

## GUEST EDITORIAL

# Reflections and Projections: Prevention, Policy, and Health

As a nation, we are consumed by the pursuit of good health. We toast, “To your health!” Health-related stories fill the news, particularly at the start of each New Year as we resolve to lose weight and become more active, and even serve as themes for TV shows. Commercials for healthcare products (diet plans, exercise equipment and cooking tools) abound. Most of us would rank living a long and healthy life above money, fame and just about anything else. Or, as a teacher of mine used to say, “all my patients want to die healthy.” Almost a fifth of every dollar spent in the US goes toward health services. While we all have the same goal, the burden of disease is unequal. We’re all in a race toward better health, but some people start from behind. Economics, education and genes play a role, as does poor health behavior such as inactivity and smoking or drinking to excess.

When it comes to taking control of our health we tend to focus on the wrong things. Even the doctors, nurses and other health professionals in my classes at the Jefferson School of Population Health are surprised to learn that, according to one estimate, health care accounts for only 10% of the many factors that help us live to a ripe old age. The rest are things like good genes (30%), social circumstances (15%) and healthy habits (40%).

While we can’t do anything—so far—about picking the right parents for better genes, there is much we can do to stack the lifetime lottery in our favor. We could take a more active role in our own health by eating less, consuming better quality food, and exercising more. Despite the best of intentions, better health is a much harder

goal for some people to achieve when they are swimming against an unhealthy tide that is largely out of their control.

The sad reality is that zip code often matters more than genetic code. Where people live and the specifics of their social situations have a tremendous effect on their health outcomes. For instance, according to the Philadelphia Department of Public Health, male life expectancy by neighborhood varied by as much as 12 years in 2010 (65 vs. 77 years). Community factors such as housing quality, violence, income, employment, and access to healthy food impact health outcomes. However, moving to a “healthier” neighborhood may not be enough to erase these differences. Other factors such as discrimination, stigma, lack of social support and the stress these conditions cause can literally make us sick.

Unfortunately, our political and policy-making institutions often fail to address these concerns. Telling people that they should take better care of themselves is not controversial. Despite the debate over Obamacare, politicians of all stripes generally agree that access to high-quality health care is a good thing. However, promoting public policies that raise wages so people don’t have the stress of living hand to mouth is considered a political act. Raising taxes on certain junk foods—shown to help decrease calorie consumption—is derided as an attack on American free choice. Earnest discussions about the health impacts of racism and other forms of bias often devolve into petty partisan debates and victim blaming. We must find a way to depoliticize these issues.

Policy interventions that improve health are not just a moral imperative. Poor health outcomes result in higher premiums, lost worker productivity and increasing taxes. Even if you believe that people have ultimate responsibility for their own health, helping them achieve it makes economic sense.

All of us and our political leaders must acknowledge that health is determined by many factors—some of which are beyond an individual’s control. We must identify and apply proven policies to ensure everyone has equal access to social, environmental and economic conditions that promote rather than harm health.

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*This editorial is based on an article that first appeared in the [Field Clinic Blog](#) on Philly.com.*

## Bidirectional Global Health Education: The RVCP-Jeff HEALTH Exchange Program

In 2005, Thomas Jefferson University (TJU) medical students and faculty from the Department of Family and Community Medicine (DFCM) started the Rwanda Health and Healing Project, a community oriented health project in two rural villages in Rwanda. This project has been previously described in the *Population Health Matters* article, "Partnerships for Health in Rwandan Genocide Survivors Village: The Rwanda Health and Healing Project and Barefoot Artists."<sup>1</sup> Since its inception, over 80 students and faculty from TJU have traveled to Rwanda to work with these villages on a variety of public health and income generating projects.<sup>2</sup> As part of this program, a partnership was formed with the Rwanda Village Concept Project (RVCP), a Rwandan medical student-driven public health and community development organization. In 2007, a group of dedicated Jefferson students from the student organization Jeff HEALTH worked with faculty from the DFCM to establish an exchange program to bring RVCP medical students to Jefferson. Through the Jeff HEALTH-RVCP partnership, Jefferson selects 2-3 Rwandan students per year (through a rigorous essay and interview process) for 2-month long TJU rotations focused on primary care, community health, and public health. Since 2007, 21 Rwandan students have successfully completed this exchange program.

The curriculum for this exchange has become increasingly formalized over the past 7 years in response to changes in medical curriculum requirements in Rwanda and feedback from participants. Directed by an interdisciplinary group of resident and faculty global health clinical mentors across the Departments

of Pediatrics, Family and Community Medicine, Emergency Medicine, and Obstetrics and Gynecology, the current curriculum is designed to introduce the students to the many dimensions of clinical practice, health systems, and education in the United States (Table 1). The main areas of educational focus include chronic disease prevention and management, clinical skill development, care of underserved and vulnerable

populations, research/academic scholarship, comparative health systems, and physician advocacy. In addition, DFCM faculty are also working with medical educators in Rwanda to better align the exchange curriculum with the National University of Rwanda's required community and population health curriculum. Upon return to Rwanda, the participating exchange students are expected to maintain leadership roles in the RVCP,

**Table 1. RVCP-Jeff HEALTH Exchange Program Curriculum**

Educational Focus	Curricular Component/Clinical Experience
Chronic Disease Prevention and Management	Outpatient family medicine clinic
	Diabetes Group Visit Program (DISH)
	TJU Center for Urban Health community Screening programs
	JFMA Home Visit Program
Clinical Skill Development	Clinical skills training sessions at Robert & Dorothy Rector Clinical Skills & Simulation Center
	Inpatient bedside rounds
	Obstetric Ultrasound Clinic
Underserved Care Vulnerable Populations	Jeff HOPE Homeless Outreach Student Clinic
	Medical Street Outreach with Project HOME
	St. Elizabeth's Community Wellness Center
	Refugee Health Partners Student Clinic
	LGBTQ Care at Mazzoni Center
Research/Academic Scholarship	Seminars: Basic Biostatistics Program Development and Evaluation Community Based Participatory Research Methods
	Exposure to new and emerging fields of specialty care: Emergency Medicine, Family Medicine
	Comparing inpatient and outpatient models of care
Physician Advocacy	Pediatrics Advocacy Café

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provide monthly monitoring of Jeff HEALTH village public health programs, and mentor TJU students visiting Rwanda.

To date, 17 students who have completed this exchange program have graduated from the National University of Rwanda to practice in the fields of Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Psychiatry; in addition, several of the students have completed advanced degrees in public health, clinical research, and health policy. These students now populate the private, public, and non-profit health sector of Rwanda--taking on leadership roles as clinicians, researchers, educators, and health administrators. The expanding personal and professional networks that have emerged as a result of this unique program of undergraduate global health education have provided the foundation for an important model of interdisciplinary peer mentorship across multiple levels of learners. We are currently in the process of evaluating the impact of this program and mentorship network through surveys and in-depth interviews.

In 2011, faculty from the DFCM began developing a clinical program in Rwanda for advanced medical students, residents, and faculty from TJU. Focusing on the principles of reciprocal education, this program is built on the RVCP-Jeff HEALTH peer mentorship networks. Through these networks, members of the TJU community have the opportunity to expand beyond the village-based public health programs and work clinically with the exchange RVCP graduates at different institutions within the Rwandan health sector, thereby providing a bidirectional global health education experience.

The RVCP-Jeff HEALTH exchange program exposes students from both the United States and Rwanda to the practice of healthcare across health systems, institutions, and cultures. Importantly, this type of collaborative, bidirectional program in global health education has the potential to build local and international global health capacity in a way that is fundamentally more equitable, interprofessional, and relevant to the future practice of global health.

*At this time, this program is dependent on fundraising and donations. If you would like to donate to this program, please contact [Ellen.Plumb@jefferson.edu](mailto:Ellen.Plumb@jefferson.edu).*

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## Refugee Resettlement in Philadelphia: Medical and Community Partnership

The events at the U.S. border with Mexico in recent months have brought national attention to the refugee situation in the United States. Although the national spotlight on the issue of caring for refugees may be new, the fact that the US has been a leader in helping to resettle persecuted people from war-torn parts of the world is not. In fact, according to the United Nations High Commission for Refugees (UNHCR), the U.S. ranks in the top 10 countries of refugee asylum<sup>1</sup> and resettles 30,000-110,000 refugees per year.<sup>2</sup> Each year 800 of these refugees are resettled right here in Philadelphia.<sup>3</sup>

According to the UN, a refugee is someone who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country."<sup>1</sup> As political situations evolve around the world so does the makeup of the current U.S. refugee population. For fiscal year 2013, the U.S. government has allocated funding for the resettlement of 70,000 refugees, with nearly half from Near East/South Asia (31,000), followed by East Asia (17,000), Africa (12,000), Latin America/Caribbean (5,000) and Europe/Central Asia (2,000).<sup>4</sup>

In Philadelphia, the refugee population consists mainly of people from Bhutan, Burma, Eritrea, sub-Saharan Africa and Iraq with a quickly growing group from the Democratic Republic of the Congo. Refugees typically come from years of living in refugee camps or war-torn urban environments with poor access to basic hygiene and needs such as healthy

food and clean water. This means that many refugees arrive with acute and chronic medical conditions, including infectious diseases, post-traumatic stress and depression. Currently about 15% of refugees resettled in Philadelphia have significant medical conditions requiring ongoing subspecialist care.<sup>3</sup>

In 2007, local resettlement agencies identified the need to establish a more organized and efficient system for meeting the needs of this medically complex group. Prior to this time, staff made medical appointments for clients at local public health centers or private physicians' offices accepting Medicaid. Medical providers in these locations did not always have specialized knowledge about refugee health issues and appointment scheduling and follow-up was difficult. Additionally, language access and cultural competency of providers created significant challenges.<sup>3</sup>

The model of providing medical care for refugees in Philadelphia changed dramatically in 2007 when Nationalities Service Center (NSC), the largest resettlement agency in the city, and Jefferson's Department of Family and Community Medicine launched the first refugee clinic. In this patient-centered, longitudinal model, providers set aside designated time each week to see refugee patients, greatly improving access to care for this vulnerable population and allowing providers to become proficient in the care of this complex subset of patients, resulting in higher quality of care.<sup>3</sup>

The tremendous success of the Jefferson/NSC model in 2007 encouraged other partnerships between resettlement

agencies and mainly academic medical centers. Einstein Medical Center Philadelphia was the most recent organization to join the group in September 2012, offering both pediatric care at the Pediatric and Adolescent Ambulatory Care Office and adult care at the Community Practice Center. In 2010, involved resettlement agencies and refugee clinic sites formed the Philadelphia Refugee Health Collaborative (PRHC) to solidify their relationship and collaboratively work to improve the health of our local refugee population by improving access and equity of care. This organization includes 3 resettlement agencies and 8 medical offices through which all arriving refugees receive their medical care. Through collaboration, the PRHC is able to offer easier access to appointments, enhanced communication, a robust referral network and establishment of a medical home for refugee patients. In addition, students and residents training at these offices receive global health training they may not otherwise have access to without leaving Philadelphia.<sup>3</sup> The PRHC also applies for and has been awarded a number of grants to fund projects and personnel to better serve our patients. By combining our efforts we hope to continue to provide high quality care to all refugees who resettle in Philadelphia. This unique model of care has been so successful that it has been presented at the national level as an example of well-organized, exemplary refugee medical care. In fact, members of the PRHC have been asked to visit the state of Wisconsin and serve as advisors to refugee health leaders in setting up a similar model of care. Given its great success in the Philadelphia region, we hope this care model continues to be replicated across the country.

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Although the refugee population in Philadelphia is medically vulnerable and often has complex medical needs, the systematic approach offered by local resettlement agencies and refugee clinics offers multidisciplinary care to this special patient population. By working together to meet the

many physical and mental health needs of refugees, the members of the Philadelphia Refugee Health Collaborative provide high quality care in a culturally sensitive manner to meet unique patient needs.

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## JSPH Hosts a Successful Gathering of Future Leaders in Quality and Safety

December 6, 2014

On Saturday, December 6, 2014 over 50 students, residents, and faculty representing universities and hospitals throughout the mid-Atlantic region convened on the campus of Thomas Jefferson University to further explore their interests in quality and safety. The conference, "Future Leaders in Quality and Safety," is the American College of Medical Quality (ACMQ) Student and Resident Section Annual National Workshop on Quality and Safety. Now in its fourth year, this conference serves as the Mid-Year Conference for the College and is targeted primarily towards students and residents. However, a significant number of practicing faculty also participated, using the event as an opportunity to further engage in quality and examine ways to apply new ideas, while also sharing their knowledge with less experienced attendees.

This year's conference was hosted by JSPH and moderated by its dean, David B. Nash, MD, MBA, a passionate leader committed to

promoting the quality agenda in all segments of health care and medical education. JSPH also shows its commitment to quality by offering a Master of Science in Healthcare Quality and Safety, and a Master of Science in Healthcare Quality and Safety Management.

Over 15 conference faculty, experts in quality and safety, contributed to the day's success by presenting and facilitating discussions. Plenary speakers included:

**Peter Angood, MD, FRCS(C), FACS, MCCM**  
*Chief Executive Officer, American Association for Physician Leadership*

**Samara Ginzburg, MD**  
*Associate Dean for Case-Based Learning, Hofstra North Shore-LIJ School of Medicine*

**Jennifer Myers, MD, FHM, FACP**  
*Associate Professor of Clinical Medicine and Director of Quality and Safety Education, Perelman School of Medicine, University of Pennsylvania*

**Susan Freeman, MD, MS**  
*Chief Medical Officer, Temple University Health System; President & CEO, Temple Center for Population Health, LLC; and Vice Dean, Health Care Systems, Temple University School of Medicine*

**Mark Lyles, MD, MBA, FACMQ**  
*Vice President, ACMQ; Chief Strategic Officer, Medical University of South Carolina Clinical Enterprise*

**James Pelegano, MD, MS**  
*Assistant Professor, Program Director, Masters in Healthcare Quality and Safety, JSPH*

**Kathleen W. McNicholas, MD, FACS, JD, LLM**  
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The conference offered highly interactive group discussions on a variety of topics including: quality in undergraduate and graduate curriculum; ACMQ leadership; IHI Open School; interprofessional approaches to quality; and faculty development. Additionally, panel presentations on "Careers in Quality" and "Engaging in Quality" allowed young attendees to envision their own futures in quality.



Careers in Quality panel from left to right: Joseph M. Montella, MD, MS, CPE (moderator); Robert M. Dressler, MD, MBA; Lawrence D. Ward, MD, MPH, FACP; and Marina Zeltser, MD, MBA.

Photo by Andrew Jerdonek



Workshop attendees engaged in a small group discussion. Photo by Andrew Jerdonek.

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## Figure 1. Comments From Attendee Evaluations.

*“Hearing the stories of how everyone got to their current roles professionally and hearing about what opportunities are out there was very useful to me.”*

*“Medical quality improvement seems less abstract and scary and more tangible. It is something that I already have the desire and capacity to do.”*

*“I think as a medical student right now, it was interesting to learn about QI efforts in undergraduate curriculum.”*

*“I will be working to change residency program to include more QI/PS education and mentoring (for both residents and faculty).”*

*“I will work on an IHI chapter at my school and do the IHI modules to start my initial training. May possibly plan for JSPH degree/certificate.”*

*“I plan to become more involved in steering committees at my medical school and be more aware of opportunities at different residency programs. I may also pursue another degree and ultimately integrate QI into how I practice.”*

Overall, the message was that quality is just as pressing an issue now as it was 10 years ago, and that professionals who receive special training in quality will serve themselves and the healthcare system well. The enthusiastic response from attendees was evident (Figure 1) and inspiring throughout the program.

To access presentations from this conference and view a complete list of faculty and topics visit [Jefferson Digital Commons](#). [Click here](#) if you are interested in learning more about the Student and Resident section of ACMQ.

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## 12th Annual Interclerkship Day: Improving Patient Safety

January 5, 2015

Every year JSPH hosts the Patient Safety Clerkship for the entire 3rd Year Sidney Kimmel Medical College (SKMC). Now in its 12th year, this clerkship offers a unique opportunity for students to increase their awareness about medical error, patient safety, communication, and culture change in healthcare.

John J. Nance, JD, an internationally known aviation expert, served as the keynote speaker. Nance is a founding board member of the National Patient Safety Foundation and an ABC News broadcast analyst on aviation. Through the use of videos and real scenarios, Nance demonstrates how medicine can use crew resource management (CRM) principles from the airline industry to improve patient safety. He discussed the importance of communication and the creation of an environment and culture that allows a student or resident to speak up if something is wrong. Nance believes this type of environment will foster a team and culture where all team members are committed to improving patient safety. "Understand your own limitations as a human being," states Nance.

Rachel Sorokin, MD, FACP, Chief Patient Safety and Quality Officer of Thomas Jefferson University Hospital presented real cases to illustrate the importance of team communication and handoffs. Using Jefferson data, Dr. Sorokin honed in on specific errors, provided an analysis of how the errors occurred, and what could have been done to prevent the errors. She acknowledged the difficulty of communicating up the authority gradient, but she also encouraged students to speak up.

An Interprofessional panel representing surgery, nursing, pharmacy, rehabilitation medicine and respiratory therapy described the ABCDE Bundle approach to coordinated care for the mechanically ventilated patient to reveal how interprofessional teams can work together to ensure patient safety. The panel was moderated by Lauren Collins, MD, Associate Director of the Jefferson Center for Interprofessional Education.

Barry M. Mann, MD, Chief Academic Officer for Main Line Health and Professor of Surgery, SKMC discussed culture change and shared educational initiatives used at Main Line Health to "speak up for safety." Dr. Mann engaged students in a surgery related



*From left to right: Barry B. Mann, MD; John J. Nance, JD; David B. Nash, MD, MBA; and Jason K. Baxter MD, MSCP, FACOG*

scenario to demonstrate and model ways to enhance safety behaviors and integrate error prevention tools.

The day concluded with a lively and interactive session on the importance of skillful communication when discussing bad news or errors with patients and families. Jason Baxter, MD, MSCP, FACOG, Associate Professor in the Department of Obstetrics and Gynecology, helped to characterize the elements of a successful encounter with patients and families while the audience observed important skills and participated in role plays.



## Medical Mystery: The Importance of Patient History

My 29-year old daughter recently visited me following a ten-day sojourn to [Kyrgyzstan](#). A PhD candidate in psychology at UMass-Boston, she had been invited to this central Asian republic to present a paper at an international conference. She found the people to be warm and friendly, but realized the country was a study in contrasts. Bleak Soviet-style buildings defined the cities, while yurts (large, round tents) filled with spectacular color dotted the countryside. A center for Silk Road spices, the cuisine was nonetheless bland, relying on meat and raw milk products reflective of a nomadic heritage. *Kymyz*, a slightly alcoholic drink made from fermented mare's milk, is the national drink, available fresh in late spring and summer and bottled for year-round consumption.

We had planned an extended weekend of fun-filled activities, but she woke up the first morning with very sharp and persistent pain in her left eye. She didn't remember injuring herself, and her eye wasn't swollen or puffy. Strong light made her teary. The entire white of her eye (the sclera) was bright red. It was as if someone had taken a red magic-marker and colored in the entire white space around her iris. Successive doses of extra-strength Tylenol had no impact on the pain which persisted throughout the day and into a very sleepless night.

The next morning, Saturday, we parked ourselves in the ER at Wills Eye Hospital. The young ER doctor diagnosed her condition as "acute diffuse scleritis" — extreme inflammation of the sclera — and prescribed 800 mg of ibuprofen every six hours to reduce the inflammation and hence the pain. The condition would have to resolve itself on its own. Relatively rare, we learned that scleritis favors women over men, especially women in their late twenties to early forties. The concern,

however, was that, in the majority (60%) of cases, scleritis is a sign of an underlying auto-immune disorder, usually lupus or rheumatoid arthritis. It was strongly recommended that my daughter consult a specialist as soon as she returned home for testing to identify and treat the underlying cause.

We were in shock. Lupus? Rheumatoid arthritis? Was this really possible? There was no history of these ailments in our family, and my seemingly healthy daughter, a marathon runner, was preparing for her next race. A shadow descended on our fun-filled weekend. As a super-concerned mother, my worry level kicked into overdrive.

Back in Boston, my daughter arrived for her appointment at Massachusetts Eye and Ear. She dutifully filled out a multi-page questionnaire that asked extensive questions about her health, her occupation, recent travel, consumption of unusual foods, and any other symptoms she was experiencing. A kindly, white-haired ophthalmologist examined her eye and listened to her tale of pain and a spoiled weekend. Yes, he confirmed, in most instances diffuse scleritis is a sign of a serious underlying auto-immune disease. Extensive blood work would need to be done to determine the cause.

As he continued his explanations, the doctor scanned her paperwork and glanced at the checkmarks in her personal history. Suddenly, he stopped. The personal history indicated that she had recently traveled to Kyrgyzstan and consumed raw milk products. The doctor questioned her about her trip. "They drink a lot of raw milk in Kyrgystan," she explained, "and much of their cuisine is based around it."

"Well, you have absolutely no rashes, back or joint pain, and you have enough energy

to be a PhD student and exercise several times a week," replied the doctor, "so I'd say chances are slim to none that you have an autoimmune disorder." He recommended that she not waste her time getting blood tests.

She would be perfectly fine within a day or two, he assured her, but she should stay away from raw milk in the future. Bacteria in unpasteurized (raw) milk are known to cause scleritis, especially if ingested in large and consistent amounts.

What a relief! Thank heaven for personal histories, I thought, and for kindly doctors who take the time to read them. This experience made me realize how important it is for patients to fully answer all the seemingly pointless questions on medical history forms and for clinicians to ensure that they review them thoroughly.

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## It Takes A...Workplace! Insights from an Employee Weight Loss Program

Over two-thirds of U.S. adults are considered overweight or obese,<sup>1</sup> putting them at increased risk to develop health conditions such as type 2 diabetes, hypertension and cardiovascular disease.<sup>2</sup> Health care spending for obese adults under the age of 65 is estimated to be 36% higher than for normal weight adults.<sup>3</sup> With increased health expenses, employee absenteeism and loss of productivity, obese individuals are more costly to employers.<sup>4</sup> Addressing obesity is part of a long-term solution for improving health and many have identified the workplace as a prime setting for interventions.<sup>5-6</sup> Currently, published literature about worksite wellness initiatives focus on the implementation and evaluation of randomized trials. These include testing the use of incentives,<sup>7</sup> increasing physical activity,<sup>8</sup> and interventions in workplace cafeterias.<sup>9</sup> While broad recommendations for workplace wellness initiatives are available, there is a need for employers to share specific weight loss interventions to provide more comprehensive population health solutions.

In 2009, the Benefits and Wellness Department at Einstein Healthcare Network started 'Greatest Loser,' a voluntary program for employees who wanted to lose weight. Loosely based off the television show 'Biggest Loser,' the competition rewards those who lose the greatest percentage of body weight over a 10-week period. *The Greatest Loser* program has an approved budget to advertise throughout the network, to offer participants tools for the competition (e.g. notebooks for capturing weights) and to provide prizes. In addition, through cultivating relationships with outside vendors, generous donations have been made by grocery stores, fitness centers and food companies to provide giveaways to participants throughout the competition. Since its inception, the program has evolved into a

wellness program that integrates incentives, education, and resources to encourage employees to become more conscious of their health status and achieve any amount of weight loss.

Employees enter the competition as either an individual or as a team, depending on personal preference. During enrollment, they also select a fellow employee (from a provided list of weighers) who is responsible for recording all weights collected during the program. Participants have official weigh-ins every other week, with optional weekly weigh-ins offered. At the end of the competition, substantial cash prizes are awarded to the male, female, and two-person team who lose the greatest percentage of body weight. In 2014, to engage employees interested in adopting healthier behaviors or losing smaller amounts of weight, additional challenges were offered, including weight (i.e., setting a goal of losing 10 pounds in 10 weeks) and behavior-specific tasks (e.g., taking the stairs every day, giving up sugar-sweetened beverages) was also set at each weigh-in. This past year, a survey of participants revealed that these challenges were named the most helpful and motivating aspects of the competition.

*The Greatest Loser* combines multilevel support (individual, interpersonal, institutional and community factors) to motivate employees to make healthier choices. According to the ecological model of health,<sup>10</sup> these factors are essential targets for achieving population health improvement. Each level is a focus of the program and helps to engage employees while at work and at home. To address individual support, participants receive daily actionable tips either by email or text, weekly newsletters, and an electronic copy of an employee-designed healthy eating cookbook. Various surveys are

sent out during the 10 weeks to test individual knowledge, attitudes and behaviors for successful weight loss.

*Greatest Loser* utilizes the value of interpersonal relationships, both inside and outside the workplace, for weight loss. In the workplace, the team of 50 weighers is offered a motivational interviewing training (before the competition starts) to help maximize interactions with participants. Once the competition begins, weighers meet with participants to offer support, to motivate, and to provide giveaways. At the first weigh-in, participants are given a notebook, complete with weigh-in dates, discounts, and other pertinent information. They are encouraged to bring it to all weigh-ins to record weights throughout the competition, with weighers also using the notebook to acknowledge weight loss. In 2014, recognizing the critical role of social support from family members, the program expanded to allow employees to enter the program with their spouses or partners.

Additional internal and external resources are promoted to offer convenient options for weight loss at the institutional level. On-site fitness classes, such as Zumba, line dancing and yoga, are offered at varying times, both during and after work hours, with the first session of each free of charge. A hospital dietitian offers an in-person workshop once a week to answer healthy eating questions and is available by email; a psychologist, formally trained in motivational interviewing, offers weight loss counseling to those interested. Both provide these services voluntarily.

To provide support to participants in the community, Einstein collaborates with fitness center locations (convenient to employees and their families) to offer weigh-ins for

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night and weekend employees, as well as participating spouses or partners. Over 20 vendors provide employees special discounts on fitness related goods (such as memberships and personal training sessions) as well as wellness and food services (such as bags of groceries and fruit arrangements).

Over 1,100 Einstein employees signed up for the *Greatest Loser* 2014 (almost 14% of the total Einstein workforce), with close to 40% completing the competition (or half of all employees who came to the first weigh-in). In total, almost 3,000 pounds were lost and 355 participants lowered their Body Mass Index (BMI). Most of this reduction happened within the BMI categories; however, 47 participants successfully lowered their BMI by a full category (e.g. going from 'obese' to 'overweight'). Last year, we evaluated participants before and after the competition. We used a survey to assess lifestyle changes including, but not limited to, physical activity levels (using the [International Physical Activity Questionnaire \(IPAQ\)](#)) and perceived support from family and friends/coworkers (using the [Social Support for Diet and Exercise](#)). The IPAQ uses 3 questions to assess the

number of times per week spent walking and performing moderate and vigorous exercise. The Social Support for Diet and Exercise rates the perceived support for adaptation of new dietary behaviors and exercise routines, respectively, by family members and friends/coworkers. Over 600 participants responded to the pre-competition survey and almost 400 responded to the post-competition survey, with 236 employees responding to both. Of these, almost forty percent (39.3%) reported an increase in days per week spent walking for 30 minutes or more; 37% increased the frequency of days per week engaging in moderate-intensity exercise; and over one-third increased the frequency of days per week engaging in vigorous-intensity exercise. Two-thirds of employees reported an increase in the social support from family and friends/coworkers when attempting to implement dietary changes. Half of employees also reported an increase in the support received from family and friends/coworkers when implementing new exercise routines. These increases in social support may be evidence of adaptation of healthier behaviors both inside and outside the workplace.

Worksite weight loss initiatives can be designed to help employees succeed in losing weight. This requires fostering a supportive workplace environment, including education, incentives, and increased access to skilled professionals and outside resources to make it both possible and easier for employees to adopt healthy living behaviors. Einstein has created an infrastructure that encourages and motivates employees to adopt healthier lifestyles. Moving forward, the program hopes to expand to weight maintenance to focus on sustained weight loss, identify which employee characteristics are associated with greater drop-out rates in order to provide additional tailored support, and continue to develop and cultivate collaborations with outside vendors.

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## POPULATION HEALTH FORUMS

### Transforming Health Care in Pennsylvania: Preparing for the Future

**Michael Consuelos, MD, MBA, FAAP**

*Senior Vice President*

*The Hospital & Healthsystem Association of Pennsylvania (HAP)*

*December 10, 2014*

Turning the somewhat vague vision of a healthy Pennsylvania into a hardnosed reality is a major challenge, given that the state scores poorly in many indicators of health.

At a recent JSPH Forum, Michael J. Consuelos, MD, MBA, senior vice president at the Hospital and Health System Association of Pennsylvania (HAP) spoke on the challenges of preparing the current system of care to be more accountable for health outcomes. Dr. Consuelos is responsible for facilitating the work of HAP with its member hospital and health system leaders to promote innovative ways of improving health care delivery.

A pediatrician, Consuelos has an MD from the University of Pennsylvania and an executive MBA from the Pennsylvania State University Smeal College of Business.

He believes that health care in Pennsylvania is at a critical juncture, one in which greater collaboration between physicians and hospitals can create improved quality and drive community health efforts.

What HAP is doing to bring about that transformation, he said, is to focus on integration of care, community health and well-being, and population health metrics... all of which, he said, will result in a better experience for patients and consumers; healthier communities; lower annual growth in per capita spending and financial sustainability for providers to achieve these goals.

Dr. Consuelos outlined five strategic priorities for HAP that will help accomplish these goals:

- Serve as a catalyst for integrating care across the continuum, specifically by facilitating dialogue among providers and by removing barriers to coordination of care;
- Expand HAP's role as a convener of stakeholders within healthcare and particularly by encouraging them to understand consumer health needs;

- Engage the broader healthcare community in advocacy and in working to achieve better health;
- Become more consumer focused, in part by conducting consumer research and creating a consumer advisory council; and
- Champion hospital priorities related to strengthening health care financing and the operating environment. This means in part advocating for fair Medicaid and Medicare payments and increasing health coverage for low income or uninsured patients.

Among the enabling strategies for these, said Dr. Consuelos, is to strengthen HAP's technology platform and data analytic capacity and to develop a business model to sustain the Association's new vision.

## POPULATION HEALTH FORUMS

### Politics, Poverty and Hunger: The Population Health Impact

#### **Mariana Chilton, PhD, MPH**

*Associate Professor*

*Drexel University School of Public Health  
January 14, 2015*

"Working on hunger is difficult" explained Mariana Chilton, PhD, MPH as she opened the 2015 season of the JSPH Forums. Dr. Chilton has devoted much of her career to hunger, poverty, children's health, and policy issues. She is an Associate Professor at Drexel University School of Public Health, and Director of the Center for Hunger-Free Communities, and is Co-Principal Investigator of Children's Health Watch. She founded Witnesses to Hunger, a participatory action group, and has testified before the U.S. Senate and U.S. House of Representatives on the importance of child nutrition programs and other anti-poverty policies.

Chilton described hunger as an "experience of shame" and used the term, "food insecurity" to describe the lack of access to enough food for an active and healthy life. She went on to discuss the relationship between food insecurity and public policy. Throughout her presentation she focused on children and illustrated the connections between hunger, poverty, and health outcomes. Chilton provided an overview of "toxic stress," which in her view encompasses nutritional deprivation and economic hardship. Poverty, she explained, should be looked at as a childhood disease.

Public health policies to decrease child poverty should include good nutrition, supports for working families, and adequate public assistance that promotes health. Aside from the familiar food stamp programs, other programs such as energy assistance can also play a role in decreasing poverty and improving health.

Chilton challenged the audience to examine how public assistance interacts with the labor market. What happens when families lose benefits as a result of working? She believes this can impact food insecurity and child hunger. It is important to have family-friendly policies. Chilton also stressed the importance of analyzing current assistance programs and work on improvements, while looking at other interventions beyond public assistance.

"We must be willing to talk of the nuances of promoting self-sufficiency...we must have a fearless and sustained dialogue." Chilton's obvious passion for these issues was inspiring and thought provoking.

**To view slides and listen to audio recordings of JSPH Forums visit: [Jefferson Digital Commons](#).**

## IN THE NEWS

### Pediatrician and JSPH Student Passionate About Helping Families of Children with Obesity



**Thao-Ly Phan, MD**, a Pediatrician at Nemours Children's Health System and a student in the MPH program at JSPH, recently published "Disparities in parent confidence managing child weight-related behaviors" in *Patient Education and Counseling*. The article is based on a pilot study for her Capstone project that found that parents of young children with obesity report low self-efficacy managing their child's behaviors and that ethnic disparities in this construct exist.

Dr. Phan believes that parents play a large role in helping their children make healthy choices. Parents are responsible for ensuring a health environment for their child to grow and thrive in and most importantly they are responsible for managing their child's behaviors in a positive yet authoritative manner.

Dr. Phan explains, "working with families in the Nemours Weight Management Clinic, I hear about parents and their struggles managing behaviors like tantrums about food and sneaking food that are often not given light in public health discussions about obesity."

The study highlights the need to ensure that interventions address these behaviors and are culturally-sensitive in their approach so that disparities in obesity among children are effectively addressed.

*Thao-Ly Phan, MD is expected to graduate from the Jefferson School of Population Health MPH program in May 2015.*

## Guiding our Master of Public Health (MPH) Program: The Value of a Community Advisory Board

Since the inception of JSPH in 2008, the MPH program has worked closely with a Community Advisory Board (CAB). The growth of the MPH over time has created a need to broaden the scope of the CAB. The purpose of this change is to expand the focus of the MPH program through greater community voice from a wide range of health and social service professionals representing numerous organizations and initiatives in the greater Philadelphia region. This input will help guide our MPH program over the next several years and contribute greatly to the development of self-study as we prepare for the [Council of Education for Public Health \(CEPH\)](#) re-accreditation site visit in May 2016.

The MPH CAB will review key documents and provide recommendations on major components of our self-study. This review will include an evaluation of the program's goals and objectives, the quality of our program, faculty and student achievements, program infrastructure and sustainability, workforce development, and diversity.

Eighteen public and community health and social service professionals have agreed to serve on our program's CAB. Representatives from federal and local public health agencies, non-profit community health coalitions and organizations, private foundations, health insurance organizations, public health programs from other universities, and MPH program alumni participate in our MPH CAB, chaired by Mahak Nayyar, MPA, FCPP, Deputy Regional Health Administrator for the Region III Office of the U.S. Department of Health and Human Services.

At each meeting, representatives share their highlights of current programs and focus on opportunities for our MPH program and students to become directly engaged in important initiatives that impact on public health directly or indirectly via key social determinants of health. Examples of such future initiatives include:

- A collaboration with Pathways to Housing and the Bryn Mawr School of Social Work and Social Research for public health and social work students to be trained to work with homeless populations;

- Working with populations and service organizations on a re-entry from prison coalition; and
- Community health assessments, programs and policies engaging planning agencies and public health. These initiatives were originated through representatives on our MPH CAB from the Center City District, the Federation of Neighborhood Centers, and the Philadelphia City Planning Commission and Department of Public Health.

We look forward to the continued engagement, and support from members of our MPH Community Advisory Board in the years ahead to accomplish our MPH Program Mission to: "Develop future public health leaders through multidisciplinary and experiential education, research, practice and service in order to improve and sustain the health and well-being of populations."

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