Jefferson

# Population Health Matters

School of Population Health
Spring 2015 | Vol. 28, No. 2

GUEST EDITORIAL

Quarterly Publication

## End-of-Life Care: Crossing the Bridge from Treatment to Support

With the aging population in the United States projected to reach 83.7 million by 2050, it is more important than ever to ensure that sufficient resources and services are available to support patient-centered palliative care. The quality and costs of end-of-life care can be improved through difficult but honest discussions, shared decision-making and financial reimbursement with incentives to support implementation of advance care plans that reflect patients' wishes.[1,2]

Over the past four decades, our knowledge regarding the aging process, extended longevity, and end-of-life treatments has expanded tremendously.[1] The spectrum of sophisticated diagnostics and innovative procedures for managing illness and delaying death have served to strengthen the traditional medical paradigm of paternalistic care in a death-averse society. "[S]cientific advances have turned the process of aging and dying into medical experiences, matters to be managed by healthcare professionals...and we... have proved alarmingly unprepared for it," writes noted surgeon and author Dr. Atul Gawande, who explores these issues through professional practice, research, and personal experiences in his recent book, *Being Mortal*.[2]

There is national concern for the significant costs—economic and otherwise—associated with continued aggressive care for serious and terminal illness to patients, families and health systems. Research and clinical evidence demonstrates the value of engaging patients and families in discussions about current clinical status, treatment options, patient preferences, and designation of surrogate decision makers in advance care plans. To that end, leading organizations, including the National Quality Forum (NQF), the Institute of Medicine (IOM), the American Society of Clinical Oncology (ASCO), and the National Hospice and Palliative Care Organization (NHPCO) have identified advance care practices (including integrated palliative care) as major quality indicators associated with good end-of-life care.

Treatment teams grapple with incorporating objective quality measures, due to complex and competing options, which often arise during time-sensitive situations. Clinicians are frequently confronted with time constraints, as well as uncertainty about treatment outcomes and prognosis. This has led to repeat hospitalizations and intensive care stays associated with invasive services that are of limited benefit, and delayed decisions for transitions to supportive and comfort care, prolonged suffering, diminished quality of life and extended bereavement for families.[1,2] Additional challenges exist in those situations where patients have not communicated their preferences about end-of-life care and support.[2]

Discussing end-of-life care where prognoses are poor and recommended treatment options are limited, uncertain, or have been exhausted is difficult but necessary for patients, families and healthcare professionals.[2] Clinicians have reported a lack of experience broaching these topics, a sense of incompetency or failure to facilitate 'better' outcomes, and emotions about our

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their mortality as contributing factors.[2] Dr. Susan D. Block, a palliative care expert at the Dana-Farber Cancer Institute and the Harvard Medical School Center for Palliative Care, recommends also asking patients about their values and cultural beliefs; concerns about what to expect; trade-offs they are willing to make; how they want to spend their time if their health worsens; who they want to make decisions on their behalf if their health worsens and end-of-life preferences.[2,3,4] Over the course of illness, patients, families and caregivers can assess and revise care plans through shared decision making. Patients may choose to decline recommended treatments, seek alternative treatments and/or discontinue all treatment to achieve their best quality end-of-life. Key decisions should be documented in advance care plans, including legally executed documents (e.g., health care proxy, durable power of attorney, living will).

It is just as imperative to consider the ethical issues inherent in end-of-life planning as it is to address the clinical challenges—both in training and practice.[4] Clinicians must respect patients' choices and accept those decisions, even when they conflict with their professional or personal judgment about recommended care and avoiding harm.[2] While patients may not have the medical expertise to independently choose the most appropriate treatment options, they have the legal and ethical prerogative to define what their highest quality of end of life will be and when.

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# What's in a Name? JSPH Introduces Master of Science and Certificate Programs in Population Health

The Jefferson School of Population Health first opened its doors to students in September 2009. As the first School of Population Health in the country, there was much discussion – both positive and negative – about the appropriateness of the unusual name. Most were puzzled by the title or clueless as to what it meant. Many told us it was a mistake. Population health is a "fad" – here today and gone tomorrow. We should stick with something more recognizable, like "health policy" or "public health." Little did these skeptics realize that we were, literally, on the cutting edge of a major revolution in how we think and act about health care.

Health systems in the United States and around the world are confronting ever-rising costs, poor outcomes and economic inefficiencies. Population Health has emerged as a broad-based response to these challenges and is a key component of the Affordable Care Act: it aims to prevent and cure human disease through social interventions that engage the community and the larger society by integrating clinical care and public health practices in a new paradigm of health delivery. This approach differs greatly from conventional health care by replacing the volume of services rendered with an emphasis on value of care delivered.

There is increasing demand for practitioners who can navigate this complex and rapidly changing landscape. A recent analysis of help-wanted postings on a popular employment website (Indeed.com), for example, revealed a 20,000% (!) increase since 2006 in the number of jobs including "population health" in the description. The ads call for experts who can assume leadership and management roles in Accountable Care Organizations (ACOs) and other integrated healthcare delivery systems, hospitals, healthcare provider organizations, health insurers, third-party administrators, pharmaceutical companies, healthcare consulting firms, government agencies, and community-based advocacy and service organizations.

Responding to this demand, the Jefferson School of Population Health now offers the nation's first graduate programs in population health designed specifically for experienced health practitioners wishing to succeed in this new environment. The Certificate in Population Health provides seasoned health professionals a comprehensive foundation in the essentials of population health — new care-delivery structures, socioeconomic determinants of disease, data analytics, health finance/risk, and the basics of healthcare quality and safety. The Master of Science in Population Health (MS-PopH) offers additional skills required for leadership positions — health care policy development, epidemiology, outcomes analysis, coalition building and stakeholder management. Master's students also develop proficiency in the application of population health skills and principles, culminating in a Capstone project where theory and lessons learned are applied in real-world settings. All coursework taken for the Certificate can be applied to the Master's degree.

In the multi-year journey to prepare this new curriculum, JSPH developed and conducted a survey to identify and weigh key topics that should be included. This detailed survey (125 items taking at least 20 minutes to complete) was sent to more than 8,000 health professionals on the JSPH contact list, in addition to authors who have published scientific articles in the field. More than 700 professionals took the time to respond and sent 100+ pages of detailed comments. Incorporating this feedback, the resulting population health curriculum builds on public health and clinical care foundations by:

- Connecting prevention, wellness and behavioral health science with healthcare delivery, quality and safety, disease prevention/management and economic issues of value and risk – all in the service of specific populations and sub-populations.
- Stresses socio-economic and cultural factors that determine the health of populations and addresses policies that address the impact of these determinants.
- Employing epidemiology and biostatistics in new ways to analyze clinical data, model disease states, map their incidence, and design social and community interventions.
- Including social, economic and behavioral theory to develop new models of healthcare delivery that stress care coordination, accountability and community engagement.

MS-PopH CURRICULUM (39 credits)

***U.S. Healthcare Organization and Delivery (3)***

***Essentials of Population Health (3)***

***Introduction to Healthcare Quality and Safety (3)***

***Health Economics, Risk & Finance (3)***

***Health Informatics & Population Health Analytics (3)***

***Disease Prevention and Care Management (3)***

*Health Law and Regulatory Issues (3)*

*Epidemiology & Evidence for Outcomes Research in Population Health (3)*

*Health Policy: Analysis & Advocacy (3)*

*Organization Development & Change in Health Care (3)*

*Population Health Management Applications (3)*

*Capstone Seminar (3)*

*Capstone Project (3)*

**Bold = Certificate (18 credits)**

JSPH's population health programs are designed specifically for working professionals seeking part-time educational opportunities. All courses are offered exclusively online using best practices, asynchronous interactive learning and practitioner faculty with years of experience and recognized expertise. Three 14-week terms per year, beginning in September and ending in July, enable students to complete the Certificate in 12 - 20 months and the Master's degree in two to four+ years, depending on their chosen pace through the program.

For more information, or to sign up for an online information session, click here.

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THE FIFTEENTH

# Population Health Colloquium

## Thank you to our attendees, speakers, sponsors and exhibitors for making the 2015 Population Health Colloquium a success!

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# Early Mobilization of Intensive Care Unit Patients: An Interdisciplinary Approach

Early mobilization of patients in the intensive care units (ICUs) is a significant advancement in the treatment of critically ill ventilated patients. Early mobilization culminates in the act of getting patients out of bed while in the intensive care unit and while they are still on ventilator support, instead of waiting to do so until after they leave the unit. This progressive approach is changing the culture and the mindset of the ICU team. Without early mobilization, patients that have survived a prolonged ICU course due to critical illness are at higher risk for mental health problems (including anxiety, depression and post-traumatic stress disorder), and decreased ability to perform activities of daily living (ADLs) up to one year after discharge and neuromuscular abnormalities up to 5 years.[1] The literature has shown that early mobilization results in earlier independence with ADLs, increased strength, improved ambulation, decreased ICU delirium days, decreased ventilator days, and decreased ICU acquired paresis.[2,5] This approach requires significant coordination among the members of the interdisciplinary team (IDT) and increased therapist time devoted to the ICU patients, which is why it is part of a larger effort to keep patients awake and off sedatives. For ICU staff, this is a significant culture and process change, and issues of culture need to be addressed for the program to be successful.

In the spring of 2014, an IDT at Thomas Jefferson University Hospital (TJUH) developed and implemented an early mobilization program, with the goal of reducing ventilator days and decreasing ICU length of stay. This program was developed based on the current literature and adapted from the practices at Vanderbilt University Medical Center in Nashville, TN, as the practices from Vanderbilt were an easy-to-use digestion of all the available literature on prevention of long-term sequellae of an ICU stay.[3,5] The criteria for patient participation and progression in The Early and Progressive Mobility Protocol were created utilizing objective testing and mobility grading to ensure IDT carryover and patient safety in the program (Table 1).[3] The interdisciplinary team consists of physicians, nurses, pharmacologists, respiratory therapists, physical therapists, occupational therapists, speech therapists, and case managers. This effort was part of a larger initiative to reduce length of stay and sedative use in the ICUs called the ABCDE bundle (Spontaneous **A**wakening Trial, Spontaneous **B**reathing Trial, **C**hoice of Medical Therapies, **D**elirium, **E**arly and Progressive Mobility.)[3,5] The IDT conducts rounds daily on each patient to address the components of the ABCDE bundle and determine patient specific goals for the day. During the process of implementation, one of the authors (NSA) noticed that the education process was taking place in silos instead of in an interdisciplinary manner, and that not all units were using daily IDT rounds. She facilitated the development of a half-day interprofessional workshop that was held in conjunction with the Jefferson Center for Interprofessional Education (JCIPE) that incorporated TeamSTEPPS[4] training along with brainstorming of barriers and possible solutions. Based on surveys, the participants felt more confident in implementing the bundle after the workshop.

Once a patient is conscious, early mobilization starts. Physical and/or occupational therapists will perform an evaluation to determine the patient's current strength, functional mobility, ability to perform ADLs, and cognitive status. Vital signs and patient symptoms are closely monitored to determine how the patient is tolerating the session and if he/she is able to progress to the next level of early mobility. The treatment sessions are geared towards improving strength, balance, cardiopulmonary endurance, patient/family education, patient's ability to participate in ADLs, and cognitive retraining. It is also the role of the rehabilitation team to assist with discharge planning by identifying what services or supports the patient will require after hospitalization. Often times, this patient population benefits from a rehabilitation stay after hospital discharge. The goal of the program is for early mobility to be the standard of care in

*Continued on page 6*

## Table 1: Criteria for Early Mobilization

| Early and Progressive Mobility Protocol Level | Protocol |
|---|---|
| **Level 1**<br>**Unconscious Patient** | Passive Range of Motion twice daily<br>Turn every 2 hours |
| **Level 2**<br>**Conscious Patient, progress levels as tolerated** | Active Assisted and Active Range of Motion<br>Turn every 2 hours<br>Sitting Position 20 minutes three times daily |
| **Level 3**<br>**Conscious Patient, progress levels as tolerated** | Active-Assisted and Active Range of Motion<br>Turn every 2 hours<br>Sitting Position 20 minutes three times daily<br>Sitting on Edge of Bed |
| **Level 4**<br>**Conscious Patient, progress levels as tolerated** | Active-Assisted and Active Range of Motion<br>Turn every 2 hours<br>Sitting Position 20 minutes three times daily<br>Sitting on Edge of Bed<br>Active Transfer to Chair 20 minutes per day<br>Ambulation (marching in place, walking in halls). |

*Absolute Contraindications: Venous-Arterial Extracorpeal Membrane Oxygenation with Femoral Cannulation; Skeletal/Buck's Traction for Unstable Fractures or Any Unstable Fracture; Unstable Spine per Orders; Untreated or Suspected Cardiac Tamponade; and Intra-Aortic Balloon Pump with Femoral Insertion.*

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a protocolized fashion, so there is no need for Physical Medicine and Rehabilitation (PM&R) physician involvement for routine cases. When cases are more complex, especially for patients with pre-existing disability or new neurologic deficits, the PM&R physicians are utilized to assist with developing a clear picture of the medical and functional goals and a plan of care.

Since the JCIPE interprofessional workshop, IDT rounds in the medical ICU now include physical and occupational therapy in addition to respiratory therapy, nursing and physicians. The Cardiovascular ICU and the Surgical ICU have also implemented IDT rounds with multiple disciplines present since the JCIPE interprofessional workshop. This demonstrates increased team cohesion, as there is improved communication during daily IDT rounds and the IDT members' understanding of the benefits of early mobility based on anecdotal reports by therapists. A culture shift has been observed on the floors by the rehabilitation team, with the ICU teams developing enthusiasm for mobilizing these patients earlier in their hospital stay; previously it was difficult to obtain their help and buy-in. Throughout the development and implementation of this protocol, data collection is ongoing to determine the overall impact on TJUH ICU patients. The goal is to continue to adjust our approach in response to patient outcomes in order to meet the needs of our clientele in an ever-changing healthcare system.

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# Jefferson's New Smoking Policies: Steps Toward a Healthier Work Environment

Tobacco use in America is a grave problem that affects millions of lives every year. Although rates of smoking in the United States have decreased in the past 50 years, nearly 18% of all US adults (more than 40 million people) continue to smoke cigarettes.[1] Moreover, smoking remains as the largest cause of preventable disease and mortality in this country.[2] Smoking cigarettes results in negative economic costs to an individual and the community. The estimated costs of smoking in the US are around $133 billion in direct medical costs and, moreover, about $150 billion in productivity losses each year.[3] In Philadelphia 23% of adults smoke, representing the highest adult smoking rate among the 10 largest US cities.[4]

The City of Philadelphia has two main tobacco policies designed to protect Philadelphians from tobacco-related illness: The *Clean Indoor Air Worker Protection Law*, which protects workers from secondhand smoke (SHS) in all workplaces, and the *Smokefree Parks and Recreation Centers Initiative*, which makes Philadelphia parks and recreations centers 100% smokefree.[5] Also significant is Philadelphia's $2 tax on packs of cigarettes, which is expected to reduce smoking rates among adults. Further, Philadelphia-area universities[6], including some academic medical centers[7], have adopted tobacco-free policies in an attempt to reduce negative impacts of smoking among their students, employees and patrons of their services. These types of legislative efforts and organizational policy changes have been shown to effectively reduce the prevalence of primary smoking, increase cessation attempts and lower exposure to SHS at the organizational and population levels.[8, 9, 10]

Recently, the entire Jefferson enterprise (including the university, hospital, and related physician practices) implemented two initiatives designed to reduce the health impact of smoking among employees, students, patients, and other patrons. The first initiative, the Tobacco-Free Environment Policy (effective April 1, 2014), prohibits the use of all tobacco products on campus, within all Jefferson-owned buildings, and most public outdoor spaces. The second initiative, the Nicotine-Free Hiring Policy (effective July 1, 2014), maintains that Jefferson will no

longer hire tobacco users, and will provide incentives for current employees who use tobacco to quit, including low-cost classes and discounts on health insurance premiums after quitting for 90 days. The main goal of both initiatives is to create and maintain a tobacco-free environment to "promote the safety, health, and wellness of all patients, employees, volunteers, faculty members, students, vendors, and visitors" at Jefferson.[11]

While empirical studies have shown that smoke-free workplace policies have been beneficial for the health of workers,[12] the Jefferson tobacco-free initiatives have met some resistance. Opponents of the Nicotine-Free Hiring Policy contend that the policy discriminates against smokers because potential candidates are excluded based on personal behavior that is seemingly unrelated to job performance. Further, critics state that such policies may inadvertently serve as a barrier to employment for minorities and those with low income because these groups have a higher prevalence of tobacco use.[13, 14] Finally, smokers complain that the Tobacco-Free Environment Policy, which is enforced by Jefferson security, leaves them nowhere to smoke on campus.

Despite these arguments, the implementation of Jefferson's tobacco policies is an important step toward a healthier Jefferson. First, the Tobacco-Free Environment Policy makes the healthy choice (i.e. not smoking on campus) the easy choice and ensures that our students, employees and patients can breathe clean, non-carcinogenic air. Second, the Nicotine-Free Hiring Policy excludes smokers because smoking has a negative effect on job performance, through decreased productivity and increased absenteeism. Recent research concludes that smokers have a 33% higher risk of absenteeism compared to nonsmokers[15] and cost private employers an additional $5,816 annually per employee.[16] Finally, although empirical studies have not found that Nicotine Free Hiring Policies reduce employment opportunities for demographic groups with higher smoking rates, this possible effect should be considered and evaluated.

To support the implementation of these policies, Jefferson has worked hard to provide incentives to employees who are current smokers in their attempts to quit. Ongoing cessation programs are provided as well as a Buddy Program that pairs smokers with employees who have successfully quit and serve as mentors throughout the cessation process. In an interview, Anna Tobia, PhD, the director of the JeffQuit cessation program on campus, highlighted that a main advantage of cessation on campus is that it is reimbursable by insurance for Jefferson employees. Dr. Tobia stated, "We are encouraged by the University and Hospitals' strong policy on helping people to not smoke, and we're really excited that they made sure that the insurance company…would reimburse at 100% for Jefferson employees. (Jefferson) had a strong commitment to employees getting healthy, doing this (JeffQuit program) and getting their money back…Jefferson really stepped up to make this happen."

The policy changes are most important because they support Jefferson's mission of *Health is All We Do*, and are also compatible with the objectives of hospitals to improve the health of patients. In addition to the positive effect on individual workers, these policies may help shift the norms of tobacco use toward abstaining from tobacco initiation, and also present immediate incentives for quitting. These two new policies represent big changes and have the potential to improve the health of the Jefferson community; this is a positive step toward making Jefferson a healthier place.

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# Jefferson's Center for Refugee Health: A Model of Community Collaboration

Jefferson's Center for Refugee Health (CRH) aims to deliver compassionate, comprehensive, and longitudinal health care for refugees who have resettled in Philadelphia, PA while also supporting educational and research activities that help to advocate for refugees. The CRH delivers clinical care within Jefferson Family Medicine Associates (JFMA), an urban, ambulatory, primary care practice housed in the Department of Family and Community Medicine at Thomas Jefferson University. In 2007, JFMA partnered with the Nationalities Service Center (a local immigrant and refugee social, legal, and educational support organization) to pilot a refugee health clinic. Serving 75 refugees in its first six months of operation, the CRH has grown over the past seven years to provide initial health assessments and ongoing primary care to 1,500 refugees from 26 different countries, including Bhutan, Burma, Iraq and Eritrea. Currently, the CRH cares for one-third of the approximately 750 refugees resettled in Philadelphia annually.

The CRH provides a full range of medical services from initial medical screenings to pediatric, adolescent, adult, obstetric/gynecological, geriatric, and inpatient care. To meet the needs of the growing population of refugees resettled locally, the clinic now takes place twice each week and includes sessions dedicated to women's health and home visits. The CRH places particular attention on providing a timely domestic medical examination for newly arrived refugees to improve health and familiarize refugees with the healthcare system in the United States.

The CRH educates family medicine residents to provide culturally-humble evidence-based care for this socio-medically complex population. Marc Altshuler, MD, Director of the CRH and an Associate Professor within the Department of Family and Community Medicine, supervises clinical care for refugee patients including their initial medical screenings, follow-up visits, and coordination with specialists. He also serves as the faculty advisor for Jefferson's Refugee Health Partners, an interdisciplinary organization led by medical students to advocate for the health and well-being of refugee communities. Family medicine residents and fellows often serve as preceptors at the free bimonthly clinics organized by Refugee Health Partners in the community. CRH encourages an interprofessional framework by fostering involvement and collaboration between students of medicine, pharmacy, social work and public health. This experience provides students with the opportunity to expand their competencies as well as to learn how to work effectively within an integrated healthcare team. Members of the team gain exposure to conditions less commonly seen in Philadelphia (such as malaria and schistosomiasis) as well as different presentations and patient experiences of common conditions including hypertension, diabetes, and hepatitis. Importantly, these students directly contribute to improved access and quality of care provided to refugees.

The CRH has performed quantitative and qualitative studies to strengthen surveillance, improve quality, and inform chronic care management among newly-arrived refugees. These studies have focused on chronic disease, communicable disease, women's health, geriatric care, mental health, immunizations and pediatric growth. Findings from the research provide data needed to advocate for increased local programs, evidence-based policies and practices, and improved screening abroad. Results have been disseminated in six peer-reviewed manuscripts and over 40 conference posters and presentations. The CRH model has been replicated at five other academic primary care centers and a federally-qualified health center.

In addition to care, education, and research, the CRH also advocates for refugees, asylees, and other immigrant populations at the local, state and federal levels. Together, the CRH, partner clinics, and three refugee resettlement agencies founded the Philadelphia Refugee Health Collaborative to enhance local capacity to support refugee resettlement. The collaborative has improved access to medical screenings and ongoing quality healthcare for all refugees, and in doing so it has contributed to more

successful resettlement and less traumatic acculturation. Timely access to medical care translates to timely entrance to schools and the workforce as part of cultural integration. The CRH personnel consult for other practices and states to promulgate the integrated core model, which includes initial screening directly transitioned into longitudinal care. Since 2011, the CRH and Philadelphia Refugee Health Collaborative have hosted site visits from the Office of Refugee Resettlement, the Centers for Disease Control and Prevention, and the International Organization for Migration. The CRH used these opportunities to share experiences and offer evidence based suggestions to improve access, quality, and efficiency. One recent success was obtaining funding from the state to support a dedicated position within the Philadelphia Department of Public Health to improve tracking and treatment of tuberculosis.

In the future, the CRH plans to continue delivering quality care to refugees while offering research and advocacy opportunities for members of the community and health professionals across disciplines. The partnership between the CRH and Nationalities Service Center has facilitated the identification of community needs, while allowing for ongoing adaptation as the demographics of the population change and as new disparities are recognized. Meanwhile, the CRH along with the Philadelphia Refugee Health Collaborative are making strides to establish and provide coordinated care for the refugees of Philadelphia with the eventual goal of improved healthcare outcomes for refugees across the United States. The CRH continues to look for additional partners to forward the goal of improving access to quality healthcare while preparing providers across the disciplines to participate in these activities.

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# When Policy Meets Practice: A Trip to Harrisburg

On February 27, 2015 students in the Policy and Advocacy class taught by MPH Program Director, Dr. Robert Simmons, had the privilege of meeting with various distinguished members of the Pennsylvania Department of Health as well as the Executive Director of the House Republicans Health Committee.

We were warmly greeted by Deputy Secretary of Health Planning and Assessment Marty Raniowsky, who opened for Dr. Karen Murphy, the Acting Secretary of the Pennsylvania Department of Health. Dr. Murphy, although being in her position for a matter of weeks, was well-versed and eager to share with us the Department of Health priorities and policies. She was gracious enough to answer our questions, which included a broad range of public health topics.

For the next hour and a half we had an insider's look at the various programs run by the PA Department of Health. We had a question and answer session with Robin Rothermel from the Bureau of Communicable Diseases, Douglas Koszalka from the Bureau of Community Health Systems, Tomas Aguilar from the Bureau of Health Promotion and Risk Reduction, Ram Nambiar from the Bureau of Epidemiology, and Jay Taylor from the Bureau of Health Preparedness. As we left the information session, we all had the feeling that Pennsylvania is at the vanguard of emergency preparedness. Furthermore, they have built a strong framework within which the different public health disciplines can execute their functions effectively both as a unit and individually.

*Top row left to right: Edward Jasper, Martha Romney, Komal Patel*

*Middle row left to right: Melissa DiCarlo, Jameice Decoster, Audrey Tiberio, Nicole Fernandez, Neda Bionghi, Elizabeth deArmas, Miyori Panis, Karie Youngdahl, Bhagwate Mansi*

*Bottom row left to right: April Smith, Rishi Thaker, Gabriel Meshekow, Hirsh Sharma, Tara Ketterer, Thao-Ly Phan, Rob Simmons*

After lunch in the cafeteria, we met with Whitney Krosse, General Counsel and the Executive Director for the House Republican Health Committee. Ms. Krosse was kind enough to speak to us about upcoming legislative issues. Specifically, issues surrounding physician reimbursement for

*Continued on page 10*

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chemotherapy treatments and welfare assistance for Megan's Law offenders. Again, we were amazed at the generosity of time and energy that was given to our group.

Lastly, we were treated to a personal tour of the Capitol Building, where we not only learned about the various pieces of art and architecture, but also saw the rooms where the real action happens. In addition to where the Senate and House meet, we also saw the Pennsylvania Supreme Court. The stained glass, marble, and tile work were a splendor to behold.

Each of us was inspired by the trip, especially the fact that the Department of Health is run by such an accomplished and capable woman. We were honored that she recognized Jefferson's ongoing collaboration with the Department. As students, it was heartening to see the state of Public Health today and exciting to know that we will be a part of its future. Lastly, we owe a debt of gratitude to Dr. Robert Simmons, without whom this trip would not have been possible.

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# STUDENTS IN THE NEWS

## JSPH Students Awarded Scholarships

*Left to right: Joseph S. Gonnella, MD, Distinguished Professor of Medicine; Hirsh Sharma, MD/MPH Student and recipient of the Joseph S. Gonnella Scholarship; David B. Nash MD, MBA, Dean, JSPH; Britany Haltzman, MPH Student and recipient of the John Ekarius Scholarship; and John Ekarius, Executive VP and COO, Jefferson.*

## Public Health Student Organization Receives Recognition


*JeffSAPHE (Student Activities for Public Health Education) received the recognition, "Team Effort of the Year" award from the Office of Student Life and Engagement*

*JSPH MPH Students, Brittany DiVito, Elizabeth deArmas, and Philip Manasseh.*

## JSPH MPH Students Win Philadelphia Public Policy Case Competition

*The Winners: Rachel Powell, Brittany Haltzman, and Amber Bowie.*

*For more information click here.*

## "Raising the Grade" JeffSAPHE Hosts National Public Health Week Event on Maternal and Child Health

*Top row left to right: Philip Manasseh, Vincent Basile, Gabriel Meshekow, Brittany DiVito, Rishi Thaker*

*Bottom row left to right: Connie Choi; Elizabeth deArmas; Mazvita Nyamukapa, JSPH MPH Alumna; Assistant Director, Early Head Start, Maternity Care Coalition, and featured presenter.*

# The Unmet Eye Care Needs in Diabetic Patients on Hemodialysis

Type-2 diabetic nephropathy is a common cause of increasing prevalence and incidence of end-stage renal disease (ESRD).[1] Diabetic nephropathy results from damaged vessels that filter wastes. As the disease progresses, type-2 diabetic patients with ESRD, can develop retinopathy. The Trial to Reduce Cardiovascular Events with Aranesp Therapy (TREAT) showed that retinopathy was present in 47% of individuals with type 2 diabetes, chronic kidney disease (CKD) and anemia.[2]

Despite the potential for retinopathy, diabetes patients with ESRD underutilize eye care services. A study showed that only 25% of hemodialysis patients with diabetes had annual eye exams, yet diabetic retinopathy was found in 45% of the patients of the cohort.[3] Due to the nature of the disease, individuals tend not to seek eye care because they are symptom-free until they experience significant vision impairment. Additionally, hemodialysis can take up nearly 7-8 hours per day for 3-4 times a week. Consequently, patients frequently experience "treatment fatigue" and may not be willing to seek out eye care.

Hemodialysis can be a significant financial burden for patients, especially since it may not be covered by insurance. They may have limited finances available to cover the cost of eye exams and therefore be unable to utilize that healthcare service. Employability can also be an issue for patients receiving treatment in hemodialysis centers multiple times a week may be unable to secure full-time employment. This can have a significant impact on their work status and earning potential, further limiting their access to eye care services due to financial limitations.

This high-risk hemodialysis population also faces challenges in obtaining eye care due in large part to comorbidities that may be perceived to be more pressing. These comorbidities include hypertension, cardiac-related issues, dyslipidemia, and complications from end-stage renal disease (e.g., renal osteodystrophy and peripheral neuropathy). Each of these conditions requires care from various healthcare practitioners. Additionally, time and transportation can be greater challenges to this patient population than most.

At Wills Eye Hospital, a research team supported by intramural funds will test the hypothesis that there is a critical population health need for improved access to eye care by hemodialysis patients leading to undiagnosed diabetic retinopathy in this population. The study is a prospective cohort design with a single patient encounter. It includes diabetic patients at two hemodialysis centers; one urban (Walnut Towers, in downtown Philadelphia) and one suburban (Marlton, New Jersey). Of the 66 patients at the Marlton site and 100 at the Walnut Towers site, it was estimated that 70-100 total had diabetes. The inclusion criteria enrolled adult diabetes patients who were able to consent in English. The patients' demographics, last dilated eye exam, last podiatry exam, barriers to specialty doctor examinations, visual function (NEI VFQ-9), and patients' pharmacy satisfaction will all be assessed via a survey. The research assistant will administer the survey while the patients are receiving hemodialysis. Following hemodialysis, the research assistant will measure visual acuity and take an undilated fundus photo of each eye using a non-mydriatic camera. The results of the eye photographs will be notified to the patients along with recommendation of a follow-up eye care in coordination with the Hemodialysis Director.

The study has the potential to identify a gap that may exist in a high-risk diabetes population. Additionally, diagnostic imaging of the undilated fundus presents a way to identify hemodialysis patients that may need earlier treatment. These tools have overcome the eye-care screening barriers and help to identify those needing treatment earlier, lowering the economic burden to the system and improving vision outcomes.

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2. Cardiovascular and metabolic risk: Retinopathy and clinical outcomes in patients with type 2 diabetes mellitus, chronic kidney disease, and anemia. Bello NA, Pfeffer MA, Skali H, et al. *BMJ Open Diab Res Care* 2014;2. doi:10.1136/bmjdrc-2013-000011.
3. El-menyar A, Al thani H, Hussein A, Sadek A, Sharaf A, Al suwaidi J. Diabetic retinopathy: a new predictor in patients on regular hemodialysis. *Curr Med Res Opin*. 2012;28(6):999-1055.

# JSPH Partners with Hearst Health to Offer $100,000 Prize in Population Health

Hearst Health, a division of Hearst Corporation, and the Jefferson School of Population Health (JSPH) of Thomas Jefferson University, have created the annual ***Hearst Health Prize***, a $100,000 cash award given in recognition of outstanding achievement by an organization or individual in managing or improving population health.

The announcement was made at the 15th Annual Population Health Colloquium in Philadelphia by Gregory Dorn, MD, president of Hearst Health, and David B. Nash, MD, MBA, dean of JSPH. The call for submissions will open in the summer of 2015, and the inaugural winner of the $100,000 award will be announced at the 2016 Population Health Colloquium.

"Hearst Health is the ideal partner in awarding this prize for excellence in population health," Nash said. "Hearst's deeply rooted tradition of being independent, unbiased, and evidence-based, along with their proven track record of innovation, is representative of the ideals we pursue and uphold through the Jefferson School of Population Health."

As the administrator of the ***Hearst Health Prize***, JSPH will assemble an interdisciplinary panel of judges to select the winner. JSPH is currently seeking nominations for members of the judging panel, as well as expressions of interest or nominations for Hearst Health Prize entrants. Entries are open to organizations, individuals or institutions who have demonstrated proven outcomes in managing or improving the health of a population through pioneering programs that may incorporate areas such as technology, care delivery, processes, care guidance and more. For details and submission instructions as they become available, please click here.

# JOIN THE GRANDON SOCIETY TODAY!

Jefferson School of Population Health invites you to join the

## GRANDON SOCIETY

a membership organization for individuals and organizations focused on advancing population health.

The Grandon Society is designed for leaders throughout the healthcare sector who are dedicated to transforming the US health care system through 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: Jefferson.edu/GrandonSociety**

**Questions?**
Contact Alexis Skoufalos at 215-955-2822 or Alexis.Skoufalos@Jefferson.edu


*Mark Fendrick, MD a nationally recognized expert in value-based insurance design, leads a special session for Members.*

# POPULATION HEALTH FORUMS

## Transforming the Health Workforce to Improve Population Health: Innovative Approaches in Medical Education

**Malika Fair, MD, MPH, FACEP**
*Director, Public Health Initiatives*
*Association of American Medical Colleges*
*February 11, 2015*

Dr. Malika Fair is the Director of Public Health Initiatives at the Association of American Medical Colleges, (AAMC) where she directs both the Urban Universities for HEALTH initiative and the Centers for Disease Control and Prevention (CDC) Cooperative Agreement with the AAMC. Dr. Fair is also an Assistant Clinical Professor and practicing physician in the Department of Emergency Medicine at The George Washington University.

The central theme in Dr. Fair's Forum presentation focused on improving health equity and population health in the US. The main lever that AAMC has for achieving this is through modifying and enhancing the workforce, particularly the physician workforce. "When thinking about the healthcare workforce taking

care of the populations we have under healthcare reform…business as usual is not okay anymore," states Fair. Tackling ways to improve the workforce that is positioned to improve population health is very important to the AAMC.

Dr. Fair discussed the social determinants of health and the significant role of physicians in influencing health. The important lever for doing this is through partnerships with the public health, social work, and legal communities. From an AAMC perspective, however, the main lever is the health care workforce. Fair went on to describe the imbalances in the physician workforce and quality of care. Fair explained, "Despite our best efforts…we have not improved the rate of having underrepresented minorities in the medical field."

The AAMC is forging ahead on a number of initiatives to address these issues. One program, Urban Universities for HEALTH, is a partnership between the AAMC, the Coalition of Urban-Serving Universities/Association of Public and Land-grant Universities, and the National Institutes of Health. The program works with urban university presidents and health professions deans to strengthen institutional capacity, implement learning collaboratives, and develop metrics to improve health and reduce health disparities in urban communities. It is important to view these institutions as anchor institutions that contribute to the economic vitality of the community.

If a university wants to influence a workforce, what are the main lenses used? Fair identifies these as *access, educational opportunity* and *competence*. Access is the university's ability to assess, identify, and serve the needs of a particular community or neighborhood. *Educational opportunity* not only has to do with creating the health workforce for the community, but creating the pathways from the community to the institution. *Competence* is related to ensuring that graduates are equipped with the proper skills to provide effective and equitable care.

Dr. Fair went on to discuss the shift in medical education toward a future-oriented environment that embraces diversity, patient-centered care, collaboration, and ethics, and allows students to be inquisitive. She summarized her presentation by emphasizing the importance of the alignment of the institutional mission with community needs and the program goals to the institutional mission.

**RESOURCES**

- Urban Universities for HEALTH
- AAMC-CDC Cooperative Agreement
- Public Health Pathways
- Public Health in Medical Education Online Community of Practice
- MedEdPORTAL Public Health Collection

## New York's Delivery System Reform Incentive Payment (DSRIP) Program: How "DSRIPtive" will this $8 Billion Initiative Be?

**James B. Couch, MD, JD, FACPE**
*Senior Physician Executive, JHD Group, Inc.*

Dr. James Couch has over 30 years of accomplishments in healthcare delivery and management with an emphasis on evaluating, developing and implementing systems to improve quality, safety, and value. He is currently Senior Physician Executive at JHD Group, Inc., a consulting firm that assists organizations and physicians in navigating the implementation of healthcare reforms.

Dr. Couch first described the Delivery System Reform Incentive Payment (DSRIP) Program as an incentive payment program that rewards providers for performance on delivery system transformation projects that improve care for low-income patients. This program is federally funded by Medicaid (Section 1115) waivers. DSRIPs shift hospital payments from paying for coverage to paying for improvement efforts and results. Couch added that DSRIP projects and milestones are state specific and focus on outcomes over time. Any state is eligible to apply. The Centers for Medicare & Medicaid Services (CMS) currently supports 7 approved DSRIP programs.

Couch provided an overview of national DSRIP trends. He explained that over time, DSRIPs have evolved, with program requirements becoming more prescriptive and narrowly defined. Recent models tend to support wider-scale payment and delivery reform and encompass a broader set of providers beyond just hospitals alone. "Population health encompasses so much more than health care itself…it gets to the issues and impact of housing, nutrition, and access to some of the basics that people need to survive and thrive," explains Couch.

Medicaid Program redesign within New York State is rooted in the MRT Waiver Amendment. This allowed the state to reinvest $8 billion of the $17.1 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The DSRIP Program funded by this $8 billion will transform the state's healthcare system, bend the Medicaid cost curve (and likely that of other public and private sector payers), and assure access to quality care for all Medicaid members. The funding will support, over the five years of the DSRIP Program in New York

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(starting April 1, 2015), the Interim Access Assurance Funding (AAAF) to provide a financial lifeline to safety net hospitals which will see a substantial decrease in inpatient revenues as care is shunted to the community setting; dozens of DSRIP projects approved in the 25 provider performing systems (PPSs); and further Medicaid Program redesign.

There are currently 267 hospitals in New York State, and almost all of these now fall under the 25 PPSs. PPSs are composed of hospitals of various sizes and types; skilled nursing and other extended-care facilities, rehabilitation centers, outpatient clinics, federally qualified health centers (or FQHCs); hospices and other palliative care facilities; behavioral health operations and physician practices. "The whole landscape of healthcare delivery in one of the largest states in this country has been transformed due to the formation of these PPSs," states Couch. In this new landscape there is emphasis on the "health home," slightly different from a Patient-Centered Medical Home. In the "health home," there is a broader focus on primary care and community health. Also very important in this model is behavioral health, especially when integrated with primary medical care.

Some of the key characteristics of the New York State DSRIP plan are centered on avoidable hospitalizations; inclusion of large public hospital systems and safety-net providers; payments based on performance and outcome milestones; and an emphasis on collaboration. One of the overarching goals is to decrease avoidable hospital use in New York by 25%, moving the state ranking from 50th to the top quintile in this area across the country. All this needs to be achieved while preparing for 90% of all Medicaid payments to be value-based by 2020.

Dr. Couch went on to describe how project implementation is divided into domains for selection and reporting. For example, *overall project progress* is a domain focused on how well the project is set up, which is critical in the first year for payment. Another domain, *system transformation*, emphasizes the creation of integrated delivery systems. Overall, there is a clear framework and design for outcomes and performance measurement. PPSs that do not meet specific performance milestones may receive less than their maximum allocation. For example, missing one of five performance milestones during a specific reporting period could result in loss of 20% of DSRIP payments otherwise payable in that timeframe. Funds payable to each and every PPS may also be reduced for missed milestones statewide.

Dr. Couch discussed the importance of learning collaboratives that will help PPSs in New York to engage in peer-to-peer and community stakeholder input. The collaboratives will be set up to share project development information, best practices, and program updates and outcomes.

Couch summarized his presentation by describing important lessons learned from CMS. Flexibility has been key in New York's ability to evolve and expand its intent from its original proposal. Also critical has been accountability and a targeted proposal. Couch credits Governor Cuomo for having provided the kind of leadership during his first four-year term that allowed for this program through his advocacy, which he refers to as "revolutionary."

**To view slides and listen to audio recordings of JSPH Forums visit: Jefferson Digital Commons: jdc.Jefferson.edu/hpforum/.**

# UPCOMING JSPH FORUMS - WINTER/SPRING 2015

## May 13, 2015

### Integrating Population Health into Residency Training: Challenges and Opportunities

**Arthur Boll**
*Chief Executive Officer*
*Germane Solutions*

Bluemle Life Sciences Building
233 South 10th Street
Room 105

## June 10, 2015

### Jefferson's Integrated Clinical Enterprise

**Ann Boland Docimo, MD, MBA**
*Chief Medical Officer*

Bluemle Life Sciences Building
233 South 10th Street
Room 105

**Forums take place from 8:30 am – 9:30 am and are free of charge.**

**For more information call: 215-955-6969.**

Forums are designed for Jefferson students, faculty and staff; health care professionals, administrators and advocates; public policy analysts and community health leaders.

For directions and parking visit: Jefferson.edu

# EXL PHARMA 5TH PARTNERING WITH ACOs SUMMIT

## June 1 - 2, 2015

For details and registration visit:
http://exlevents.com/5th-partnering-with-aco-summit/

Thomas Jefferson University

# JSPH PRESENTATIONS

Huang D, **Frelick E, Nash DB.** Future leaders in quality and safety: galvanizing change in medical education from the bottom up. Poster presented at: The 2015 Annual Meeting of American College of Medical Quality, March 26-28, 2015, Alexandria, VA.

**McIntire RK.** Health care provider's advice to quit- Does it work for adolescent smokers? A propensity score matching approach. Poster presented at: Society for Research on Nicotine and Tobacco 21st Annual Meeting, February 27, 2015, Philadelphia, PA.

**Pelegano J.** Quality and safety in population Health. Presented at: American Association for Physician Leadership, November 2014, Scottsdale Arizona.

**Puskarz K, Harris D, Golab C.** Development of a Master of Science in Population Health Curriculum. Poster presented at: ASPPH (Association of Schools & Programs of Public Health) 2015 Annual Conference, March 22-25, 2015, Washington, DC.

**Simmons R.** Opportunities and strategies in developing affiliation and articulation agreements with undergraduate public health and health science programs. Presented at: Association of Schools and Programs in Public Health (ASPPH) Annual Meeting, March 23, 2015, Washington, DC

**Simmons R**, Plumb, J, Pilling, L, Plumb E. Experiential global health education for the health professions: students, healthcare and population health professionals. Poster presented at: Association of Schools and Programs in Public Health (ASPPH) Annual Meeting, March 23, 2015, Washington, DC.

**Simmons R.** Expanding interprofessional health education through dual degree programs: strategies and articulation agreements. Association of Prevention Teaching and Research (APTR) Annual Meeting, March 16, 2015, Charleston, SC.

# JSPH PUBLICATIONS

**Amos T,** Keith SW, Del Canale S, Orsi P, Maggio M, Baccarini S, Gonzi G, Liu M, **Maio V.** Inappropriate prescribing in a large community-dwelling older population: a focus on prevalence and how it relates to patient and physician characteristics. *J Clin Pharm & Ther*. 2015; 40(1):7-13. doi: 10.1111/jcpt.12212.

**Clarke JL,** Ladapo JL, Monane M, Lansky A, **Skoufalos A, Nash DB.** The diagnosis of CAD in women: addressing the unmet need—a report from the national expert roundtable meeting. *Popul Health Manage*.2015;18(2):86-92. doi:10.1089/pop.2015.0006.

**Jackson JD.** Real-world consequences of the 2013 ACC/AHA cholesterol guidelines for the prevention of cardiovascular disease. *Am Health Drug Benefits*. 2014; 7(8):442-442.

**Lieberthal RD, Leon J.** Engaging health professionals in health economics: a human capital informed approach for adults learning Online. *J Econ Educ*. 2015;46(1):45-55. http://www.tandfonline.com/doi/full/10.1080/00220485.2014.979305

**Nash DB.** N = 1. *Am Health Drug Benefits*. 2015; 8(1):12-13.

**Nash DB.** Note to self: remember your lines. *Medpage Today*. February 19, 2015.

**Nash DB.** Healthcare trend-spotting 2015. *Medpage Today*. January 27, 2015.

**Nash DB.** Population health: where's the beef? *Popul Health Manage*. 2015; 18(1):1-3.

Showalter TN, Hegarty SE, Rabinowitz C, **Maio V**, Hyslop T, Dicker AP, Louis DZ. Assessing adverse events of postprostectamy radiation therapy for prostate cancer: evaluation of outcomes in the Regione Emilia-Romagne, Italy. *Int J Radiat Oncol*. 2015; 91(4):752-759.

# Population Health *Matters*

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