," "clear," and "precise." One student even commented that "the test was truly AWESOME – clear, concise, great examples." (Imagine, a student enjoying a test and calling it awesome!) One student summed it up the best

when she commented, "I was not really expecting to enjoy this class, but I did – a lot! I will miss it."

When not teaching, researching, or traveling back and forth to Italy, he lives in Center City with his wife, Evie Cogan. He enjoys basketball, visiting his two daughters, reading mysteries, and playing with his new iPhone, which he had to be coaxed into buying but which he now cannot live without. He is a wine and food connoisseur, and his secret ambition is to emulate his son-in-law and become an internationally recognized food critic who travels the world in search of the perfect meal accompanied by the perfect wine.

It is with sincere appreciation that we present you with the 2012 Award for Excellence in Teaching. We thank you for sharing your prodigious knowledge with our students, for your generosity in devoting your time and effort to their learning, and for the elegance and excellence of your teaching – precise, clear and always engaging. As the students say, you are AWESOME – or FANTASTICO. In either language, that's all in capital letters! ■

*Presentation of Award for Excellence in Teaching
written by Caroline Golab, PhD, Associate Dean for
Academic and Student Affairs, Jefferson School of
Population Health*

Mark McClellan, MD, PhD featured at The 21st Annual Dr. Raymond C. Grandon Lecture: Health Reform, Two Years On



Mark McClellan, MD, PhD, Director of the Engelberg Center for Health Care Reform at the Brookings Institute speaks to a full house in the Connelly Auditorium.



Grandon Lecture panelists left to right: Robert I. Field, JD, MPH, PhD, Vijay Rao, MD, Donald F. Schwarz, MD, MPH, and Mark L. Tykocinski, MD.

To listen to a podcast of the Grandon Lecture visit: <http://jdc.jefferson.edu/hplectures/25/>

Evaluation of a Community-Based Diabetes Education Program

This article describes how Jefferson University Hospital's Center for Urban Health conducted a diabetes self-management education program evaluation guided by National Standards for Diabetes Education to improve program quality and receive accreditation from the American Association of Diabetes Educators.

Diabetes self-management education (DSME) is the formal process of improving knowledge, skills and abilities necessary for self-care for individuals with, or at risk for, diabetes.¹ To receive program recognition and comply with evidenced-based practice, the structure, process, and outcomes of a DSME program must meet national standards and the essential elements defined by the American Diabetes Association (ADA), Indian Health Services (IHS), or the American Association of Diabetes Educators (AADE). The AADE Diabetes Education Accreditation Program (DEAP), established in 2009, was designed to be sensitive to the unique characteristics of a community-based program, allowing a flexible process to accredit multiple sites with one application and fee.²

In response to the burden of diabetes in the Philadelphia community, the Thomas Jefferson University Hospital Center for Urban Health (CUH) has provided community-based diabetes education for over 10 years. The DSME program is designed to reach vulnerable populations in the Jefferson service area. The curriculum content area includes: disease process and treatment, nutrition, benefits of physical activity, safe and proper use of medications, blood pressure and blood glucose monitoring, strategies for preventing, detecting, and treating complications, stress management and problem solving. Behavior goals are assessed and monitored using the AADE 7 Self-Care Behaviors.³ These 7 behaviors – healthy eating, being active, monitoring, taking medication, problem solving, reducing risks and healthy coping – provide a framework for measurable behavior change. The CUH's DSME program supports a patient-centered

approach to DSME that is skills based and promotes collaboration with an interprofessional health care team. To sustain and grow the DSME program, an extensive program evaluation was conducted to identify gaps and implement recommendations to ensure that the program is consistent with the goals of the AADE DEAP.

Program documentation from 2008-2010 was selected for this review. Sources of data included the CUH's policies and procedures, grant reports, the DSME curriculum, de-identified participant pre- and post-session documents, attendance records, and quality improvement information. Findings from this review suggested that the department needed clearer identification of staff roles and responsibilities specific to the DSME program. The diabetes education sessions needed more opportunities for staff and participant collaboration in the development of individualized personal action plans, and follow-up and ongoing plan support. The program curriculum was revised to integrate assessed learner needs into educational interventions and to provide adequate time for class discussions, and skill-building exercises (return demonstration of glucose monitoring, blood pressure monitoring, etc.). Policies and procedures specific to the DSME program were developed, as well as mechanisms to more accurately measure attainment of patient-defined goals.

To strengthen team-building skills and interprofessional collaboration, the CUH staff participated in an interprofessional learning practicum offered through the Jefferson Center for Interprofessional Education (JCIFE). The practicum was designed to improve interprofessional care through implementing and evaluating patient-centered education. The staff worked together to revise the program structure and process for data collection and continuous quality improvement.

The administration and staff of CUH partnered with a local community center to conduct a pilot

of the revised DSME program. Each participant worked collaboratively with staff to create an individualized follow up and ongoing support plan. At least one self-care behavior goal was met by each participant one month post-class.

Based on the revisions to the DSME program and positive patient outcomes, an application was submitted to the AADE and approved. These outcomes include a structured individualized self-management and follow-up support plan for each participant that is reviewed with participants at regular intervals. In September 2011, the CUH received AADE accreditation for the DSME program.

Diabetes is a serious public health concern. Aligning with the goal of Healthy People 2020 to increase access to DSME, community-based programs offer an innovative and effective strategy for care delivery to at-risk communities.⁴ The CUH has established a community-based DSME program that is accredited and recognized by the AADE. This program remains a work in progress, as performance measures that reflect evidence-based outcomes are continuously reviewed. ■

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REFERENCES

1. Funnel M, Brown T, Childs B, et al. National standards for diabetes self-management education. *Diabetes Care*. 2011; 35 (suppl): S101-S108.
2. Mensing C. Comparing the processes: Accreditation and recognition. *Diabetes Educ*. 2010; 36: 219-243.
3. Mulcahy K, Maryniuk M, Peoples M, et al. Diabetes self-management education core outcomes measures *Diabetes Educ*. 2003; 20:768-803.
4. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Diabetes. <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8> Accessed June 19, 2012.

Tele-ophthalmology in the Community Pharmacy Setting: A Novel Model of Care

Diabetic retinopathy (DR) is a retinal vascular disorder characterized by changes in the blood vessels of the retina that begins without symptoms and can advance to blurry vision, dark or floating spots, difficulty differentiating colors, and/or problems focusing.^{1,2} Blindness and vision impairment in adults due to DR are highly prevalent and disabling conditions in the US, affecting at least 3.3 million people over age 65.²⁻⁶ The number of people with DR will increase more than three-fold by 2050, creating an immense and costly public health problem.⁷⁻⁹ In 2004, for example, blindness from DR accounted for approximately \$500 million in direct medical costs, and exponentially more in indirect costs to society.¹⁰ Clinical trials demonstrating the efficacy of these treatments led the American Academy of Ophthalmology and the American Diabetes Association to recommend that all patients with diabetes have annual **dilated fundus examinations (DFEs)** to reduce their risk of vision loss.^{11,12} In addition, *Healthy People 2010* goals encourage 75% of all persons with diabetes to have a DFE.¹³ New effective treatment can also slow the rate of progression of retinopathy¹. Despite this fact, only 50% to 60% of adults with diabetes follow this recommendation and an estimated 50% of patients are diagnosed too late for treatment to be effective.¹³⁻¹⁵

The Wills Eye Institute Department of Research is participating in a collaborative study with the Centers for Disease Control and Prevention along with other leading U.S. eye care institutions. One of the initiatives being tested is the use of a non-dilated eye screening program for people with diabetes, in a pharmacy-based setting. These screenings have the potential to improve health care outcomes and compliance by increasing access to eye care and earlier detection of diabetic retinopathy.

Eye screenings are taking place at the outpatient pharmacy operated by the Thomas Jefferson University Hospital in Philadelphia. Before patients are screened, they complete a brief questionnaire to capture the patient's past medical history, hemoglobin A1c levels, and current diabetes medications. The screening process takes less than ten minutes and consists of a visual acuity test, followed by a fundus photo (painless, non-dilated image of the retina taken with a Nidek camera). The images are sent electronically to the Wills Eye Department of Telemedicine and read by retina specialists. The final diagnosis and follow-up recommendations are mailed to the patient within two weeks. This technology has the potential to facilitate access to eye care for patients with diabetes, and to delay the progression to diabetic retinopathy. Furthermore, when located in a community pharmacy setting, this screening is very convenient for patients who are short on time or do not have the financial resources or health insurance to cover visits to a specialist. Since this eye screening does not require dilation of the pupils, minimal time is spent getting an eye exam.

While tele-ophthalmology screenings hold promise for improving patient care, the utility of this technology in community settings depends on the volume of patients screened. The current study is being conducted in a pharmacy with an average of 1700 prescriptions filled weekly. Long-term sustainability will depend on 1) whether or not insurance companies will add it to health care coverage, and 2) whether participating pharmacists are afforded the necessary time to contribute. To date, Wills Eye has screened a total of 143 patients; preliminary findings suggest that more than 10% of patients show signs of diabetic retinopathy (background diabetic retinopathy, proliferative diabetic retinopathy, pre-proliferative

diabetic retinopathy, maculopathy or previous laser treatment). Early data also suggest that the camera has the potential to detect other eye abnormalities such as cataracts and hypertensive changes. These results provide incentive and purpose for future utilization of tele-ophthalmology screenings.

The program represents a novel model for engaging community pharmacists in a team approach to managing diabetes. Pharmacists are considered to be trusted health professionals and are generally very accessible. Specific actions taken by pharmacists involved in the program include: counseling patients on the importance of eye screening when they pick up their diabetes medications and providing continued reminders to the patient about the importance of following up with their physician about diabetes eye care.

Data on the impact of the program, number of patients with DR, and outcomes are being collected. Primary measures include the impact of the screening in detecting DR and the rate of patient follow-up to an ophthalmologist for ocular pathology detection at the screening. If successful, the program has the potential to stimulate adoption of this emerging technology in other community pharmacy settings. ■

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REFERENCES

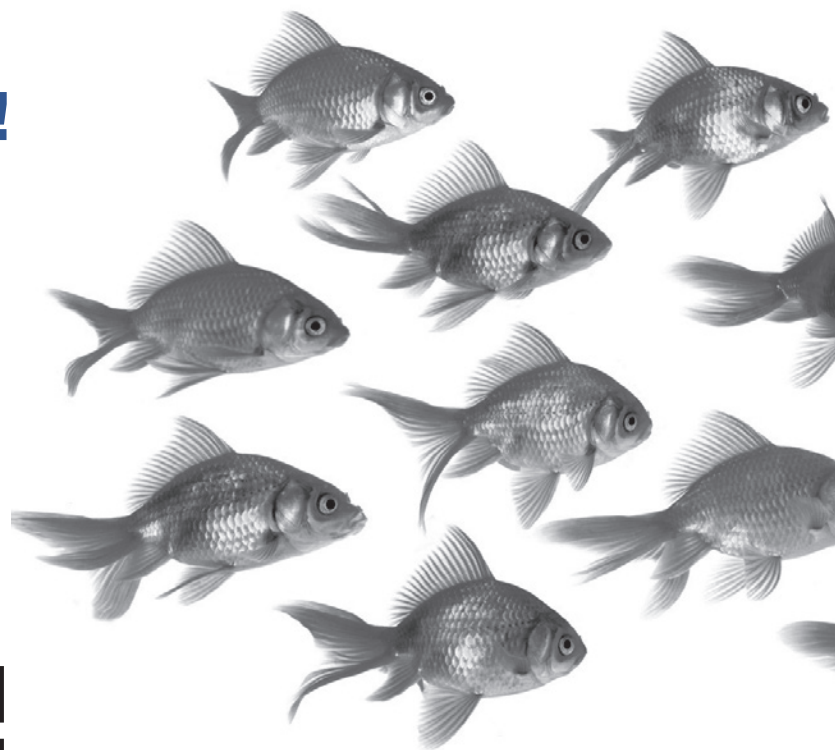
1. Fraser C, D'Amico D. Classification and clinical features of diabetic retinopathy. UpToDate. <http://www.uptodate.com/contents/classification-and-clinical-features-of-diabetic-retinopathy>. Accessed June 19, 2012.
2. The Eye Diseases Prevalence Research Group. Causes and prevalence of visual impairment among adults in the United States. *Arch Ophthalmol*. 2004; 122:477-485.
3. The Eye Diseases Prevalence Research Group. Prevalence of cataract and pseudophakia/aphakia among adults in the United States. *Arch Ophthalmol*. 2004; 122:487-494.
4. Lee PP, Feldman ZW, Ostermann J, et al. Longitudinal prevalence of major eye diseases. *Arch Ophthalmol*. 2003; 121:1303-1310.
5. Vitale S, Cotch MF, Sperduto RD. Prevalence of visual impairment in the United States. *JAMA*. 2006; 295:2158-2163.

6. Kempen JH, O'Colmain BJ, Leske MC, et al. The Eye Diseases Prevalence Research Group. The prevalence of diabetic retinopathy among adults in the United States. *Arch Ophthalmology*. 2004;122(4):552-563.
7. Saaddine JB, Honeycutt AA, Narayan KM, et al. Projection of diabetic retinopathy and other major eye diseases among people with diabetes mellitus. *Arch Ophthalmol*. 2008;126:1740-1747.
8. Fricke KD, Gower E, Kemben J, et al. Economic impact of visual impairment and blindness in the United States. *Arch Ophthalmol*. 2007; 125: 544-550.
9. Javitt JC, Zhou Z, Willke RJ. Association between vision loss and higher medical care costs in medicare beneficiaries. *American Academy of Ophthalmology* 2007; 114: 238-245.
10. Rein T, Zhang B, Wirth K, et al. The economic burden of major adult visual disorders in the United States. *Arch Ophthalmol* 2006; 124: 1754-1760.
11. Diabetic Retinopathy Summary Benchmark - November 2008: *O.N.E. Network*: American Academy of Ophthalmology. <http://one.aao.org/CE/PracticeGuidelines/SummaryBenchmark.aspx?cid=ea5c6d25-2ab9-4398-b00b-8efcb8cc5bc7>. Accessed June 19, 2012.
12. Diabetic Retinopathy. American Diabetes Association. *Diabetes Care* 2000;23 (Suppl 1): S73-76.
13. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: Department of Health and Human Services; 2000.
14. Zhang X, Saaddine, JB, Lee PP, et al. Eye care in the United States. Do we deliver to high-risk people who can benefit most from it? *Arch Ophthalmol* 2007;125: 411-418.
15. Schoenfeld E, Greene J, Wu S, et al. Patterns of adherence to diabetes vision care guidelines, *Ophthalmology* 2001; 108: 563-571.

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Improving Health and Creating Change: 2012 Schweitzer Celebration of Service Honors Emerging and Established Community Health Leaders

Jefferson School of Population Health

May 16, 2012

From bringing blood pressure screenings to barbershops in West Philadelphia, to implementing a diabetes management program among Northern Philadelphia's Hispanic population, fifteen graduate student Schweitzer Fellows spent the past year working to improve the health of vulnerable communities in the Greater Philadelphia area.

At the sixth annual Greater Philadelphia Schweitzer Celebration of Service ceremony those Schweitzer Fellows were honored—as was Dr. George L. Spaeth of Wills Eye Institute, who was presented with the 2012 Schweitzer Leadership Award by Dr. David B. Nash, Greater Philadelphia Schweitzer Program Chair and Dean of the Jefferson School of Population Health.

The cocktail reception that launched the event was warm and buzzing as newly selected Schweitzer Fellows mingled with graduating Fellows, Schweitzer Fellows for Life (program alumni) and a host of academic and community site mentors, local advisory board members, family, friends, and funders. In addition to Drs. Spaeth and Nash, the ceremony was attended by distinguished guests including Sally Harris, Vice Chair of The Albert Schweitzer Fellowship (ASF)'s National Board of Directors, and Dr. Cornelius Pitts of Zion Baptist Church, who served as community site mentor for 2011-12 Schweitzer Fellow Lawrence Onishi, a

Temple University medical student. A new ASF video “*Creating Change, Improving Health*” described the Schweitzer Fellowship story and set the stage for the event. Dr. Nash then shared a behind-the-scenes look at the genesis of the Greater Philadelphia Schweitzer Fellows Program, and Harris shared a personal perspective on Albert Schweitzer and the Fellowship's work to develop a corps of Leaders in Service across the U.S. Dr. Nash also had the pleasure of presenting Dr. Spaeth with the Schweitzer Leadership Award. Dr. Spaeth's ensuing keynote speech charged the Fellows to continue leading lives of service.

Against the backdrop of posters that illustrated their year-long service projects, the Fellows spoke about their Fellowship experience, including the ways in which the Fellowship's structure and guidance helped them to overcome the metaphorical “boulders” they faced. In the words of the Fellowship's namesake, Dr. Albert Schweitzer, “*Anyone who proposes to do good must not expect people to roll stones out of his way, but must accept his lot calmly if they even roll a few more upon it. A strength which becomes clearer and stronger through its experience of such obstacles is the only strength that can conquer them.*”

In sharing their remarks, all Fellows noted that their year-long, mentored community service

and leadership development experience with the Fellowship has helped to shape their personal and professional lives as future health care leaders. The celebration culminated in the outgoing Fellows receiving their official ASF pins and being inducted into the Schweitzer Fellows for Life alumni network—and the new 2012-13 Fellows being introduced as they embark on a year of personal and professional growth and skilled service to vulnerable communities. ■

The Albert Schweitzer Fellowship (ASF) is improving the health of vulnerable people now and for the future by developing a corps of *Leaders in Service*—professionals skilled in creating positive change *with* and *in* our communities, our health and human service systems, and our world. To learn more about ASF's Greater Philadelphia Schweitzer Fellows Program, which is funded entirely through charitable donations and grants, visit: www.schweitzerfellowship.org/philadelphia.

Nicole Cobb Moore, MA
Greater Philadelphia Program Director
Albert Schweitzer Fellowship

The most important thing in education is to make young people think for themselves.
~ Albert Schweitzer



From left to right, newly pinned Schweitzer Fellows for Life: Emily Day, Nicholas Kenji Taylor, Sarah Nguyen, Quidest Kiki Sheriff, Isata Sesay, Jules Chyten-Brennan, Maria Geyman, Charles G. Taylor, Sara Shuman, Gordon Crabtree, and Akhila Vasthare. (Not pictured, Victor Cueto, Franklin Jeng, Tiffany “TK” Rodgers and Lawrence Onishi)



Dr. George L. Spaeth, Schweitzer Leadership Awardee, Nicole Cobb Moore, MA, Greater Philadelphia Program Director, and Dr. David B. Nash, Dean, Jefferson School of Population Health

Getting to Know Tiffany “Tk” Rodgers, Recipient of Outstanding Student Award

Tiffany Rodgers, known as “Tk,” is a student in the MPH program at JSPH and recently received the 2012 Outstanding Student Award. This is an award given by the College of Physicians, recognizing the contributions of Philadelphia area students, leaders, colleges, and institutions in public health. Tk was honored and thrilled to receive the award.

It is not easy to keep up with Tk. Her repertoire of community service activities keeps her going at an invigorating pace. From the moment you meet Tk, you feel her enthusiasm, passion, and dedication to the many health care issues that she has immersed herself in. Tiffany is currently a community organizer for Camden Churches Organized for People (CCOP), a coalition of congregations whose goal is to work together to address issues such as unemployment, crime, housing, and healthcare in Camden. Between her past experience as a community organizer, her ability to speak Spanish, and her expertise in graphic design, she is able to offer a complete skill set to the coalition. . . and she truly *loves* the work.

Tk recently completed the Albert Schweitzer Fellowship (ASF) Program, a service and leadership program dedicated to addressing health care needs of underserved populations. Her desire to become a Schweitzer Fellow began with her experience

volunteering as a Spanish translator at Esperanza Health Center, a community-based health center in North Philadelphia. She became very concerned about the number of Hispanics who were suffering from type 2 diabetes. Through the ASF program she set out to develop the Community Health Promoter program. This program helps to identify and train peers/mentors in understanding and managing diabetes so they can disseminate information within their communities. Tk developed the *Diabetes Manual* in English and Spanish as a tool to train Health Promoters to teach others about diabetes. The Community Health Promoter Program has also been expanded to Abigail House, a skilled nursing and rehabilitation facility in Camden. When asked what the ASF program meant to her, Tk explained, “It’s about the people I come across, the staff and clients, and the other fellows in my cohort.”

Tk’s diverse service background also includes her clerkship with the Kimmel Cancer Center in collaboration with MEE Productions Inc. MEE (Motivational Educational Entertainment) is a nationally recognized communications and research company that specializes in developing effective and culturally relevant messages for hard to reach populations. Tk examined culturally appropriate materials regarding the risk of cervical



Tk Rodgers, MPH Student, JSPH

cancer among African-American women. Along with Dr. Amy Leader, Assistant Professor of Medical Oncology, Tk helped to develop, “Your Role, Your Part” Stylist Training Program, which utilizes stylists in hair salons to educate African-American female guardians about the HPV vaccine.

Tk is from California and attended William Jewell College in Missouri. She came to the East coast specifically for the Public Health program at Jefferson. She believes the Philadelphia area is a great place to gain experience in the field of public health. Tk wants to be able to “help in a balanced way” and enjoys matching services to needs. In public health, Tk explains, “you have the opportunity to a safe life and save many lives; it’s the sum of all efforts.” Tk’s orientation towards serving others continues to blossom as she shares this final thought, “Know what your gifts and talents are and share it with the world.” ■

Health Care Quality Data: A Summer Intern Gains Project Experience

In May 2012 I started my internship under the guidance of Dr. David Nash at the Jefferson School of Population Health (JSPH). I knew that this would be a great experience but I had no idea how much I would learn so quickly. I have assisted on many research projects but there is one in particular that has been influential on my time here. This article focuses on the project and the benefits that I have reaped from participating in it.

Faculty and staff at the School of Population Health have partnered with the California HealthCare Foundation on a research project focused on the use of clinical registries for public reporting of health care quality data. The project has two objectives: 1) conduct an environmental scan across the US

and several foreign countries to identify innovative registries; 2) narrow the research to include four main areas of registries, including cardiology, cancer, maternity, and hip/knee replacement. We are using a “positive deviance” approach in which we are defining and learning from high performing registries.

Clinical registries have traditionally been used to conduct surveillance, but more recently have also been used for quality improvement purposes. This project focuses on expanding the use of existing registries in order to assist patients in decision-making regarding providers and treatment options based on performance data. Initially, we conducted an environmental scan of existing registries in order to identify high performing registries for the purposes

of public reporting. We engaged a consulting panel of experts in registry design to help guide our search and confirm our findings. Currently, we are interviewing key informants from each of the “positive deviant” registries in order to learn from their experience developing and maintaining registries.

At the end of the project there will be three deliverables. The first will be a Final Report to the California HealthCare Foundation. The second will be an Issue Brief that will be useful to policy makers and consumer advocacy organizations. The final deliverable will be a manuscript for publication that focuses on a particular clinical area; the audience for which will include healthcare providers and health policy researchers.

Continued on page 12

I have been working with very talented people on this project including Tamar Klaiman, PhD, MPH, Assistant Professor. When I asked her about the potential impact of the project she noted that, “This project will help to inform the California HealthCare Foundation’s future work in this area. Utilizing existing data to help inform patient choice is a promising area and can help improve quality of care

in key clinical areas.” As an intern I have learned a great deal from every person on this project. In my undergraduate career I have had to write a number of research papers but until now I never understood how to differentiate which sources were important and which ones could be left behind. I also am learning to work in a group setting. Each member on this team has a specific role that complements

the others. Working with such accomplished people has made me decide to further my education in public health once I complete my bachelor’s degree in Health Policy Administration from Penn State University in the fall. ■

Brittany Christaldi
Jefferson School of Population Health Intern

JSPH Fellows Reflect

As the first year of our health economics and outcomes research fellowship draws to a close, we reflect upon our collective experiences and realize how far we have come in just one short year. The Health Economics and Outcomes Research fellowship at the Jefferson School of Population Health (JSPH) has not only developed us into budding health services researchers, but also leaders in our profession. One of the positives was working closely with so many passionate health policy professionals at JSPH. The talented minds who work at JSPH are always enthusiastic and willing to offer any assistance, whether we needed career advice or an excuse to grab a cup of coffee. Even though we were each assigned one formal mentor to oversee our professional development, we have been greatly influenced and shaped by the faculty. From our interactions with JSPH, affiliated partnerships and sponsors, we have come away from the first year of the fellowship with not just one mentor, but a deep and diverse network of mentorship and support.

Working in an integrated system such as Jefferson provided us with many opportunities to gain

experience in health services research and to see firsthand how that research affects policy at Thomas Jefferson University Hospital and their physician practice group. We both enrolled in Masters programs at JSPH and the online coursework has broadened and deepened our knowledge of health policy, the US healthcare delivery system, and research methods.

We have taken advantage of professional development opportunities such as national conferences for Population Health, Quality, Healthcare Improvement, and Outcomes Research. We have presented posters and podium presentations of our research at the Institute for Healthcare Improvement (IHI) and International Society of Pharmacoeconomics and Outcomes Research (ISPOR) national meetings. We ended our first year with a bang, as both of us received prestigious awards at this past ISPOR meeting!

The first year at our JSPH fellowship has proved to be an amazing experience and we feel well-prepared to face new challenges in our second year. We look forward to continued growth and success next year! ■

Dominique Comer, PharmD
Zoe Clancy, PharmD
*Health Economics and Outcomes Research Fellows
Jefferson School of Population Health*

Dominique Comer will continue her second year at JSPH, and will be supported by Post Doctoral Fellowship award on Health Outcomes from the PhRMA Foundation. She anticipates taking on greater responsibility and autonomy with her various projects, focusing on health disparities and health policy. Zoe Clancy received the award for Best Student Podium Presentation at ISPOR. She will continue her fellowship by transitioning to Janssen Scientific Affairs, LLC in Titusville, NJ. She will be working on projects with Health Economics and Outcomes Research team members across many therapeutic areas. She is looking forward to learning about HEOR in a new setting and expanding her HEOR “toolkit.”

For more information on the HEOR Fellowship Program at JSPH visit: <http://tinyurl.com/8898ktf> or contact Joseph.Jackson@jefferson.edu.

Health Policy Forums

The Challenges of Health Reporting

Taunya English
Maiken Scott
WHYY

April 11, 2012

One of the most important aspects of understanding current health and related policy issues is having a mechanism of communication and a public exchange of news and ideas. The media plays a critical role in elevating complex health care issues in a way that is tangible to listeners and viewers. At a recent Forum,

WHYY health reporters Taunya English and Maiken Scott treated us to a unique behind the scenes look at their work and experiences.

“When I look out into the audience, every single one of your faces is a news story.” That is how

Taunya English kicked off the morning with her engaging manner. English is a health reporter with a special interest in population and community health. She covers stories across the region as well policy issues at the state and federal level.

English provided an overview of radio, TV, and web programs of WHYY including: *Morning Edition, All Things Considered, NewsWorks Tonight, First, and newsworks*. WHYY has a team of four working on health care stories, which English describes as “unheard of” in the field. Having a dedicated team covering health care stories sets WHYY apart from other media and enables the team to cover a diverse range of topics.

A typical week at WHYY may include stories such as: lead-absorbing grass; meditation for teachers; care transitions; vaccinations; walkable neighborhoods; medical marijuana; raw milk controversy; and autism prevalence in New Jersey. English shared an example of a story she worked on about an urban farmer who is working creatively to impact the health and lives of the community through the production of and access to healthier produce. English loves stories about innovators and renegades.

Maiken Scott followed with a very forthcoming presentation about her experiences. Scott is a behavioral health reporter who has covered a range of topics such as new treatments for depression, the impact of foster care, and the portrayal of mental illness in pop culture. She is also the executive producer of the highly acclaimed weekly mental health program, *Voices in the Family with Dan Gottlieb*.

Staying current and communicating effectively is one of the primary challenges faced by health reporters. Scott described the challenge of striking a balance between the scientific information and the information that is deconstructed for the general public.

Because her work primarily focuses on mental and behavioral health, Scott strives to bring these often serious and sad stories to life. It is extremely important to her to get these patient/client stories

“right.” When preparing for an interview, she feels it is her job to create a comfortable yet intimate platform with a complete stranger. She tries to factor in time, reassure, comfort, and *listen*. “I try to focus on the love and compassion I have for that person,” Scott explains.

Scott also discussed the stress of this type of reporting and her personal emotions around it. She openly described her own transformations and responses to different experiences. Scott poignantly states, “the story the person has given to me is a treasure...I carry it.”

For more information on WHYY programming visit: <http://www.whyy.org/>

Pennsylvania’s Aging Initiatives: Planning for the Future

Brian Duke, MBE

Secretary of Aging

Pennsylvania Department of Aging

May 9, 2012

The May Health Policy Forum featured Brian Duke, Secretary of Aging for the Pennsylvania Department of Aging (PDA). Secretary Duke was nominated for this position by Governor Tom Corbett in February 2011. Duke has an extensive history working within the aging field and has previously held positions such as Director of the Bucks County Area Agency on Aging; Executive Director of the New Jersey Foundation for Aging; Consultant, US Administration on Aging and the AARP; and Director of Geriatric Program Initiatives with the Institute of Aging of the University of Pennsylvania Health System. He began his career as a hospital administrator for Thomas Jefferson University.

Secretary Duke first shared the mission of the Department of Aging: *Enhancing the quality of life of all older Pennsylvanians by empowering diverse communities, the family and the individual*. He identified two main goals: prevention and protection.

Prevention focuses on instability in health and well-being through assessment, service care coordination, nutrition programs, transportation,

and Program of All-Inclusive Care for the Elderly (PACE and PACENet). Health and wellness programs such as Primetime Health, Healthy Steps, and Chronic Disease Self-Management are also included. Advocacy for consumers of long-term care and community partnerships are key components of prevention. The goal of protection also covers protection from abuse, which includes safeguarding the rights of residents in facilities.

Secretary Duke explained some important demographics in Pennsylvania. He characterized the state as the 4th grayest state in the nation, with more than 300,000 residents over the age of 85 and 22% of the population age 60 and over. Based on census data, it is projected that Pennsylvania’s age 60+ population will increase by 1.04 million from 2010 to 2030. With the older population growing rapidly (including aging baby boomers), this larger population of older Americans will be more racially diverse and better educated compared to previous generations.

What are the implications of the increase in the aging population? Duke explained how Americans are living longer with more complex conditions

and disabilities. This means that more Americans will be eligible for Medicare which, in turn, affects Medicare spending costs. Older adults tend to have chronic conditions (i.e. heart disease, diabetes, arthritis), and access healthcare more than younger adults.

Secretary Duke went on to discuss some of the department’s programs and services. In Pennsylvania, there are 52 area agencies on aging. Pharmaceutical assistance (through PACE) provides prescriptions for over 520,000 older adults. The average person served by the PDA is a woman over the age of 80 who is widowed.

In the future Secretary Duke envisions more collaborations and, in particular, partnerships with academic centers. He wants to make sure that research is translated to practice and that best practices are identified and understood. Duke is committed to ensuring that Pennsylvanians will age and live well *and* communities are places to age and live well.

For more information on the Pennsylvania Department of Aging visit: <http://www.aging.state.pa.us>

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

Raymond L. Singer, MD, MMM, CPE, FACS

Vice Chair, Quality, Patient Safety, and Outreach
Chief, Division of Cardiothoracic Surgery

Lehigh Valley Health Network

June 13, 2012

In a touching tribute, Dr. Singer opened his talk by acknowledging and honoring his mentor, Herbert E. Cohn, MD, Professor and Vice Chair of Surgery, Thomas Jefferson University, who was in the Forum audience. Many years ago Dr. Singer completed his general surgery and cardiothoracic surgery fellowship at Jefferson; it was Dr. Cohn who inspired Singer and he attributes much of his success to his time with Dr. Cohn at Jefferson.

Dr. Singer is currently the Chief of Cardiothoracic Surgery and Vice Chair of Quality, Patient Safety, and Outreach for the Department of Surgery at Lehigh Valley Health Network (LVHN). He is the Associate Medical Director of the Regional Heart and Vascular Center and the Chair of the Technology Assessment Committee at LVHN.

The main focus of Dr. Singer's presentation was a personal perspective on the examination of the history of cardiac surgery outcomes reporting and its implications. He provided an overview of the Pennsylvania Healthcare Cost Containment Council

(PHC4), an independent state agency established in 1986. PHC4 is charged with addressing health costs, ensuring the quality of health care, and increasing access to care. Its strategy is to provide competition in the healthcare market place by sharing comparative information about the most efficient and effective health care providers to consumers and purchasers. Pennsylvania is widely considered a leader in the realm of public "report cards."

The first cardiac surgery report was published by PHC4 in 1992. The most recent report was published in 2009 and it examined the results of 31,000 coronary artery bypass graft surgeries (CABG) and/or valve surgeries.¹ Some of the key findings of this report focused on decreasing mortality rates, and readmission rates for both CABG and valve surgery. The report also captured health care associated infection (HAI) rates and increasing costs associated with HAIs.

Dr. Singer pointed out the pros and cons of the report. He stated that the report has very grounded

intentions around measuring quality and ensuring accountability and it creates transparency. It is a tool to educate the public and encourage consumers to access high quality providers. Dr. Singer did express his concerns that the information is somewhat obsolete by the time it is actually published. He also feels that the data does not include complex cases, nor does it distinguish between conventional and less invasive techniques, or other new technologies. He fears unintended negative consequences, such as the denial of surgical treatment to high-risk patients.

Dr. Singer summarized his presentation by reiterating the fact that the heart surgeons in Pennsylvania have 20 years of experience measuring and reporting outcomes. Public reporting is now a fixture in health care and patients are slowly becoming more aware of performance reports.

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

REFERENCES

1. Pennsylvania Health Care Cost Containment Council. Cardiac Surgery in Pennsylvania 2008-2009. <http://www.phc4.org/reports/cabg/09/>. Accessed June 22, 2012.

JSPH Publications

Berman B, Pracilio VP. Measuring quality in ambulatory care. In: **Nash D, Clarke J, Skoufalos A, Horowitz M,** editors. *Health care quality: the clinician's primer*. American College of Physician Executives; 2012:177-190.

Couto JE, Comer DM. Patient engagement: the critical catalyst to health reform in the USA. *J Compar Effect Res.* 2012;1(3):209-211.

Gitlin LN, Chernett NL, Dennis MP, Hauck WW. Identification of and beliefs about depressive symptoms and preferred treatment approaches among community-living older African Americans. *Am J Geriatr Psychiatry.* 2012 May 25.

Khubchandani J, Simmons R. Going global: building a foundation for global health promotion research to practice. *Health Promotion Practice.* 2012;13(3):293-297.

Nash DB. "SCOTUS": Will they or won't they? *Am Health & Drug Benefits.* 2012;5(3):141-142.

Nash DB. Summary of proceedings from the Association of American Medical Colleges. *AJMQ.* 2012;27(3S)3S-4S.

Nash DB. Pop Health 101. *Medpage Today.* April 17, 2012.

Nash DB. Emmanuel's Perspective. *Medpage Today.* May 24, 2012.

Nash DB. VALUE in Caps! *Medpage Today.* June 28, 2012.

Simmons R. Interview with Dr. Omar Khan, noted global health specialist. *Health Promotion Practice.* 2012;13(4):444-446.

JSPH Presentations

Berman B. Practical experiences with the Physician Quality Reporting System (PQRS). Presented at: The Business of Medicine 2012 San Diego Summit; June 12, 2012, San Diego, CA.

Berman B. Are you ready for meaningful use? How to make the most out of Medicare and Medicaid incentives. Presented at: The Business of Medicine 2012 San Diego Summit; June 11, San Diego, CA.

Brennan N, Cohen S, Lieberthal RD. It's public: government (and non-government) health resources available data. Presented at: Society of Actuaries Spring Health Meeting; June 14, 2012, New Orleans, LA.

Claud D, Lieberthal RD, Sawney TG. Population health and public health: why should we care? Presented at: Society of Actuaries Spring Health Meeting; June 13, 2012, New Orleans, LA.

Heck J, Warriner M, Loveless T, Moore NC. Interprofessional collaboration for community outreach project to educate Philadelphia youth regarding HIV/AIDS prevention, myths, and truths through sport. Poster presented at: Interprofessional Care for the 21st Century: Redefining Education for the future; May 19, 2012, Philadelphia, PA.

Klaiman T. Reducing pertussis among infants through parental vaccination. Presented at: The 2012 AcademyHealth Public Health Law Research Reception; June 24-June 26, 2012, Orlando, FL.

Klaiman T, O'Connell K, Stoto M. Mechanisms for mass vaccination clinic success during pH1N1. Poster presented at: AcademyHealth Annual Research Meeting; June 24-June 26, 2012, Orlando, FL.

Klaiman T, O'Connell K, Stoto, M. Successful school-based vaccination clinics during pH1N1." Poster presented at: AcademyHealth Annual Research Meeting; June 24-June 26, 2012, Orlando, FL.

Klaiman T, Higdon M, Galarce E. Creating and evaluating messages to increase medical reserve corps participation in local health department activities. Presented at: 2012 Keeneland Conference for Public Health Systems and Services Research; April 18, 2012, Lexington, KY.

Klaiman T, O'Connell K, Stoto, M. Mechanisms for school-based vaccination clinic success during pH1N1." Poster Presented at: 2012 Keeneland Conference for Public Health Systems and Services Research; April 18, 2012, Lexington, KY.

Nash DB, Pracilio VP. Paving the path toward quality. Presented at: AAMC 2012 Integrating Quality Meeting: Collaborating for Care; June 7-8, 2012, Rosemont, IL.

Upcoming Jefferson School of Population Health Forums – Fall 2012

Implementing Decision Support Tools to Enhance Care for Older Adults

Sept 12, 2012

Kathryn H. Bowles, PhD, RN, FAAN

*Professor and Ralston House Endowed Term Chair in Gerontological Nursing
Associate Director NewCourtland Center for Transitions and Health
University of Pennsylvania School of Nursing
Beatrice Renfield Visiting Scholar Visiting Nurse Service of New York*

Population Health: Integrating Medicine and Public Health

Nov 14, 2012

Marc N. Gourevitch, MD, MPH

*Professor and Chair, Department of Population Health
NYU School of Medicine*

Empathy in Patient Care - Myth or Reality?

Oct 10, 2012

Mohammadreza Hojat, PhD

Vittorio Maio, PharmD, MS, MSPH

Daniel Louis, MS

Thomas Jefferson University

**Special Grandon Society Member-Only Workshop
9:45 am – 10:45 am**

Location:

**Bluemle Life Sciences Building
233 South 10th Street, Room 101
Philadelphia, PA 19107**

Time: 8:30 am – 9:30 am

For more information call: (215) 955-6969

Health Policy NEWSLETTER

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