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EDITORIAL

Innovation and Collaboration in the New Health Care Ecosystem

Since the passing of the Affordable Care Act, many who have heard me [DBN] speak are familiar with my four-word summary of 955 pages of legislation: "No outcome, no income." At its core, health reform legislation is an attempt to build transparency and accountability into the system. This will require a completely different mindset on everyone's part. In order to get the optimal value from our considerable investment in health care, we must work to create a new health care ecosystem – one marked by innovation and collaboration among all of its component parts.

When you boil it down to its essence, reform is an attempt to operationalize the "triple aim," a key component of the legislation and a concept articulated years ago by former CMS Administrator Dr. Don Berwick. The first part of the triple aim is *better care for individuals*; the second part is *better health for populations*; and the third part is *slower growth in the cost of healthcare* through improvements in care delivery. Below we deconstruct each of the three components.

Better care for individuals is really all about promoting use of the evidence (where it exists) to deliver better care – for example, don't do unscientific things like prescribing antibiotics for every child with an earache or ordering an x-ray on every patient with back pain on their very first visit to the doctor. These two pretty basic things are unfortunately quite common practice, and add hundreds of millions of dollars a year in cost with little or no return on the investment.

Better health for populations. Population health is a critical aspect of health reform, as it requires looking at all of the elements that have an impact on the overall health and quality of life. Prevention, health promotion and wellness, and care coordination are the key points in this arena. You probably appreciate that the care of patients with chronic illnesses like diabetes and heart disease is about 80% of the problem in our country. If we could just properly coordinate the care of patients with chronic illnesses – or better yet, encourage the healthy behaviors that would prevent people from developing these conditions – we could go a long way toward addressing the healthcare cost crisis. It's not rocket science; it's all about blocking and tackling. Did you see the doctor? Did you take your medicine? Are you exercising regularly? Are you following up as instructed?

Slower growth in costs through improvements in the system of care is a little bit more complicated. That involves taking the

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science that you may know as process improvement, total quality management, lean, re-engineering, and applying it to the healthcare system. A system, by the way, that's not accustomed to using any of these tools and barely understands that language.

The idea of the triple aim is powerful and it is being operationalized by health reform in two major ways. One is by changing the economic incentives, for example, bundling the payment for services. These bundled payments are designed to cover the appropriate services for a given condition, and steers the system away from a fee-for-service model that pays based on the number of procedures. This will be an interesting endeavor moving forward, since when the size of the pie shrinks, table manners tend to deteriorate. The other way to operationalize the triple aim is to change the model of service delivery through Patient-Centered Medical Homes and Accountable Care Organizations, and a special board that's being charged with making some final decisions on payments for doctor services. We must find an effective way to bend this cost curve, since the one thing that we know for sure is that there is no new money at the end of this rainbow.

There's so much waste, and so much at stake. There's a gigantic "upside opportunity" for innovators and collaborators willing to take on the challenge of reworking the system to make it function more effectively. As industry works to develop new technologies and bring new drugs to market, and we create new processes in healthcare, we'll need to pay close attention to whether those new systems, drugs or technologies bring value to the system and help to bend the cost curve. In the new health ecosystem, yesterday's competitor is today's collaborator. We are all in this together, and will sink or swim collectively.

In order to function in an outcomes-based environment from a population health perspective, we must harness the power of collaboration, especially as it pertains to the exchange of crucial information that allows us to make improvements and evaluate the success of our efforts. PricewaterhouseCoopers (PwC) Health recently issued a report[1] underscoring the importance of collaborative partnerships among payers, providers and pharmaceutical companies in terms of sharing healthcare data. Each segment captures data differently, but when information that isolates procedure codes, prescriptions, and patient demographics is combined and observed longitudinally, it becomes easier to isolate important trends and commonalities that can improve clinical practice.

A new, richer dialogue among those who organize, deliver and pay for health care can help us to identify important gaps and understand where we need to structure supports to help patients improve their health behaviors and to manage any existing conditions to prevent them from getting worse. Leading integrated providers and payers, like Kaiser Permanente and Pennsylvania's own Geisinger, are working to improve communications between physicians and patients as a way to reduce readmission rates and improve medication compliance. Other, more unusual, collaborations occur among non-affiliated entities. The PwC report cites a pilot collaboration between the Indianapolis-based payer Wellpoint, IBM, and California's Cedars-Sinai Samuel Oschin Comprehensive Cancer Institute to guide clinical practices as a model program to improve outcomes and meet the unique health needs of different populations.

As we strive to create a more effective, transparent and accountable system, we must focus on encouraging radical collaboration and innovation. It is the only way to reduce waste and to create value in our industry. This blurring of the lines provides us with a huge opportunity to create a robust health care ecosystem that delivers on the promise of reform. ■

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Jefferson School of Population Health Invites you to join the Grandon Society!

This new membership organization, named for our longtime benefactor and champion, **Raymond C. Grandon, MD,** and his wife, **Doris,** is designed for leaders throughout the healthcare sector who are dedicated to transforming the US health care system through collaboration, education and innovation.

Benefits of membership include exclusive member-only programs and events, a member e-newsletter, and early notice and special registration rates for JSPH conferences and events.

Memberships are available for individuals and for organizations, with special rates for academic, non-profit and government institutions.

For more information visit: http://www.jefferson.edu/population_health/GrandonSociety.html.

Impact of Culture and a Performance Improvement Framework on the "Superior Care Experience" at Main Line Health System

It is widely acknowledged that hospitals across the United States have a significant opportunity to improve their performance in safety and quality.[1] This article describes Main Line Health System's (MLHS) efforts to address two strategic aims: building a reliable culture of safety and establishing a process improvement infrastructure. We committed to applying the principles and tools related to our strategic aims to areas where performance was suboptimal, including the reduction of Central Line-Associated Blood Stream Infections (CLABSI) and patient falls with harm, as well as to increasing compliance with influenza vaccination.

Main Line Health System's vision to provide a "Superior Care Experience" for patients, staff and the community translates into consistent delivery of safe, high-quality care in the absence of preventable harm. The work and data presented in this paper supports the first superior patient experience goal in the strategic plan: eliminating preventable harm and death. We address the two objectives driving this goal which include: 1) embedding a reliable culture of safety and 2) eliminating device-related infections. We also strongly believe that all MLHS physicians and staff must be immunized against vaccine-preventable diseases that could harm our patients.

In US healthcare facilities, over 80,000 patients develop healthcare-associated CLABSIs in ICUs annually; almost 28,000 die as a result.[2] Similarly, from 2007-2008, over 50,000 patients reported falls, in which 50 patients died and over 200 were severely harmed.[3] It is additionally known that the influenza vaccine effectively reduces infection in healthcare workers, yet only 53% of all health care professionals receive the vaccine for a virus that has killed 59,000 Americans in the last 30 years.[4] Given that the metrics illustrate a substantial need for quality and patient safety improvement efforts, this concerning background information underscores why these initiatives have been among our top strategic priorities at MLHS over the last few years.

Data on over 40 indicators published on the Quality and Patient Safety Dashboard compelled us to focus on three indicators where we demonstrated performance well below nationally published averages. For example, in 2009, the MLHS CLABSI rate for 5 hospitals was 1.62 per 1,000 line days, with 29 persons harmed. The MLHS "Fall with Harm" rate in 2009 was 0.10 per 98,000 patient days, with 10 people harmed and the system flu vaccination compliance for 2009-2010 was only 55%. Thus, our priority goals for 2010-11 included: 1) achievement of CDC's reported top decile performance for CLABSI in Intensive Care Units (ICU) with prevention measures used *for all patients with central lines*; 2) reduction of falls among all inpatients, but a decrease in "Falls with Harm" for Medical/Surgical patients by at least 50%; and 3) 100% influenza vaccination compliance among individuals employed by or in a contractual agreement with MLHS.

To address these patient safety issues effectively, we needed to create a reliable culture of safety, in which the organization rigorously reinforces safe behavior expectations as work habit, by everyone in all situations, while leaders find and fix system problems that influence behavior. Furthermore, safety exists as an explicit core value, not an implicit assumption within the organization. Another priority included the establishment of a system-wide framework and infrastructure to increase organizational competency in performance improvement. Over 100 managers, directors and VPs were trained on basic Lean and Six Sigma[5,6] tools and methods (a disciplined, data-driven approach for improving productivity and eliminating defects) to better focus on decreasing non-value-added work (waste) and reduction of variation. Specific performance improvement concepts used by the CLABSI and Patient Falls teams included creation of standard work, visual cues, identification and elimination of waste, improved flow, inventory control and voice of the customer.

To reduce CLABSI, the Hospital Epidemiologist, Infection Prevention Director and clinical leaders led efforts to decrease blood draws through central lines. "Batching" of lab orders for routine testing was organized to a once/day schedule to protect sterile central line integrity. Leaders successfully launched the *scrub the hub* campaign[7] in addition to audits providing feedback on bundle/checklist compliance. Reminders to remove lines ASAP were hardwired into daily rounds with medical staff and new workflow screens were designed by Information Systems partners to support these changes.

To support reduction of device-related infections *and* patient falls, the Nursing Department at MLHS developed a new bedside handoff process, designed to ensure that shift changes were safer and more efficient with accurate information transferred and acted upon. Incorporating the review of the falls bundle, along with reassessment of need for continued vascular access, provided another opportunity to ensure safe practice.

A new mandatory vaccination program warranted early planning, constant communication about rationale, rigorous project management and visible leadership commitment. The CEO and Chief Medical Officer decided that universal compliance was the only fair and safe strategy; therefore, vaccination was a condition of employment and requirement for medical staff privileges. Exceptions were, however, made on a case-by-case basis for employees with medical and religious stipulations. Action steps included a concise communication plan with timelines and responsible parties, town hall gatherings, a new website for staff education and automated reminders when physicians accessed the electronic medical record.

Upon implementation of these strategies, our CLABSI rate in 2010 fell to 0.78 per 1,000 line days, demonstrating a 52% reduction from the previous year. "Falls with Harm" were reduced by 80% to 0.02 per 100,000 patient days, and the flu

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vaccination compliance was 99.9% for 10,170 employees and 100% compliance for 2,750 physicians/advanced healthcare practitioners.

The key to success for the discussed initiatives involved taking the time to learn what other organizations in our state and across the country were doing to improve outcomes. Benchmarking with pioneers of the Comprehensive Unit-based Safety Project (CUSP)[8] and adoption of Lean Six Sigma methods to expedite change further enabled us to create a System Performance Improvement curriculum that could be applied at any organization. Embracing rules for culture change, including setting clear expectations, providing training, education and tools required to do the job well, then building and sustaining accountability allowed for system-wide success. Ultimately, our executives took the lead by setting fair expectations, with specific details for behavior and consequences of non compliance in order to *reliably* deliver safe, high-quality care. ■

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AMSA Patient Safety and Quality Symposium

On September 7-8, 2012, the American Medical Student Association (AMSA) hosted a Patient Safety and Quality Symposium (PSQS) at the Jefferson School of Population Health (JSPH). Organized in partnership with the National Patient Safety Foundation (NPSF) and JSPH, and funded through a grant from the Agency for Healthcare Research and Quality (AHRQ), the nearly two-day event brought together students, residents, and some of the most prominent leaders in patient safety and health quality.

In 1999, the Institute of Medicine report *To Err is Human* estimated that there were between 44,000 and 98,000 preventable deaths in the U.S. each year.[1] The World Health Organization has also estimated that in developed countries, serious preventable adverse events occur in one out of every ten patient hospitalizations.[2] These alarming statistics have spurred efforts over the past several years to improve patient safety. In 2010, the Lucian Leape Institute at the National Patient Safety Foundation published *UNMET NEEDS: Teaching Physicians to Provide Safe Patient Care*. This white paper identifies a series of high-level recommendations needed to reform medical education and educate clinicians-in-training about providing safe, effective care.

This is the third year that JSPH has partnered with AMSA to respond to the call of *UNMET NEEDS*, having hosted two of the past three AMSA Patient Safety and Quality Leadership Institutes. Besides increasing awareness of the white paper report, the key objectives of the conference were to improve the knowledge, skills, and attitudes among physicians-in-training, medical schools, and teaching hospitals about patient safety; to bring the participants together in order to discuss safe patient care, and to develop actionable steps for how to improve it.

Over 50 students and practitioners from a variety of disciplines, including medicine, public health, and pharmacy, gathered for the two-day event. On the first day, they heard from the leaders in the field of patient safety. Carolyn Clancy, MD, the Director of AHRQ, discussed the strategic goals of the government agency, particularly to improve the quality, safety, efficiency, and effectiveness of the health care system. Dr. Clancy highlighted some of the AHRQ projects related to patient safety, such as the AHRQ Patient Safety Network, the Patient Safety Culture Surveys, Team STEPPS, Project RED, MATCH for

Lucian Leape, MD, renowned expert on safety and quality speaks to attendees at the American Student Medical Association Patient Safety Symposium.

medication reconciliation, and reducing Healthcare Associated Infections (HAIs), among others. Resources for each of these initiatives can be found on the AHRQ website at www.ahrq.gov.

Diane Pinakiewicz, MBA, CPPS, the President of the NSPF, shared some of the work the foundation has done in the patient safety movement, particularly with the Lucian Leape Institute. Lucian Leape, MD, Adjunct Professor of Health Policy at the Harvard School of Public Health, noted challenges when facing disruptive behavior from a health care provider, and how an individual's attitude can also be a threat to patient safety.

Other speakers included Tim McDonald, MD, JD, the Chief Safety and Risk Officer at the University of Illinois at Chicago, who discussed the work he is pioneering at UIC. The Seven Pillars Project, which is supported by AHRQ, is a comprehensive response to examining patient incidents when they do occur. David Mayer, MD, the Vice President of Quality and Safety at MedStar Health, Jennifer Myers, MD, the Director of Quality and Safety Education at University of Pennsylvania, and JSPH's Dr. James Pelegano and Dr. David Nash discussed a wide range of topics, from creating a culture of safety to practicing safe transitions of care.

The second portion of the event allowed attendees to work in small groups and discuss challenging issues in patient safety and health quality, such as the culture of medicine, curriculum, institutional capacity, and leveraging change. They then identified concrete, actionable steps to overcome some of these obstacles. After sharing these ideas with the rest of the group, students were equipped with strategies to promote patient safety at their home institutions. Sonia Lazreg, an MD/MPH student at Mt. Sinai University and event organizer, stated "The symposium was successful in ways I did not expect. We were interested in getting trainees involved in the safety movement and their own education, and I've been overwhelmed by the work attendees are already putting into improving systems nationally and at their own institutions since the conclusion of the program."

The PSQS advanced the discussions around patient safety among students, health care providers, and national leaders. For the third year, it has built upon the *UNMET NEEDS* report to train the next generation health care providers to embark upon safe patient care practices. The PSQS will likely continue next year, and will again seek to empower students to strive for patient safety in all components of their educational and professional experiences. ■

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JSPH Online CME Collaboration with Johns Hopkins University

Traditional continuing education activities that focus on knowledge acquisition (i.e. didactic lectures, CME monographs, and self-paced medical-literature reviews) are an important component of professional development, but they do not help physicians to address or identify many challenges to providing quality, guideline-based care to patients. Health-system complexities and healthcare reform, patient adherence to therapy, reimbursement considerations, busy providers, and an over-burdened healthcare system often result in suboptimal patient outcomes. Increasing demands to link CME directly to improved patient outcomes have led to transformational changes in continuing education programming. The Accreditation Council for Continuing Medical Education (ACCME) has new accreditation criteria that mandate more rigorous outcomes measurement. Commercial supporters are requiring CME activities to include higher levels of outcomes assessment. Maintenance of Certification (MOC), Maintenance of Licensure (MOL) and Pay for Performance (P4P) initiatives rely on quality metrics as a standard.

Effective CME programming improves upon the traditional paradigm focused on knowledge acquisition to engaging clinicians in initiatives that directly address quality and process improvement, patient outcomes and population health. One proven methodology is Performance Improvement CME (PI-CME), coined by the American Medical Association to be "the core of the new CME." In PI-CME programs, providers gather some real-world data about their patients and practice, review the information and commit to improvement in certain areas, then re-assess their practice some months later. This structured approach to CME has been shown to directly improve provider performance and patient health, yet few institutions are successfully deploying these impactful programs.

The Jefferson School of Population Health is establishing exciting new partnerships to develop professional development and CME opportunities that are directly relevant to clinical practice in this changing healthcare landscape. A recent collaboration, **The Johns Hopkins University Practice Improvement Strategies in Cardiometabolic Disease Therapies** presents a complimentary PI-CME activity that provides primary care physicians, endocrinologists, cardiologists, NPs and PAs with the tools to measure quality of care and to identify opportunities to improve the outcomes of patients with cardiometabolic disease. All practicing clinicians can earn 20 CME/CE credits without the need to attend a live program. After collecting some basic data on their patients, participants will be provided with benchmarking reports that satisfy American Board of Internal Medicine (ABIM) MOC Part IV requirements. Participants will also receive detailed clinical reports analyzing care delivered to patients with cardiometabolic disease against individual peers (anonymously) and national trends. Participants will also have exclusive access to a secure and moderated "mentor program," an online Q&A forum with nationally-recognized experts in the field.

If you are a clinician, you are invited to share the benefits of this educational grant, which includes funding for each participating practice to collect data on 25 patients with diabetes, hypertension, dyslipidemia and/or obesity. Funding is limited and on a "first come, first served" basis. Those interested are encouraged to complete a brief registration online at http://jhucardio.imedicaldecisions.com, or contact PIsupport@imedicaldecisions.com, or to call 610-891-1640. ■

The Johns Hopkins University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Johns Hopkins University School of Medicine designates this PI CME activity for a maximum of **20.0** ***AMA PRA Category 1 Credit(s)™.*** Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Quality Management Across the Continuum of Care in Orthopedics

The Rothman Institute, Thomas Jefferson University

To date, quality management and quality reporting in orthopedics have concentrated in two specific clinical areas, joint replacement and spine surgery. Furthermore, this reporting has almost totally focused on in-patient metrics that have been culled from either the Centers for Medicare and Medicaid Service (CMS) or, occasionally, from all payer billing data. To date, these metrics are totally focused on the area of surgical complications. In public reporting, two major web-based rating organizations (HealthGrades and Hospital Compare) use these complication metrics to rate hospitals and eventually plan on using them to rate physicians.

While surgical complications are certainly an essential metric to track and directly affect quality, they do not represent the quality outcomes of specific orthopedic care, nor does focusing on the surgical component of that care represent the entire care continuum. With the average hospital stay for knee replacement surgery now 3

days or even less, given an average two-year course of therapy for osteoarthritis of the knee (pre-operative medical management, surgical care, and post-operative rehabilitative care), the in-patient stay represents only 0.41% of the entire therapeutic course.

Recognizing the limitations of a "surgical complication" approach to quality improvement and management, The Rothman Orthopedic Institute at Thomas Jefferson University has designed and is implementing a system that will allow for the measurement of orthopedic outcomes based on patient function and pain. This approach recognizes the fact that orthopedic care does not start and end at the door to the operating room.

The measurement of function and pain, the orthopedics' outcomes that patients rightly focus on, has long been standardized by the use of specific validated "tools." Questionnaires such as the Disabilities of the Arm, Shoulder and Hand (DASH) Score[4] and The WOMAC (Western Ontario and McMaster Universities Index of Osteoarthritis)[5] allow patients to answer simple function and pain questions that lead to quantifiable measures of orthopedic outcomes. The challenge is to be able to collect this information reliably at specific intervals during the course of therapy, analyze it across multiple practitioners so as to identify best practice, and then link the outcomes to specific therapeutic variables (pain management, anesthesia, pharmaceutical interventions, surgical approach, rehabilitation pathways, etc.). Rothman has developed a system whereby, for example, a "knee patient" completes the appropriate functional tool at certain specific intervals (before and after knee injections, before and after surgery, before and after medical management, etc.). The same tool is used for similar patients no matter who the treating physician may be within the Rothman practice. Consequently, as patients pass from non-operative doctors to surgeons or to physical therapists, there is continuity of the quality measurements. Both an Internet portal (which is accessible from any computer) and in-office iPads allow patients to easily supply the needed information by completing the appropriate functional tool.

In addition, the patient generates a large volume of other clinical information during the course of his/her care. This information will be collected, stored, analyzed and trended in order that evidence-based decisions can be made relative to best practice. The Rothman Institute, in conjunction with Universal Research Solutions, has developed OBERD (Outcomes-Based Electronic Research Database).[6] This system is intended to integrate data from diverse systems (outpatient EMR, Hospital EMR, Rehabilitation IT systems, etc.) and allow for tracking of function and pain measurements from the moment a new patient enters the practice until his/her course of treatment is completed. Specific variables such as type of pain medication, surgical anesthesia, and rehabilitative course can then be linked to functional outcomes across the entire continuum. Rothman, understanding that such information is of little use unless it is accessible to the patient's orthopedist, has incorporated into its system design the ability to illustrate patient functional trends in graphic form, comparing like patients to like patients, a patient to a patient population, or a patient to other patients within a practitioner's own panel. Once the system is fully functional, information will be available within the Rothman Institute's EMR and viewable in real time during the patient's office visit. A patient who falls outside certain standard parameters with regards to their therapeutic outcomes is readily obvious, allowing the physician to appropriately modify the care.

The long-term goal of this initiative is to bring other orthopedic practices into similar data collection systems so that therapeutic and outcome information can be pooled into a larger data base that would allow for a more robust identification of best practices and, subsequently, true quality benchmarking across the specialty. While quality management will continue to track surgical complications, this initiative will move these activities into the area of true orthopedic outcomes. ■

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JSPH Hosts Region III HIV/AIDS Meeting August 2, 2012

On August 2, on the heels of the 19th International AIDS Conference in Washington, DC, clinicians, researchers, service providers, advocacy groups, clients and other stakeholders met at the Department of Health and Human Services (HHS) Region III National HIV/AIDS Strategy summit, hosted by Jefferson School of Population Health. The purpose of the meeting was to address the accomplishments and future directions of the government's effort to reduce HIV infections nationally, to increase access to care and optimize health outcomes for HIV-positive individuals, and to reduce HIV-related health disparities. These goals, outlined by the initiative, are based on a roadmap established by the July 13, 2010 National HIV/AIDS Strategy for the United States (NHAS), the first comprehensive strategy initiative of its kind for this country.

Dalton Paxman, PhD, Regional Health Administrator, Region III, U.S. Department of Health and Human Services, welcomes attendees to the Region III National HIV/AIDS Strategy Conference.

The program, attended by 135 participants, featured a mixture of presentations from leaders in the field, panel discussions featuring stakeholder and advocacy groups, and ended with town hall sessions to gather feedback and encourage greater collaboration. Timothy Harrison, PhD, Senior Policy Advisor at the HHS Office of HIV/AIDS and Infectious Disease Policy, focused on the value of collaboration between health care providers, all levels of government, and the community. His talk was followed by a panel discussion led by members of key community organizations serving individuals with HIV/AIDS. Another notable speaker in the morning session was Linda Frank, PhD, MSN, Associate Professor of Public Health at the University of Pittsburgh and Director of the Pennsylvania/Mid-Atlantic AIDS Education and Training Center, who spoke about the role of mental health, substance abuse and comorbidities of psychiatric disorders as barriers to care for persons living with HIV/AIDS. During her presentation, Dr. Frank indicated that often times mental illness precedes HIV transmission in the most at-risk populations: injection-drug users, men who have sex with men (MSM) and sex workers. Dr. Frank also illustrated the complexities involved in treating an addicted or mentally ill individual, such as poor medication adherence, participation in high-risk behavior and impaired judgment. Compounding these difficulties are the additional issues of poverty, cultural barriers, and language barriers.

The afternoon session was marked by presentations from Lisa Belcher, PhD and behavioral scientist Mary Neumann, PhD of the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention. They presented their work on the Enhanced Comprehensive HIV Prevention Planning (ECHPP) initiative in Baltimore, Philadelphia, and Washington, DC, which seeks to increase evidence-based HIV prevention. Following these presentations were three town hall meetings on the topics of Early Intervention with Adolescents, Trauma and Substance Abuse, and Stigmatization of Persons with Mental Illness. Although participation was encouraged and practiced throughout the meeting, these town hall get-togethers allowed attendees to give their suggestions for improving patient access to care, de-stigmatizing an otherwise stigmatized group, and coordination of services. An underlying theme of coordination, collaboration and integration of services' was emphasized throughout the meeting by certified peer counselors, healthcare providers, and community organizations. ■

The Department of Health and Human Services Region III is made up of Delaware, Washington, DC, Maryland, Pennsylvania, Virginia, and West Virginia.

To obtain a copy the strategy and an update of the federal implementation plan, visit www.aids.gov.

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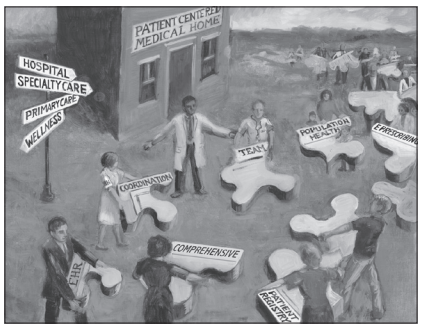

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Jefferson Hosts Third Interprofessional Education Conference

In 1972, the Institute of Medicine (IOM) first articulated the need for interprofessional education for all health professionals.[1] Interprofessional education and collaboration has continued to be identified as a cornerstone strategy to deliver high-quality, safe, effective, efficient, patient-centered, team-based care.[2] Over the years, many national and international organizations have reaffirmed the need for interprofessional education, including the Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), the Josiah Macy, Jr. Foundation, Pew Commission, Robert Wood Johnson Foundation, and the World Health Organization.[3-5] As a result, Interprofessional education (IPE) is fast becoming an accepted way to prepare future health professionals to successfully collaborate as members of health care teams.

In response to this need for new models of care, Thomas Jefferson University implemented the Jefferson InterProfessional Education Center (JCIPE) in 2007 with the mission, "To promote excellence in health through interprofessional education and scholarship." The Center has developed a comprehensive approach to IPE, consisting of interprofessional preclinical/didactic education, clinical simulation and clinical education within team-care settings in a variety of venues, including Thomas Jefferson University Hospitals. In October 2008, The Center held a one-day conference to share these activities with the larger University community. As the Center grew and developed more comprehensive programs a second conference was organized in 2010, which was initially envisioned as a local and regional meeting. As a result of the increased national interest in IPE, papers delivered by many of the leaders in JCIPE at national and international conferences and through their work with the fledgling American Interprofessional Health Collaborative, the conference soon grew into an international event drawing presenters from across the US and Canada.

JCIPE held its' third conference on May 18-19, 2012, entitled "Interprofessional Care for the 21st Century: Redefining Education and Practice." Two hundred sixteen individuals from the US, Canada and Australia attended the conference, which featured 61 peer-reviewed presentations. In addition to sharing important research outcomes in interprofessional education and practice, a major focus of the conference was discussion of the core competencies for IPE developed by the Interprofessional Education Collaborative (IPEC), an expert panel convened to define a common language and the major competencies necessary to engage in successful interprofessional education (IPE) and collaborative practice.

The program featured keynote addresses by two leaders in IPE: Carol Aschenbrener, Executive Vice President of the Association of American Medical Colleges and Dr. Susan Meyer, Associate Dean for Education in the School of Pharmacy at the University of Pittsburgh. Dr. Aschenbrener identified key initiatives of the IPEC intended to help universities and other organizations integrate IPE into their curriculum in a meaningful way. She also discussed the role of competency-based learning and assessment in creating a continuum of physician education and its relationship to IPE in the AAMC portfolio. Dr. Meyer provided an overview of the IPEC core competences and the principles that guided the panel's work in their development. She also provided some specific examples of how the competencies are being used to stimulate conversation on university campuses and to guide surveys of interprofessional learning activities.

Many individuals from the Jefferson community, representing the University and the Hospital, were involved during the Saturday sessions, sharing the results of their research and interprofessional programs. As in past conferences, in order to encourage dialog among participants, the format for this meeting allowed for more sharing of IPE experiences rather than a series of submitted papers. This discussion-heavy format exposed participants to more ideas and tended to be more useful in helping them understand what they could do to improve their own programs.

The success of this conference highlights the important role of collaborative, team-based care that is responsive to patient values in the transformation of the health care system. It also highlights the leadership role that Jefferson has assumed in helping to facilitate this transformation. ■

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Assistant Vice President for Program Evaluation and Director Center for Collaborative Research

Christine Arenson, MD
Associate Professor, Family and Community Medicine and Co-Director, JCIPE

Elizabeth Speakman, RN, PhD
Professor, Jefferson School of Nursing and Co-Director, JCIPE

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Senior Research Analyst, Center for Collaborative Research

For more information on the Jefferson Interprofessional Education Center visit: http://jeffline.jefferson.edu/jcipe/.

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5. World Health Organization. Framework for action on interprofessional education and collaborative practice. 2010.

JSPH and Bryn Mawr College Collaborate to Offer New Graduate Program

The Fall 2012 term marks the beginning of a new academic offering through the Jefferson School of Population Health (JSPH).

Bryn Mawr College's Graduate School of Social Work and Social Research (GSSWSR) and JSPH are partnering to offer a unique opportunity to complete dual degrees in social work (Master of Social Services – MSS) and public health (Master of Public Health – MPH).

Increasingly, the practice of healthcare, especially in serving the neediest populations, depends on community-based multidisciplinary teams of practitioners, researchers, and policy makers who are well-grounded in health, social, and legal services. The Bryn Mawr-Jefferson collaboration acknowledges the long-standing synergy between social work and public health and also recognizes the growing interest among professionals to further their preparation by earning multiple graduate degrees.

Bryn Mawr College's MSS is one of the nation's oldest and most respected academic programs in social work. Accredited by the Council on Social Work Education's Commission on Accreditation, it is fully equivalent to a Master of Social Work (MSW).

Jefferson's MPH program is nationally accredited through the Council of Education for Public Health (CEPH). This dual degree offering reflects the mission of both institutions to enhance the wellness and quality of life of individuals, families, and their communities through the shared commitment to social justice and human rights.

With advanced study in both social work and public health, professionals who complete the dual degree program acquire expanded knowledge and skills that broaden their appeal and value in the workplace. Graduates work in managed care organizations and hospitals, local and state health and welfare departments, federal and voluntary health and social service agencies, community based organizations, medical-legal partnerships, and advocacy coalitions. ■

Further information can be obtained by contacting the Bryn Mawr College Admissions Office at (610) 526-5152, or visiting www.brynmawr.edu/socialwork/admissions.

Book Review

McGuckin M.

The Patient Survival Guide: 8 Simple Solutions to Prevent Hospital- and Healthcare-Associated Infection

New York, NY: Demos Health; 2012.

In *The Patient Survival Guide: 8 Simple Solutions to Prevent Hospital-and Healthcare-Associated Infections*, Dr. Maryanne McGuckin educates and empowers the average person to take control of their healthcare. Dr. McGuckin is founder and president of McGuckin Methods International, Inc. (MMI), an advisory company that promotes patient empowerment, hand hygiene, and consumer education. The possibility of acquiring a healthcare-associated infection can be extremely frightening, and in this book, Dr. McGuckin educates the reader on how to prevent these all-too-common occurrences. Among the 8 simple solutions are: knowing the signs of a healthcare-associated infection; understanding what daily care you should be receiving; and the questions you should definitely be asking.

Written for the general public, this book offers insight as to how and why infections are acquired in healthcare settings, primarily hospitals. The four most prevalent healthcare-associated infections are: urinary tract infections, respiratory infections, surgery site infections, and bloodstream infections. In an easy-to-read manner, McGuckin describes the microbiology of how these infections are spread and the effects that they have on the body. The recurrent message in this book, mentioned at least once in each chapter, is for people to simply wash their hands. Handwashing is imperative for anyone that enters a patient's room.

McGuckin stresses the importance of the patient being in total control of his/her healthcare experience. In the chapter entitled, "Power to the Patient," McGuckin supplies readers with useful tips to assert control over the healthcare they receive using the "3 Cs" – *commitment*, *continuity*, and *communication*. This chapter also explains what patients should know before signing consent forms and the value of enlisting the help of an advocate.

McGuckin uses stories in an attempt to connect with and educate her readers. One story that was especially heart wrenching was the story of Julie Rich. Julie's mother was a healthy sixty-five year old woman who went to the hospital for an elective same-day surgery to insert a bladder sling. Once home it seemed as the catheter was not working properly and Julie and her mother returned to the doctor's office. It was discovered that the catheter had been placed upside down inside the body. The nurse at the doctor's office fixed it and sent Julie's mother home. Within the next few days Julie's mother developed a fever and once again returned to the doctor's office. The doctor then admitted to the family that Julie's mother had developed a "Staph" *(Staphylococcus aureus)* infection

Continued on page 12

which then developed into sepsis, the sling had become infected and needed to be removed. After two more surgeries Julie's mother went to stay in a nursing home. When she was finally able to go to her own home Julie's mother was still heavily relying on medication and the use of an oxygen tank.

Through Julie's story the reader realizes that a medical error from an elective surgery could result in such pain and suffering.

The Patient Survival Guide provides useful information that is readily accessible for lay people, and would be especially useful for those preparing for surgery or other medical procedure. The author's knowledge and passion for the subject comes through, making this book a fast, easy read. ■

Reviewed by Brittany Christaldi
Jefferson School of Population Health Intern

Jefferson School of Population Health Forum

Formerly Health Policy Forum

Implementing Decision Support Tools to Enhance Care for Older Adults

Kathyrn H. Bowles, PhD, RN, FAAN

Professor and Raltson House Endowed Term Chair in Gerontological Nursing
Director of the Center for Integrative Science in Aging
University of Pennsylvania School of Nursing

September 12, 2012

The fall 2012 season of the Jefferson School of Population Health Forum opened with an enlightening presentation about care for older adults. Dr. Kathyrn Bowles of the University of Pennsylvania discussed innovative methods for improving discharge planning decision support tools and the current state of research in this area. Dr. Bowles dedicates much of her time to examining decision support that is guided by information technology to improve care for older adults. She is committed to improving systems that will enhance transitions of care.

Dr. Bowles began her presentation by describing the barriers to effective discharge planning. For example, lack of protocol can be exacerbated by shortened lengths of stay, inconsistent assessments, and varying levels of expertise and risk tolerance. Additionally, there is a lack of post-acute referrals, increased costs, and poor discharge outcomes. Sometimes over-referral is also a problem. Many issues contribute to these barriers, such as discharge planners (DP) who are overwhelmed; varying models as to which patients are assessed or screened by a DP; and lack of evidence-based support tools for discharge planning.

Dr. Bowles and her colleagues have been very involved with a National Institutes of Health (NIH) study that focused on a new discharge decision support system known as D^2S^2.[1] This system is designed to assist in identifying patients who should be referred for post-acute care and avoid missing those who need care. This should also help decrease the problem of over-referral.

Using real case studies of hospitalized older adults, two versions of the tool were developed: one for cognitively intact patients; and the other for cognitively impaired patients to be used by the caregiver or proxy. The tool takes 5 minutes to complete and can be administered any time prior to discharge, but preferably within 24 to 48 hours of admission. The tool consists of questions surrounding walking ability, self-rated health, length of stay, age in years, number of co-morbid conditions, and depression.

The study analyzed care without decision support and care with decision support. The control phase (without support) included self-developed assessment forms. Referral decision was not structured and was made by individuals. In the experimental phase with decision support, discharge planners and staff nurses were educated about the D^2S^2 and workflow was analyzed to determine the best way to share decision support with clinicians.

Dr. Bowles explained the summary of the findings, which in general focused on the notion that supplying decision support for post-acute care (PAC) referral decision making is associated with better DC plans. Between the two phases there was a 6% decline in readmissions by 30 days and 9% by 60 days. Dr. Bowles stated that timely sharing of the tools is critical to deliver the decision support at the right time to the right person. Clinicians reported that the tools were valuable in guiding or confirming their discharge decision making and identifying high-risk patients early in the hospital stay.

In conclusion, providing decision support with the D^2S^2 revealed the helpfulness in identifying patients likely to have readmissions and an impact on time to readmissions. Dr. Bowles describes the implementation process as complex, involving careful adherence to established steps; an information system inventory and workflow analysis; and evaluations. Future plans are underway to license the D^2S^2, and develop smart capabilities and dashboard reporting. ■

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

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1. D^2S^2 Discharge decision support system platform. 2012. http://www.rightcaresolutions.com/#!solutions/ch6q. Accessed October 4, 2012.

Dr. Nash Receives the Joseph Wharton Award for Social Impact

In what he described as the "culmination of my Wharton journey," David B. Nash, MD, MBA, Dean of the Jefferson School of Population Health, received the 2012 Joseph Wharton Social Impact Award in a ceremony at the Essex House hotel in New York City on October 4.

The award was presented by Dr. Mehmet Oz, last year's honoree and a former Wharton classmate. "I'm very grateful to receive this award," Dr. Nash told the crowd. "The (Wharton) Health Care Management Program enabled me to view our industry through a new lens. It put me on the path toward becoming a physician leader."

In nominating Dr. Nash, the Wharton School said, "As one of the leading Wharton alumni in the world, you have demonstrated leadership not only as Founding Dean of the Jefferson School of Population Health, but your dedication to medical education and healthcare have helped shape an industry. Your experiences represent the founding spirit of the Wharton School and set a standard for future leaders."

James David Power III, WG'59, Founder, J.D. Power and Associates, served as the 2012 Honorary Chair of the Awards ceremony, and CNBC's Bill Griffeth served as emcee.

"Wharton remains a very special place for me," Dr. Nash said. "Nearly every day I try to use some of the skills I spoke of. This award energizes my continued journey as a physician leader." ■

Upcoming Jefferson School of Population Health Forums

Nov 14, 2012

Population Health: Integrating Medicine and Public Health

Marc N. Gourevitch, MD, MPH
Professor and Chair, Department of Population Health
NYU School of Medicine

December 19, 2012

Less Talk, More Action: Accelerating Innovative Strategies to Eliminate Racial and Ethnic Health Disparities

Stephen B. Thomas, PhD
Professor, Health Services Administration
Director, Maryland Center for Health Equity
School of Public Health, University of Maryland

Location:
Thomas Jefferson University
Bluemle Life Sciences Building, Room 101
233 South 10th Street, Philadelphia, PA 19107

Time: 8:30 am – 9:30 am

For more information call: (215) 955-6969

JSPH Publications

Del Canale S, Louis DZ, **Maio V**, Wang X, Rossi G, Hojat, M. Gonnella JS. The relationship between physician empathy and disease complications: An empirical study of primary care physicians and their diabetic patients in Parma, Italy. *Acad Med.* 2012;87(9):1243-1249.

Meiris DC. Insights from the 12th Population Health Management and Care Coordination Colloquium. *Popul Health Manag.* 2012;15:127-128.

Nash DB. Scotus redux. *Am Health & Drug Benefits.* 2012;5(5);268-269.

Nash DB. Anatomy of a momentous decision. *Medpage Today.* July 31, 2012

Nash DB. Good news for a change! *Medpage Today.* August 28, 2012.

Nash DB. Is there an "app" for that? *Medpage Today.* September 25, 2012.

JSPH Presentations

Lieberthal, RD. Financing Guaranteed Renewable Health Insurance. Presented at: American Risk and Insurance Association Annual Meeting. August 7, 2012, Minneapolis, MN.

Simmons R. Key Issues in global health (five session series for faculty). Presented at: CES University, University of Antioquia School of Public Health, August 2-24, 2012, Medellín, Colombia

Simmons R. Milestones and challenges of public health in the 21st century. Presented at Global Public Health Forum, Secretary of Health, Fulbright Foundation, August 23, 2012, Medellín, Colombia.

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