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EDITORIAL

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Beyond Balance Billing

Imagine the following scenario which, regrettably, is all too common. You are admitted to the hospital for an elective procedure and something goes awry. A super sub-specialist is called in to help and while you did all of your due diligence to have a procedure in a hospital in your network, you subsequently receive an unanticipated bill from the sub-specialist for thousands of dollars. You *thought* you were covered; after all, you made an extra effort to confirm that your physician was in the network. What you failed to do was to ask your physician a question that most patients would never think of: "if something goes wrong, are the specialists whom you may call on to help covered by my current plan?" I think that most folks – even those with a health care background – would never consider such a question and, as a result, are at risk of facing a situation that I call "beyond balance billing."

Let's first put this in context, as it relates to the policies of organizations like the Centers for Medicare and Medicaid Services (CMS), and then juxtapose the tactical reality of the behavior inside a "narrow network."

In March 2015, CMS published five "statements" that define their strategic vision for the future of all quality reporting programs.[1] Put together, these vision statements articulate a future state where quality measurement and public reporting play a critical role in healthcare quality improvement: "....CMS quality reporting programs are guided by input from patients, caregivers, and healthcare professionals... feedback and data drives rapid cycle quality improvement...public reporting provides meaningful transparent, and actionable information...quality reporting programs rely on an aligned measure portfolio...quality reporting in value-based purchasing program policies are aligned." These laudable policy statements are the key components of the CMS physician-specific quality apparatus for the near term. Nowhere does it say, "Be careful, you could be balance-billed by practitioners outside of your network."

Opposite CMS are the private payers, such as Aetna, Cigna, and Anthem. They are responding to the pressures of the Affordable Care Act by creating so-called "narrow networks," those that limit patients' choice of hospitals and physicians to roughly 50% of those covered within a specific area.[2] These networks are established using traditional and non-traditional insurance tools. For example, traditionally speaking, networks are established to help drive patients to "higher quality providers" who deliver services with a good outcome at a competitive price. This nicely connects to those five aforementioned CMS strategies, whereby everyone is transparent regarding his total charge and outcome with a particular procedure or test. This represents the ideal scenario.

Non-traditional network construction might borrow some of those same attributes, but also be more focused on reducing professional fees and reducing costs *across the board*. Ideally, narrow networks should also deliver high value (good outcome at a very low price), but in practice, narrow networks have come under criticism because patients do not understand the choices available to them; frequently they are surprised when hospitals and doctors do not appear in the network in their particular marketplace. Clearly, there is plenty of blame to go around here as it relates to both

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traditional and non-traditional narrow network design and construction.

However, "beyond balance billing" is a real syndrome. In a recent *Modern Healthcare* story,[3] even physicians who are admitted to a hospital may not recognize the extent to which they are liable for balance billing by non-participating specialists who may not be in the narrow network, whatever its fundamental design. As patients, physicians may be able to have such charges reversed or diminished, but the average, well-meaning patient with good private insurance, albeit in a narrow network, may have no idea as to which specific providers are covered. It is unrealistic to expect the average patient to ask, "Who is my anesthesiologist? Who is the pathologist who will review my biopsy? What if the pathologist consults with a colleague in an institution outside of the insurance company's network?"

This is another example of the consequences of our fractured non-system. With good intentions, CMS and the private payors want networks that will deliver high quality, low cost care that all consumers would appreciate. In practice, because hospitals and doctors are largely separate entities, we are faced with the conundrum of balance billing from persons most patients will never meet face to face. No wonder our patients are frustrated with the care we deliver and public policy makers want reform!

What recourse do we really have in this very complex situation? I believe, from a policy perspective, we ought to commit to the following:

- Let's ban balance billing altogether and prohibit providers from billing patients for more than the agreed upon co-payment or deductible.[2]
- Let's make the bills that patients receive easier to discern and drop arcane language that only an actuary would appreciate.
- In addition, let us mandate that insurance companies "shelter" plan members[2] from balance billing in at least certain specific clinical situations and let's provide a public list of said emergency situations that everyone can agree to.
- Let's implement a dispute resolution process akin to the one that already exists in the state of New York to keep these kinds of matters out of the courts and make the findings of the dispute resolution apparatus completely transparent and publicly available online.
- Finally, let's be frank about both traditional and non-traditional narrow network design and construction by giving our patients all the information they need to make an informed purchase decision.

We cannot hold patients responsible, *a priori*, for every potential financial contingency relative to their care, either in a planned or emergent situation. We can provide transparency about our clinical services and certainly more information about what specific providers actually do on a day to day basis. Narrow networks, in my view, are a good idea. Let's make them agile for the future by promoting unprecedented levels of transparency and public accountability.

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Non-profit Hospitals and Community Benefit – What's Next?

The latest federal Internal Revenue Service requirements offer an important new opportunity for non-profit hospitals to improve population health management in their communities by developing Community Health Needs Assessments (CHNAs) and Implementation Plans in collaboration with other hospitals and health systems serving the same communities. This requirement builds on the regulations issued three years ago.

As detailed in 2012,[1] Section 9007 of the Patient Protection and Affordable Care Act of 2010 contained requirements that non-profit hospitals must meet as 501(c)(3) charitable organizations. Key new obligations for tax-exempt hospitals included:

- Completion of a community health needs assessment (CHNA) at least once every 3 years by an individual with special knowledge or expertise in public health.
- Development of a written community benefit implementation plan (IP) that addresses identified needs.
- Formal adoption of the community benefit strategic and implementation plan by the hospital's governing body.

- Publication of the CHNA findings and community benefit plan so that it is widely available to the public.

- Demonstration of effectiveness of community benefit efforts.

Since that time, non-profit hospitals have performed community health needs assessments and implemented community health improvement plans. These have been posted on hospital websites throughout the country. For example, Thomas Jefferson University Hospital's assessment and plan focuses on improving access to care, chronic disease prevention and management, and healthy lifestyle behaviors and the environment.[2]

To support hospitals embarking on their population health journey, the Health Research & Educational Trust and the Association for Community Health Improvement, in partnership with the Public Health Institute, conducted a nationwide survey of hospitals and health care systems to assess the state of population health efforts in 2015. The survey elicited responses from more than 1,400 hospitals and addressed how population health initiatives are structured, partnerships with community organizations, and the process of assessing community health needs.[3] The most important use of a CHNA was to integrate population health into the hospital's strategic plan, with 85% of hospitals reporting strong or total commitment to population health or have population health in their vision statement. Although over 90% of hospitals agreed or strongly agreed that population health was aligned with their mission, only 19% strongly agreed that they had the financial resources available for population health, and less than 20% strongly agreed that their hospital has programs to address socioeconomic determinants of health.

Young and colleagues conducted a national study of the level and pattern of community benefits that tax-exempt hospitals provide.[4] The study comprised more than 1800 tax-exempt hospitals, approximately two-thirds of all such institutions. They used reports that hospitals filed with the Internal Revenue Service for fiscal year 2009 that document expenditures for 7 types of community benefits. They combined these reports with other data to examine whether institutional, community, and market characteristics are associated with the provision of community benefits by hospitals.

Overall, tax-exempt hospitals spent 7.5% of their operating expenses on community benefits during fiscal year 2009. More than 85% of these expenditures were devoted to charity care and other patient care services. Of the remaining community-benefit expenditures, approximately 5% were devoted to community health improvements that hospitals undertook directly. The rest went to education in health professions, research, and contributions to community groups. The level of benefits provided varied widely among the hospitals (hospitals in the top decile devoted approximately 20% of operating expenses to community benefits; hospitals in the bottom decile devoted approximately 1%). This variation was not accounted for by indicators of community need.[4]

As noted above, only 5% of community benefit activities were devoted directly to community health improvements, but this may be changing. Recent estimates from the Department of Health and Human Services (HHS) indicate that uncompensated care provided by hospitals is estimated to have declined by approximately $7.4 billion in 2014.[5] If a portion of community benefit contributions were redirected toward high-leverage community health improvement initiatives, it could represent a commitment of the estimated $90 billion needed for critical community supports to help vulnerable children and families[6] and build community capacity to leverage other potential sources of funding.[7]

Final Internal Revenue Service regulations issued December 29, 2014, include several significant changes from the guidance that governed the first cycle of CHNAs and IPs. These changes include:

- Collaborating hospitals from the same or different health systems may develop a joint CHNA report if their community is defined to be the same and each of their governing bodies adopts the joint report.

- Hospitals that collaborated in developing a joint CHNA report also may develop a joint IP. The joint IP must clearly identify each hospital's role and responsibilities.

- Hospitals have additional time to complete their IPs. IPs may be adopted up to four-and-a-half months after the end of the tax year when the CHNA is "due." (This timing matches the due date, without extensions, of the hospital's Form 990.)

Nationally, efforts to promote collaboration in conducting CHNAs and developing Implementation Plans (IPs) are underway. In the Southeastern Pennsylvania region the Hospital and Health System Association of Pennsylvania (HAP) and the Department of Health and Human Services (HHS) Region III are convening hospitals and health systems, public health departments, and other community stakeholders to explore how greater collaboration about CHNAs and IPs might play a part in the development of population health strategies. They have indicated that joint CHNAs/IPs would help achieve greater efficiency and effectiveness in:

- Meeting federal requirements

- Identifying common health needs in communities served

- Aligning IPs and hospital efforts and investments to achieve greater improvements in community health as well as progress toward effective population health management and the pursuit of the Triple Aim

- Enhancing the public's perception of the hospital brand through community meetings convened by multiple health systems, demonstrable improvements in community health, and media coverage of these activities and results

With Public Health Accreditation Board (PHAB) standards also calling for local health departments to conduct or participate in *collaborative* processes for assessing, prioritizing, and addressing community health needs, there now is an opportunity for mutually beneficial cooperation among hospitals, public health departments, and others who desire to improve community health. For example, the Philadelphia Department of Public Health recently completed a CHNA and will focus on maternal and child health, access to care and behavioral health as priorities. [8]

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It is hoped that hospital and health department leaders seize this opportunity and collaborate in bringing about transformational change, rather than simply complying with IRS regulations. [9]

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The People Behind Jefferson's New Patient and Family Advisory Council

After more than a year of careful planning, Jefferson has launched another forward-leaning program to further improve an already nationally recognized, top-quality Patient Experience.

The core of Jefferson's first *Patient and Family Advisory Council* (PFAC) are the patients themselves and their loved ones, those who were bedside and helped care for them during their hospital stay. Taken together, these are people who had great outcomes, but sometimes not without bumps along the way.

We sought out their involvement specifically and found people like Co-Chair Lindsay Hoff, whose good friend David Terhune survived a near-fatal car accident. Both Lindsay and David are on the Council, as is David's sister, Jennifer Sparrow, the other Co-Chair. All of the Advisors have dramatic stories to tell and a willingness to share their experiences.

David Terhune - Volunteer: *I couldn't be more grateful to the people of Jefferson. They saved me. Participating on this Council is a way to give back.*

Lindsay Hoff - Volunteer, PFAC Co-Chair: *I think when a hospital reaches out directly to the people it's supposed to be serving, it gains not only a unique perspective but also valuable insight on what the Patient Experience is really all about.*

Jennifer Sparrow - Volunteer, PFAC Co-Chair: *There are so many moving parts, so many procedures and processes attendant to a hospital stay. It's only natural that there will be places in need of improvement.*

Richard Webster, RN, MSN - President, Thomas Jefferson University Hospitals: *The purpose of an initiative like this is to gather precious first-hand feedback from the people best positioned and most qualified to provide it.*

Jennifer Jasmine Arfaa, PhD - Chief Patient Experience Officer: *In addition to patients and their families, the Council includes senior-level hospital administrators, like me and our President.*

Eleanor Gates, RN, MSN - Vice President, Surgery and Trauma: *The composition of the Council gives us the means not only to raise important issues, but also the people and process by which to address those issues to make the improvements we're seeking.*

Nora Kramer, MS, RN - Nursing Supervisor: *It was harder than you'd think to populate this Council. We were very selective, putting a high priority on both knowledge and a commitment to making things better. We were looking for people who could translate their experience, both positive and where there were opportunities for improvement, into action.*

Webster: *Jefferson was among the early adopters of the executive position of Chief Patient Experience Officer, someone whose sole focus is the patient interaction with the hospital. To this day, not that many hospitals—let alone academic medical centers—have elevated their efforts to guarantee a great patient experience to this level. In many ways Jefferson is ahead of the curve.*

Arfaa: *How patients perceive their experience here is a bottom line issue. In this new healthcare world with an emphasis on value rather than volume, patient experience survey results are an increasingly important indicator of how well we're doing. They are a point of pride and competition among hospitals. And while Jefferson has offered extraordinary care since opening our doors in 1825, you can never rest on your reputation alone.*

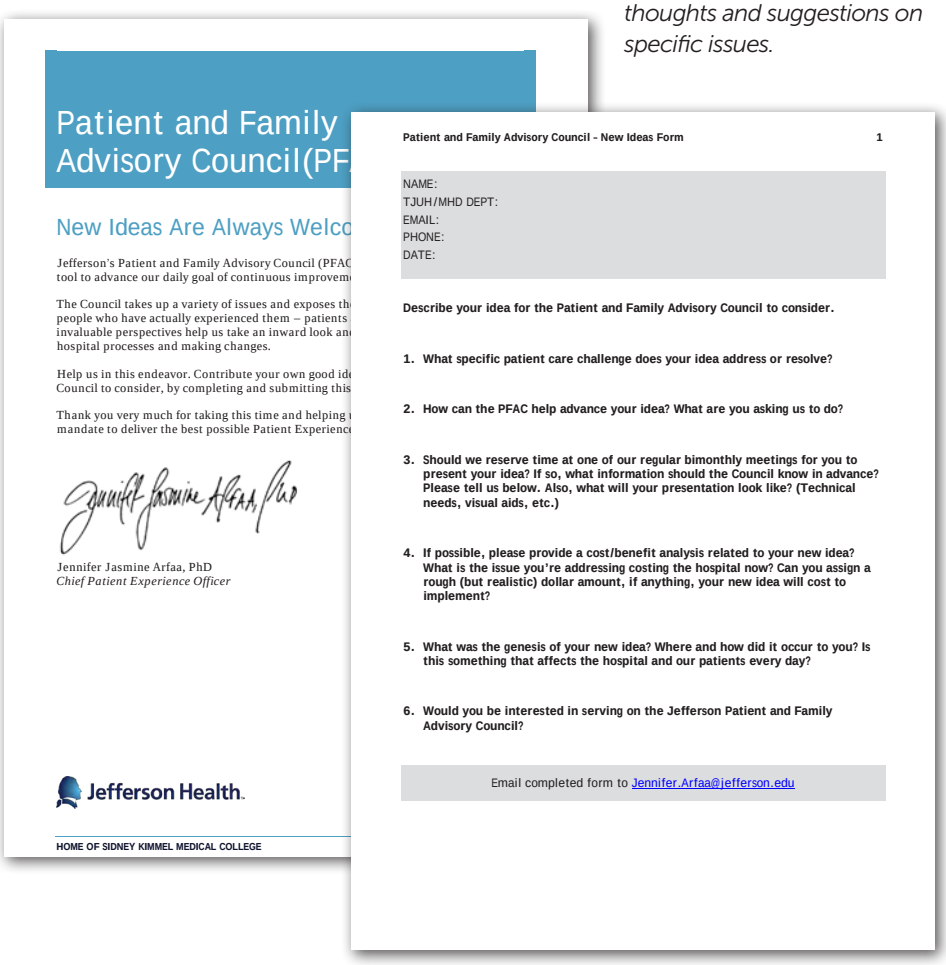
Gates: *We started this effort with 10 patients and family volunteer members, whom we call Advisors, and added another 10 staffers. We meet for two hours every other month, with regular contact in between. When we get together it's for a dinner meeting, which gives all of us time to socialize and bond. It makes for a stronger, more cohesive group in a comfortable environment different from the usual corporate fare.*

Arfaa: *As soon as we empanelled our members, we drafted the leadership from among the volunteers themselves. Our intention was to empower the laypeople and prove how serious we were about giving voice to their concerns and suggestions.*

Sparrow: *We help select items for consideration, set the agenda and run the meetings. We also conduct research to really drill down and get the facts.*

Hoff: *In both Jennifer's and my case, our professional work equips us with certain skills useful in this effort. For example, one of the first things we did was canvas our members through an online survey, to learn more about the direction we needed to go. There's been no shortage of discussion points and that's how we want it. In fact, we created a special* ***New Idea Submission Form (Figure 1.)*** *to make it easier for people around the campus to contribute their good thoughts and suggestions on specific issues.*

Figure 1. New Idea Submission Form



Patient and Family Advisory Council(PF

New Ideas Are Always Welco

Jefferson's Patient and Family Advisory Council (PFAC
tool to advance our daily goal of continuous improvem

The Council takes up a variety of issues and exposes th
people who have actually experienced them – patients
invaluable perspectives help us take an inward look an
hospital processes and making changes.

Help us in this endeavor. Contribute your own good id
Council to consider, by completing and submitting this

Thank you very much for taking this time and helping
mandate to deliver the best possible Patient Experienc

Jennifer Jasmine Arfaa, PhD
Chief Patient Experience Officer

Jefferson Health.

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Patient and Family Advisory Council - New Ideas Form 1

NAME:
TJUH/MHD DEPT:
EMAIL:
PHONE:
DATE:

Describe your idea for the Patient and Family Advisory Council to consider.

1. **What specific patient care challenge does your idea address or resolve?**
2. **How can the PFAC help advance your idea? What are you asking us to do?**
3. **Should we reserve time at one of our regular bimonthly meetings for you to present your idea? If so, what information should the Council know in advance? Please tell us below. Also, what will your presentation look like? (Technical needs, visual aids, etc.)**
4. **If possible, please provide a cost/benefit analysis related to your new idea? What is the issue you're addressing costing the hospital now? Can you assign a rough (but realistic) dollar amount, if anything, your new idea will cost to implement?**
5. **What was the genesis of your new idea? Where and how did it occur to you? Is this something that affects the hospital and our patients every day?**
6. **Would you be interested in serving on the Jefferson Patient and Family Advisory Council?**

Email completed form to Jennifer.Arfaa@jefferson.edu

Gates: *The PFAC tackles some difficult subjects, such as preventing pressure ulcers and designing patient education materials. We've even addressed many aspects of the discharge process (which is more complicated than most people think) and specific ways to improve it.*

Kramer: *We're working on raising the level of hand hygiene compliance to reduce the chance of hospital-acquired infections. These are issues that every hospital deals with, coast to coast.*

Arfaa: *Whenever a glitch surfaces in our system, we want to take a fresh look at it. PFAC is the perfect vehicle. We bring in Jefferson physicians and nurses and administrators to illuminate the issue and educate us. It works. You can hear a pin drop during these presentations.*

Webster: *What makes the PFAC so valuable an asset to Jefferson is its real-world approach. We contemplate real, everyday issues and suggest smart improvements. At the same time, we consider the costs attached to them and ways to get it done. That kind of thinking is a huge contribution to Jefferson, the benefit of which flows directly to our patients.*

Arfaa: *We're already seeing results and that's impressive for so short a time in operation. People ask me how much power this group of volunteers actually wields. Just by virtue of having direct and extended access to the people running the hospital, this Council has extraordinary power to influence and to effect change. They are uniquely positioned to help us make sure we provide the best possible quality experience for our patients and their families... and that is our #1 goal!*

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Jefferson Celebrates National Health Education Week

The JCPH MPH program celebrated National Health Education Week (NHEW) October 19-23, 2015 by honoring the work and dedication of local health education heroes in the Philadelphia region. JCPH solicited nominations through its extensive public health network, asking for a short description of the Hero's work and their dedication to the field of health education. A selection committee comprised of JCPH faculty selected 5 Health Education Heroes from diverse workplace settings including hospitals, community-based social service agencies, and private industry.

Health Education Heroes (left to right): Terri Clark, Amber Thompson, Pamela Harrod Smith, Sue Daugherty, and Alison Petok.

The 5 Health Education Heroes and their achievements were profiled on the JCPH website Jefferson.edu/university/population-health.html and in communications across the Thomas Jefferson University campus. The Health Education Heroes were also honored at a special luncheon that included JCPH faculty, staff, and MPH students. During the luncheon, our Heroes led a lively discussion about their job roles and responsibilities, their career paths in health education, and shared words of wisdom to the students. A standing-room-only crowd ended the hour truly inspired by the work that our Heroes do each day. JCPH's 2015 Health Education Heroes are:

Pamela Harrod Smith, MS is a health educator for Jefferson's Center for Urban Health. As part of the Million Hearts Campaign, Ms. Smith conducts blood pressure screenings at community sites across the Delaware Valley.

Terri Clark, MPH is the Prevention Coordinator for ActionAIDS, where she promotes LGBTQ health, facilitates access to health care services for those in need, and supports the aging population with HIV in Philadelphia.

Sue Daugherty, RN, LDN is the Chief Executive Officer for MANNA in Philadelphia. Over the past 15 years, she has counseled clients about the benefits of good nutrition, expanded nutrition services to clients with life-threatening illnesses, and fostered relationships in Africa that have launched nutrition programs abroad for orphans and vulnerable children.

Alison Petok, MSW, LSW, MPH is an oncology social worker at Jefferson's Sidney Kimmel Cancer Center (SKCC). Ms. Petok provides health education to patients across the life span, from young adults to seniors, works in the multidisciplinary palliative care clinic, and supports clinicians in the cancer center.

Amber Thompson, MS, MBA, CHE is the Vice President of Client Services and Solutions at Vree Health where she manages a team of allied health professionals who provide chronic disease care management to high risk patients.

13th Annual Interclerkship Day: Improving Patient Safety

January 4, 2016

Every January JCPH hosts the Patient Safety clerkship for the entire 3rd Year class of Sidney Kimmel Medical College (SKMC). Now in its 13th year, this clerkship offers an exceptional opportunity for students to increase their awareness about medical errors, patient safety, quality, communication, and leadership.

The morning kicked off with a welcome by Jefferson's President/CEO, Steven K. Klasko, MD, MBA , who encouraged the students to think about the importance of quality and safety and what it means for the future of medical education and healthcare. Echoing the words of Dr. Klasko, David B. Nash, MD, MBA, Dean of JCPH, shared his passion as an advocate for the creation of an undergraduate curriculum that expands the definition of professionalism to include more on quality and safety.

Keynote speaker, John J. Nance, JD, is an internationally known aviation and patient safety expert. Nance is a founding board member of the National Patient Safety Foundation and an aviation analyst for ABC News. Nance frequently appears on the news to lend context and clarity to stories and investigations regarding aviation accidents. Through the use of videos and real scenarios, Nance

Aviation and patient safety expert, John Nance.

drew parallels between physicians and pilots, demonstrating how medicine can use crew resource management (CRM) principles adapted from the airline industry to improve patient safety. He discussed the critical role of communication and emphasized the importance of creating an environment and culture that allows a student or resident to speak up if something is wrong. Nance believes that this type of environment will foster development of a culture where all team members are committed to improving patient safety. Perceptions and assumptions may impede effective communication. Nance's basic message is that "we are all individually flawed," and perfection is nearly impossible.

Barry M. Mann, MD, Chief Academic Officer for Main Line Health and Professor of Surgery, SKMC, discussed the culture change and shared educational initiatives used at Main Line Health to "speak up for safety." Dr. Mann engaged students in a surgery related scenario to demonstrate and model ways to enhance safety behaviors and integrate error prevention tools. Mann also discussed power gradients and the importance of physician "buy in."

Anne B. Docimo, MD, MBA, CMO of Jefferson Health, presented on quality and safety across the continuum with a special emphasis on the healthcare marketplace. She described the relationship between healthcare costs and quality measures, the Affordable Care Act, and the notion of patients as consumers. Docimo discussed Jefferson's strategy, driven by the Triple Aim: improve the health of a population, per capita costs, and the experience of care.

During lunch the College within A College (CwiC) students in the current cohort met with Dr. Nash, Dr. Docimo, John Nance, new JCPH Quality and Safety Program Director, Mary Reich Cooper, MD, JD, and MPH Program Director, Rob Simmons, DrPH, MPH, MCHES, CPH. Students had the opportunity to ask questions and were encouraged to get more involved and pursue leadership through service.

The afternoon began 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, and Director of Inpatient Obstetrics, helped to characterize the elements of a successful encounter with patients and families while the audience observed important skills and participated in role plays.

Interclerkship Day concluded with a panel discussion that offered advice for the students as they move forward in medical school and their future careers.

SKMC students at Interclerkship Day

Panel discussion with John Nance, Barry Mann, MD, and Jason Baxter, MD, MSCP, FACOG

CwiC Students

Educating the Physician Leaders of Tomorrow

Twenty years ago, in 1995, the first students were admitted to the MD/MBA program, a joint venture of Sidney Kimmel Medical College (then Jefferson Medical College) and Widener University. Students in the program could earn an MBA during a full-year of study in the Graduate Program in Healthcare Management in Widener's School of Business Administration, typically between the second and third years of medical school at Jefferson. At that time, there were only 8 MD/MBA programs available in the U.S. Today there are approximately 65 MD/MBA programs across the U.S., with an estimated 500 students. [1] We recently completed a survey of graduates of the Jefferson-Widener program that documents the accomplishments of our 30 MD/MBAs.

The Jefferson-Widener program is atypical, in part, because it involves collaboration between two different universities, but also because the Health Care Management (HCM) Program at Widener has dual accreditation by the Commission on Accreditation of Healthcare Management Education (CAHME) and the Association to Advance Collegiate Schools of Business (AACSB).

The HCM Program combines the basic management disciplines found in most MBA programs with applications to the health care industry. The target population for the HCM Program is working health care professionals who pursue an MBA on a part-time basis. This gives the Jefferson students the opportunity to study with a variety of clinical and non-clinical professionals, including practicing physicians and physicians in managerial positions. The Program gives them the experience of working on projects in interdisciplinary teams, as they will once they complete their training.

We consider this unique arrangement to be a distinct advantage for the Jefferson students. Most MD/MBA programs offer a general MBA that is not connected to the health care industry. While the skills needed by physician managers and general managers are essentially the same, "by divorcing management education from medicine, these training programs and the physicians who participate in them lose

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much of the opportunity to integrate clinical and management principles into a broad understanding of how best to operate medical organizations."[2]

The Jefferson-Widener MD/MBA program was created in recognition of the need for physician leaders. In the 1990s, there was growing concern about both cost and quality in the U.S. healthcare system and a belief that physician managers were uniquely qualified to meet those challenges. Further, "the blurring of the distinction between management and medical care decision-making mandates that physicians assume a high level of responsibility for administration of health care institutions and systems."[3]

Goldfield and Nash foresaw two different types of physician leaders in the future. One type would design the interventions needed to assure cost effective care, including conducting outcomes research, crafting clinical guidelines, evaluating physician practice patterns, and advising on economic credentialing of medical staff members. The other type of physician leader would communicate those interventions to practicing physicians, serving as the boundary spanners of the future.[4]

Since its inception, the Jefferson-Widener MD/MBA Program has graduated 30 students. All of them have completed, or are currently in, residency programs, even if they did not intend to enter private practice, based on the assumption that physician leaders cannot work effectively with practicing physicians without some level of clinical credibility. In addition:

- 15 of the graduates are in or have completed fellowship training.
- Residencies have been in a wide variety of specialty fields including psychiatry, anesthesiology, general surgery, neurology, preventive medicine, and pediatrics.
- The modal choice is internal medicine, frequently followed by sub-specialty fellowships.
- Some graduates also have earned Master's degrees in Public Health, Epidemiology, and Clinical Research.

Twelve of our graduates are still in residencies or fellowships. Eighteen of the graduates have completed their graduate medical education. Of the 15 graduates we were able to contact, we learned the following:

- 3 are in private practice and do not have a managerial role
- 5 are in private practice or health systems with significant leadership roles. Five are Medical Directors, one is a Chief Operating Officer, and one is Vice Chief of Staff.
- There is one graduate each working in insurance, pharmaceuticals, and community-based mental health; two working in the public sector; and two in academic positions.

For many of our graduates, leadership began during their residencies. Several were chief residents, and most worked on projects during residency that utilized their management education. These included, for example, a process improvement project related to tPA (tissue plasminogen activator) administration for stroke patients; research on the costs of obesity; creation of a house staff quality council and the opportunity to serve as a resident patient safety officer; advocacy through the state medical society; a quality improvement project related to outpatient urologic services; and the design and implementation of a peri-operative clinical care pathway at a major academic medical center. Three graduates have continued to work in quality improvement roles after residency.

We asked the graduates how the MBA has affected their careers. Many commented that the MBA gave them a broader view of the health care system than the one they develop during their medical education. Students often noted this difference between their fellow medical students who had not done the MBA year and themselves, once they returned to Jefferson to finish medical school. "The MBA has certainly given me a different perspective on healthcare and a knowledge that most physicians never receive, or don't learn until later in their careers."[5] Several noted that the MBA had a positive impact on their residency and job-hunting interviews. "I started looking for jobs and all those who interviewed me commented about how my MBA, health policy internship at Jefferson, and QI work during residency made me stand out."[6]

For many, the skills developed in the MBA contributed directly to their daily management activities, whether working in the public or private sector.[7] "Business skills have been useful for my medical director role, understanding how large health care organizations operate, and leading quality projects."[8] The MBA helped me to "develop a niche of practice development and marketing to take a small practice and grow it through targeted marketing and networking."[9]

For many of our graduates, the MD/MBA profoundly shaped their careers. "I feel the MBA will be one of the most important factors in the trajectory of my career path. Its teachings serve as the basis of my current research projects and lend immediate credibility to my interest in pursuing involvement in my health system's quality improvement initiatives."[10] One graduate working in a community-based, not-for-profit that he founded said the MBA "has been critical in shaping my career direction, and in helping me to effectively lead and manage organizations, navigate a changing healthcare landscape, and be an effective teacher of fellows and other students."[11]

As someone who has worked with the MD/MBA students from the program's inception, it is gratifying to see the substantial accomplishments of our graduates. It is also reassuring to note that the roles they are playing today are exactly those we saw the need for 20 years ago.

Today the need for well-trained physician leaders is even greater than it was in 1995. We foresee even more opportunities for our MD/MBA graduates as the U.S. health care system continues to evolve, with changes in organizational structure, payment mechanisms, and the process of care.

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The Village: A Key Option for Older Adults

In 2050, the population aged 65 and over is projected to be 88.7 million, almost double the estimated 43.1 million in 2012.[1] Ninety percent of these older Americans want to stay in their own homes for as long as possible.[2] The fact that two of three older Americans have multiple chronic conditions[3] and will need some level of support to stay in their communities has inspired the rapidly growing village movement: consumer-driven social support organizations that aim to enhance the social engagement, independence, and well-being of community-dwelling seniors through a combination of social activities, volunteer opportunities, service referral, and direct assistance.

There are 190 villages, most in the U.S., but they are now appearing in other countries; an additional 185 are in the development stage.[4] Although there are some villages that are part of larger organizations, most are independent non-profit organizations funded through annual membership fees, contributions (from neighbors and local businesses), and grants to subsidize the cost for low-income individuals. Villages collaborate through the national Village to Village Network, sharing successes and challenges, helping new villages get started and established villages to mature.

Villages reflect the needs of their individual communities and there are variations in design, but all are dedicated to supporting neighbors who wish to remain in their homes as they age. All villages address the isolation that often affects the health, well-being and quality of life of many older adults. [5] Even those with a network of family and friends often do not want to rely on them for everyday tasks. Villages bring people together through educational, social and cultural activities, and by linking a member with a volunteer "friendly visitor." Villages typically rely on volunteers to provide services and perform administrative tasks, and volunteering itself keeps one connected to the community as a whole and to other individuals.

Many villages offer services and support that significantly increase the probability that a member can remain relatively independent. Members call one telephone number to request assistance. Transportation is the most utilized service: Volunteers take members to health care appointments or the grocery store, for example. They assist with errands and household tasks, take care of a pet or even make sure all is well at home if a member is on vacation Villages often connect members with prescreened providers such as home health agencies, electricians and plumbers. A volunteer might help with home organization and then connect to an organization that will pick up donated items.

Penn's Village, serving Center City Philadelphia, has a new program, Health Pals, helping members to be informed and proactive patients and therefore more likely to be compliant with the course of care recommended by their health care providers. Among the multiple factors within the complex issue of compliance may be the complexity of the medical explanation, the stress of the situation and the fact that the patient may be intimidated and afraid to ask questions, and the reality that some patients simply forget.[6]

A trained Health Pal volunteer will help a member formulate questions prior to an appointment, fill out forms, be a "second set of ears" then compare notes to make sure that all have heard the same thing. The Health Pal volunteer will assist with follow-up instructions such as scheduling appointments, picking up prescriptions and setting up a reminder system so that medications are taken as prescribed. Through a partnership with Centennial Health Services, members receive one-on-one at-home medication counseling. The Penn's Village Health Pals leadership team is in the process of meeting with area health care providers to explore how best to work together to improve social and health outcomes for shared members and patients.

In May of 2014 researchers from the University of California at Berkeley published a study aimed to assess the perceived impact of Village membership on factors associated with the likelihood of aging in place. They surveyed 282 active Village members from five sites in California. Fifty three percent of village members reported a better quality of

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life since joining their village. Forty five percent felt happier and 33% perceived themselves to be healthier. Sixty-three percent talked to more people, 40% left home more and 39% felt less lonely. Eighty-one percent reported being able to get more help and 28% more able to get medical care. [7]

Atul Gawande, in his New York Times bestseller *Being Mortal: Medicine and What Matters in the End,* refers to the village movement several times and notes that the founders of such organizations were "committed to a singular aim. They all believed that you didn't need to sacrifice autonomy just because you needed help in your life."[8] *Forbes Magazine* lists villages as number one of 10 caregiving tips for anyone turning 50 in 2014 (and those who are already there): "It takes a village. Go find one. Ninety percent of seniors, perhaps including your own parents, want to remain in their homes as long as possible. Connecting with the Village Movement is one way to fulfill that goal."[9]

The Village to Village Network website, vtvnetwork.org, includes an interactive map to locate a village in a particular geographic area. Penn's Village can be contacted at 215-925-7333 or info@pennsvillage.org.

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The International Society for Pharmacoeconomics and Outcomes Research Jefferson Student Chapter (Jeff-ISPOR):

Expanding Students' Horizons into Careers in Health Outcomes

Outcomes research is defined as "the study of the end result of health services that takes patients' experiences, preferences, and values into account."[1] The International Society for Pharmacoeconomics and Outcomes Research (ISPOR) , the leading organization in outcomes research, was founded in 1995 with the vision to be the *leader* of "a truly international multi-disciplinary professional membership society which advances/drives the policy, science, and practice of health outcomes research."[2] In the 20 years it has been in operation, ISPOR has increased membership to more than 9,500 members over 114 countries.[3] ISPOR also facilitates student engagement and support through local student ISPOR chapters, travel grants, and educational activities. Though ISPOR was initially focused on pharmaceutical outcomes research, its members are now broadly engaged in measuring both the outcomes and economic value of drugs and other healthcare interventions such as devices, diagnostics, and behavioral programs.

Since 2005, The International Society for Pharmacoeconomics and Outcomes Research Thomas Jefferson University student chapter (Jeff-ISPOR) has exposed students to topics in the health economics and outcomes research field and provided a vehicle for them to network with professionals in these career paths. To date, the majority of Jeff-ISPOR members have been students from the Jefferson College of Pharmacy (JCP) and Jefferson College of Population Health (JCPH), but the group is open to students from all Jefferson colleges who share an interest in the field. Jeff-ISPOR is one of 75 active ISPOR student chapters globally and, with 34 members, is one of the largest in terms of membership. The group is advised by Laura Pizzi, PharmD, MPH (JCP) and Vittorio Maio, PharmD, MS, MSPH (JCPH).

Jeff-ISPOR aims to give students a working knowledge of the healthcare system, the decision-making process for drugs and other innovations, and scientific approaches for measuring the economic and outcomes value of innovations. With the increasingly complex healthcare landscape, persons trained in this discipline are proving to be a valuable resource for innovator companies, health plans and large provider systems (such as accountable care organizations).

Jeff-ISPOR members are also encouraged to submit research to the Annual ISPOR International Meeting, hosted annually in North America. The 2015 Annual Meeting was held in Philadelphia, PA, where JCP and JCPH accounted for a total of 17 poster presentations. Elizabeth Cannon-Dang, MPH, the current Jeff-ISPOR President, was awarded a ribbon for 'Outstanding Poster'. The research, developed in partnership with Jefferson and Wills Eye Hospital, reported the cost effectiveness of performing canalicular laceration repair in the operating room versus minor procedure room.[4]

Each year, Jeff-ISPOR hosts at least two philanthropic events to complement the group's educational activities. These activities give students a greater context regarding healthcare delivery issues and provide networking opportunities while giving back to the Philadelphia community. Recent events have included volunteering at Variety Children's Charity Superhero 5K and Wills Eye Hospital's Give Kids Sight Day.

Finally, Jeff-ISPOR cultivates students' awareness about career paths in applied health economics and outcomes research. In collaboration with the student chapters of JCP student government, the Academy of Managed Care Pharmacy, and Industry Pharmacists Association, Jeff-ISPOR held a Fellowship Night in November 2015 to explain the training provided through fellowships and the process of applying for these programs. Current JCPH fellows and Jeff-ISPOR members Jacquelyn McRae, PharmD, Stefan Varga, PharmD, Po-Han Chen, ScM, and Matthew Alcusky, PharmD, MS shared information about Jefferson's fellowship programs.

The unique combination of activities provides Jeff-ISPOR students with a robust opportunity to understand and explore careers in applied health economics and outcomes research. For more information or to join please visit http://www.ispor.org/Event/index/2016Washington and contact Ms. Cannon-Dang at Elizabeth.Cannon@jefferson.edu.

Elizabeth Cannon-Dang received an "Outstanding Poster" award at ISPOR.

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Introducing Behavioral Health into the Treatment of Chronic Liver Disease (CLD): An Integrated Hybrid Model

The burden of Chronic Liver Disease (CLD) is on the rise in United States. CLD is complicated by behavioral illnesses at a higher prevalence (8-31%) than the general population (1.8%).[1] The most common cause for CLD leading to early death is Hepatitis C (HCV), followed by alcohol abuse, metabolic syndrome (*diabetes, overweight, hyperlipidemia, and hypertension*) and fatty liver.[2] Three behavioral health issues common in CLD include alcohol abuse, substance abuse, and depression. These either occur prior to the disease or develop as a result of the disease, its treatment or complications (like depression). Very few patients with CLD have access to behavioral health services, and the stigma associated with these health issues can create barriers to care. There is a need to integrate collaborative behavioral health approaches within conventional hepatology, in an effort to improve patient health, raise the quality of care and reduce the total health care costs.

The adaptation of integrated care in patient-centered medical homes (PCMH) in primary care has shown to reduce fragmentation, with enhanced continuity and care coordination.[3] According to the American Hospital Association 2014 report, behavioral health integration throughout the health care delivery system will serve the patients' individual needs at the point of required service, thereby promoting patient outcomes and reducing overall costs.[4] This paper describes an innovative project integrating behavioral health services within routine care for CLD population in an outpatient hepatology clinic. While there are a few studies that have shown the positive effects of an integrated behavioral health care model for HCV patients in veteran populations, [5,6] the use of this model for CLD patients (*offering universal screening and services for the triad of alcohol, substance abuse and depression*) is a new concept.

Einstein conceived an **integrated hybrid model** through creating an on-site team of a hepatologist and a social worker (SW) to offer universal screening and management for alcohol, substance abuse and depression. *Integrated* care can be described as offering screening and brief intervention services together at the point of care (routine office visit). A *hybrid* model consists of direct access and referral to a specialist behavioral health management service for advanced or complex cases. This program is supported by the **Albert Einstein Society (AES)**. The AES supports innovative programs within Einstein Network, and serves as a vehicle for leading-edge programs to find new ways to provide care for their patients, and foster the mission of the institution towards improved patient centered care. The behavioral health model within hepatology practice includes a number of key implementation steps, with universal screening and tailored interventions (Figure 1).

Procedures: At baseline visit, the SW completes all the necessary assessments (AUDIT, DAST-10, PHQ-9), and discusses the results of their responses. The SW then explains the impact of the corresponding behaviors on the patient's health and well-being, and identifies the main concerns of patients. She also identifies the patient's perception of the issue, willingness to change and the stage of change. Based on this information, the patient and SW together create a plan of action, and identify appropriate resources needed. The SW communicates with the physician taking care of the patient for any urgent issues, and documents a note within electronic medical records. At 3 and 6 months, the assessments are repeated and action plans are modified to achieve the target of being abstinent and/or improved depression. This project was implemented in August 2015, and within three months, 330 outpatients have been screened. Of the screened, 13% were positive for alcohol, 36% for depression and 9% for substance abuse. 95% of the patients screened positive have agreed to participate in the program.

Impact of the Model: This model is one of the first of its kind, showing the acceptability and feasibility of behavioral health services within liver clinics. This has made a unique place within the

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clinical workflow, as both the providers and patients see its added value. Social work staff can be vital to these integrated approaches, in providing screening and brief interventions, identifying patient's concerns and linking them to appropriate resources necessary for continued care targeting improved outcomes. The direct benefits to patients include immediate access to behavioral health assessment and intervention, which potentially mitigates the risky behaviors and situations, overcoming the obstacles of scheduling, travel and stigma. Furthermore, identifying and initiating expedient treatment of behavioral health issues, including depression, is expected to have **positive effects** on many parameters, including health outcomes, utilization of health services (hospitalization and rehospitalization rates), patient experience and quality of life. These improvements will reduce health care costs among a group of patients with CLD who are high utilizers of healthcare services. The anticipated cost savings will more than offset the salary of a health professional trained in behavioral health techniques, including motivational interviewing as would be conducted by a social worker.

This project will inform a future research project **to test the effectiveness** of behavioral interventions to improve the quality of life, patient experience and health outcomes, with reduced healthcare costs for patients with CLD and coexisting behavioral illnesses. Funding resources could be from PCORI (Patient Centered Outcomes Research Institute), AHRQ (Agency for Healthcare Research and Quality), or Substance Abuse Mental Health Services Administration (SAMHSA).

Acknowledgement: Albert Einstein Society

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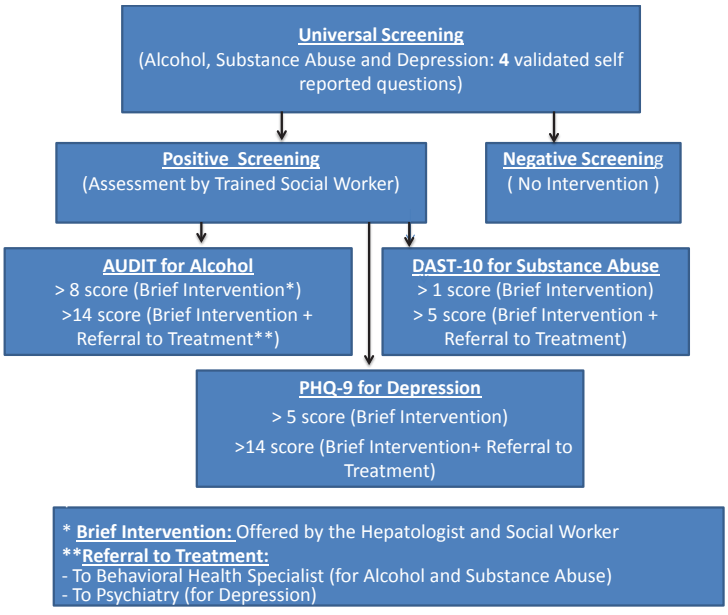
Figure 1. Key Implementation Steps and Interventions

Behavioral Health Implementation Steps	Intervention
1. Routine universal screening for alcohol, substance use and depression, using three validated questions at the time of check-in at the Hepatology practice.	Questions include: • How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?[7] • How many times in the past year have you had X or more drinks in a day?[8] • Over the past 2 weeks, how often have you been bothered by any of the following problems? a) Little interest or pleasure in doing things b) Feeling down, depressed or hopeless.[9]
2. All patients positive for alcohol/ substance abuse, depression are approached by the social worker.	Specific brief instruments are utilized to assess the problem severity e.g. AUDIT (Alcohol Use Disorders Identification Test) for alcohol, DAST-10 (Drug Abuse Screen Test) for substance abuse and PHQ-9 (Personal Health Questionnaire) for depression.
3. Brief Interventions are offered to each patient by the social worker, based on a standard algorithm **(Figure 2)** related to SBIRT (Screening Brief Intervention and Referral to Treatment) model. [10]	Brief Interventions are based on a combination of transtheoretical model, motivational interviewing and cognitive behavioral therapy. Brief interventions: • Identify ambivalence, self-efficacy, and build commitment to change. • Educate patients to reduce risky behaviors. • Therapy goals are focused on treatment for alcohol and substance abuse; treatment of depression; and improvement of medication adherence to foster better health outcomes.
4. Patients are followed up by phone at 1 month,and at 3 and 6 months in the office.	Assessments repeated at 3 and 6 months and actions plans are modified.

Figure 2: Standard Clinical/ Behavioral Health Integration Protocol (based on SBIRT Model)



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10th Anniversary V-BID Summit 2015

A Decade of Transforming The Health Care Cost Discussion from 'How Much' to 'How Well'

JCPH has been following, with great interest, the work of A. Mark Fendrick, MD and his colleagues at the University of Michigan's Center for Value-Based Insurance Design (VBID). The passage and implementation of the Affordable Care Act has hastened the move away from fee for service reimbursement and toward basing payment on high-value services that improve the quality of care and provide better outcomes.

Since its founding in 2005, the VBID Center has been actively engaged with stakeholders across the spectrum to support policy changes and demonstration projects. The Center convenes an annual summit to share ideas, discuss progress and make recommendations for future action. I had the pleasure of participating in the 10th Anniversary program this past October.

The invitation-only program was designed to provide diverse stakeholders (government, payers, academics, industry, policymakers) from across the country with the opportunity to learn about the Center's initiatives, network with one another, and engage them in meaningful dialogue to help shape future work.

More than 100 attendees from 24 states were present at the Summit, where they were treated to an excellent discussion and exchange of ideas during four expert panel sessions. The program was organized in an informal "fireside chat" type of setting, with Clifford Goodman of the Lewin Group serving as the moderator and facilitating the audience Q&A.

The program was organized into 90-minute sessions, each featuring a panel of 3 or 4 experts who offered brief remarks (5 -10 minutes each, no PowerPoint) and then were engaged in discussion with the moderator. Below are some highlights from each of the sessions, along with links to infographics that summarize key takeaways.

Session 1 – Incorporating Clinical Nuance into Medicare Advantage
http://vbidcenter.org/wp-content/uploads/2015/10/0-MA-Infographic-CMMI-Announcement.pdf

The first panel covered the issues and challenges around cost-related non-adherence for Medicare Advantage (MA) beneficiaries. The Center for Medicare and Medicaid Innovation (CMMI) is undertaking a 5-year Medicare Advantage VBID demonstration project in 7 states. Stacy Sanders, from the Medicare Rights Center, shared that there is bipartisan support in Congress to incorporate VBID into the MA program and significant interest in the project. She offered some specific recommendations regarding the design to optimize the outcomes for MA beneficiaries:

1. Incorporate lower cost sharing for high value services to encourage their use;
2. There must be transparency around criteria and the evidence base for identifying high-value services;
3. Offer complementary education for beneficiaries and health care providers;
4. Rigorous monitoring and evaluation will avoid discrimination in design
5. Ensure beneficiary protections by providing the proper tools and using appropriate channels to disseminate information when marketing, providing notices regarding benefits, and answering questions

Session 2 – Creating Consumer Directed Plans with Smarter Deductibles
http://vbidcenter.org/wp-content/uploads/2015/10/0-HSA-HDHP-Infographic.pdf

There has been an increase in consumer directed health plans (CDHPs) over the past 5 years. In exchange for higher deductibles, the premiums are lower. Sara Collins, of the Commonwealth Fund, reported that consumers, particularly those with low incomes, have been cutting back on spending in general; they will frequently forego needed

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care or skip preventive care because of the high out of pocket cost until they reach their deductible. Premium matters the most in their decision-making regarding a health plan, and more than half are choosing narrow networks.

Lydia Mitts, of Families USA, noted the need for flexible benefit designs that include assistance with deductibles and cost sharing. Plans that cover a broad scope of services, *pre-deductible,* (especially for those with chronic diseases) can help to protect low-to-moderate income families from undue financial exposure. There is a need to calibrate subsidies so that the need to meet a deductible won't prevent access to needed medical care. Significant issues remain regarding unaffordable medical expenses and medical debt.

Session 3 – Moving States from Volume to Value
http://vbidcenter.org/wp-content/uploads/2015/08/SIM-Infographic-8-5-15.png

Frances Jensen, Deputy Director of the State Innovations Group at CMMI, encouraged the states to leverage their opportunity to influence change and adopt the philosophy of "health in all things." Pennsylvania is one of the states participating in the MA VBID demonstration project, which is working to integrate behavioral health and social supports into the model. Karen Murphy, Pennsylvania's Secretary of Health, has created a Department of Innovation to help support the project and create new models and redesign care processes. Key takeaways from this panel:

1. Multiple payers must align on measures. The state can convene commercial payers without encountering antitrust issues.
2. States must move toward development and use of a single common report, in a common format and portal
3. Without line-of-sight data, physicians won't know what they need to do

Session 4 – Aligning Payment Reform and Consumer Engagement
http://vbidcenter.org/wp-content/uploads/2012/07/V-BID-Infographic-PDF.pdf

The current one-size-fits-all model of cost-sharing does not differentiate between low-value services and high-value services based on the evidence. Higher deductibles and increased out-of-pocket costs are driving consumers away from using services that they may need to enjoy optimal health outcomes. Clinically nuanced cost-sharing through a value-based insurance design has been proposed as a solution to improve access, reduce waste and encourage appropriate utilization.

Although the sessions were not audio or video recorded, photos and social media exchanges at the VBID Summit are documented on Storify.
https://storify.com/UM_VBID/vbidsummit

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POPULATION HEALTH FORUMS

Next Generation Payer Strategies

Minalkumar Patel, MD, MPH
Senior Vice President,
Horizon Blue Cross and Blue Shield of New Jersey

October 14, 2015

Minalkumar (Minal) Patel, MD, MPH is the Senior Vice President and Chief Strategy Officer of Horizon Blue Cross and Blue Shield of New Jersey (BCBSNJ), where he is responsible for the integration of strategic work throughout the enterprise; the development of business opportunities via a newly-formed business development function; alignment of data analytics with the strategy function; and the creation of a unit that serves as liaison with the Blue Cross Blue Shield Association. Dr. Patel previously served as CEO and founder of Care Management International, a company focused on applying the concept of business process outsourcing to the medical management industry.

Dr. Patel began his Forum presentation with a detailed overview of the healthcare value landscape by describing the market forces that continue to put pressure on traditional payer business models. These forces include: new entrants and intensified competition; provider consolidation and disruption; increased reliance on government; a shift to consumerism and commoditization; and advances in technology. Patel explained that the payer industry is dynamic and that, in his role, he has the opportunity to help chart the future course.

In general, payers are moving away from fee-for-service reimbursement (volume) in favor of paying for value. In order to create value for the sake of the patients and populations, payers must work closely and collaboratively with all key stakeholders. Patel outlined how payers must: partner with leader providers; promote population health management; and engage members in care delivery.

Patel went on to describe a virtual integrated delivery system, one positioned to align incentives and capabilities around efficient, high-quality care delivery. A virtual integrated delivery system may include the hospital system, non-hospital facilities (like urgent care centers and ambulatory surgical centers), and employed and affiliated physicians, and health plans. This integrated model facilitates interactions with provider partners, and payer capabilities assist in enhancing value to the healthcare consumer.

Patel discussed criteria to select system partners, with emphasis on clinical quality, leadership and commitment to a value-based model.

The future of Horizon BCBSNJ will include the provision of power analytics to providers as a means to facilitate delivery of cost-effective care in optimal settings. Patel pointed out ways in which the payer hierarchy of data continues to evolve, with new devices coming online to

produce and distribute health data along with documentation of incidences. The future will also include focus on product design of support tools for members and enhanced financial and clinical analytics for providers.

Patel challenged the audience to imagine a system where consumers can have access to care prior to getting sick…at a site that is convenient for them…perhaps even at home; clinicians can practice and refer to other clinicians at the highest level of their training and benchmark their performance; and hospitals can determine where they excel and should treat more patients; and employers can maximize productivity of their workforce and truly understand the ROI of investments in workplace wellness.

After the Forum, JCPH held a special workshop for Grandon Society members. Dr. Patel spent some time answering questions and discussing the complexities of criteria, tiering, and market strategies, as well as the company's vision.

5 Analytic Imperatives for Successful Population Health Management

Graham Hughes, MD
Chief Medical Officer
SAS Institute's Center for Health Analytics Insights

November 11, 2015

Dr. Graham Hughes is the Chief Medical Officer within SAS Institute's Center for Health Analytics and Insights. He is responsible for identifying and developing opportunities to create novel analytics solutions that help organizations improve care quality, clinical operations and patient outcomes.

Through an entertaining look at various marketing examples outside of health, Dr. Hughes explained that data in aggregate can be used to anticipate and leverage behaviors. Data mining can be used to understand visitor profiles, and data analysis can provide a high degree of accuracy. Behaviors and people are motivated by their diverse types of experiences; how to understand and leverage those behaviors is well understood in retail, finance, and insurance. According to Hughes, there are many valuable lessons from the retail industry that can be applied to healthcare.

Using the illustration of a HONDA (Hypertensive, Obese, Non-Compliant, Diabetic and Asthmatic) patient, Hughes pointed out that the 21st Century Challenge involves understanding how to ameliorate risk in these populations. He asked the audience to think about population health, starting with the individual and then layering in the various interactions between genetics, environment, behavior and related data.

Hughes when on to discuss the leap from volume to value, explaining that achieving value is really quite complicated, and goes beyond the cost/quality equation. We often don't fully understand the scope of the timespan being used to assess value or from which of perspective we are measuring value. What are we doing systemically to understand which outcomes really matter to the patient?

A robust analytics foundation includes: management of financial risks and incentives; proactive management of quality and outcomes; improvement of efficiency and care delivery; and population health management and patient engagement.

The future will include significant movement toward transparency and data sharing at the regional and international level. Connectivity will continue to play a key role. "Assume every device is connected…your t-shirt, jacket, and shoes will be submitting data over the next 10 years and the data will be used to help us understand the individual," states Hughes.

In summary Dr. Hughes described his analytics imperatives as: movement from piecemeal analytics to enterprise analytics; a mixed delivery approach – on premises and cloud-based; clinical decision support system as a continuum; rethinking the end-to-end process; and development of an analytics Center Of Excellence.

Rx for a Better Home: Philadelphia's Healthy Rowhouse Program

Kiki Bolender, AIA, LEED AP
Principal, Bolender Architects

December 9, 2015

It may seem peculiar to feature an architect for a Population Health Forum, yet it's really aligned with national efforts for a Health in All Policies approach. The relationship between housing, the built environment, and social determinants of health relate directly to the overall health of the population.

Kiki Bolender is principal at Bolender Architects, where current projects include renovation to a City of Philadelphia Health Care Center in the Northeast. Bolender's Forum presentation focused specifically on the Healthy Rowhouse Project, an initiative aimed at: creating a robust housing policy that includes repair and preservation of existing rowhouses; improving residents' health (with an emphasis on removing asthma triggers); and providing good quality affordable housing.

Bolender first gave a historical overview and description of Philadelphia's rowhomes. For example, 70% of all housing units are rowhouses; of those, 75% are over 50 years old; 40% of all renters live in single-family homes. In the past, rowhomes were built near factories to keep residents close. Though there was a strong social fabric, working conditions weren't always safe. Today, Philadelphia generally lacks affordable housing in good condition, in safe areas.

Funded by the Oak Foundation, the Healthy Rowhouse Project plans to repair 5,000 privately owned homes by very low income renters, homeowners and landlords each year. Repairing 10-20 homes on one block instead of random interventions is ideal.

The Healthy Rowhouse Project is really focused on two themes: making the

Continued on page 18

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inside of the home more conducive to health and reviving the healthy cityscape. One way to achieve this is through repairs that reduce dampness, therefore decreasing chances of poor health and in particular asthma. 40% of asthma cases are associated with triggers in the home. Repairs such as plumbing, dry wall, and roofing have wide-ranging positive consequences, explains Bolender. Helping long term home owners is ideal. "We like to talk about wealth and equality rather than income," states Bolendar, meaning that housing for a homeowner is related to wealth. Investment and giving people choices is an important step and helps to guard against gentrification. As for renters, the project strives to work with landlords to improve housing without raising rent.

Bolender discussed potential financial sources for home repair which include banks, new National Housing Trust Fund, HUD Healthy Homes Funding, social impact investing and municipal bonds.

Bolender closed the Forum session by outlining future goals of the project which emphasize the use of data and increased funding to enhance the project.

UPCOMING JCPH FORUMS - WINTER 2016/SPRING 2016

February 10, 2016

What Does Population Health Mean for Public Health?

James W. Buehler, MD
Professor, Health Management and Policy
Dornsife School of Public Health
Drexel University

Hamilton Building – Room 505

March 16, 2016

Financing Population Health Improvement

Donald Hinkle-Brown, MBA
President & CEO

Amanda High
Chief of Strategy Initiatives
The Reinvestment Group

Jefferson Alumni Hall
Solis Cohen Auditorium

April 13, 2016

*The Benefits of Building Scale for Population Health

Alan Zukerman, FACHE, FAAHC
Director & Chair

John M. Harris, MBA
Chair, Veralon

Bluemle Life Sciences Building – Room 105/107

** This forum will be followed by a special Grandon Society member-only program from 9:45 am – 10:45 am.*

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

SAVE THE DATE

The 25th Annual Dr. Raymond C. Grandon Lecture
Featuring Gail R. Wilensky, PhD, Senior Fellow, Project HOPE

May 12, 2016
12:00 pm – 2:00 pm

Connelly Auditorium, Dorrance H. Hamilton Building
Thomas Jefferson University

SPECIAL ANNOUNCEMENT

HEARSTHEALTH prize

IN PARTNERSHIP WITH

Thomas Jefferson University
Jefferson College of Population Health

Congratulations to the Finalists of the Hearst Health Prize for Excellence in Population Health

Centering Healthcare Institute

Community Care of North Carolina

Jersey City Medical Center – Barnabas Health

For details visit: Jefferson.edu/PopulationHealth

JCPH PRESENTATIONS

Dogra M, Diecidue R, **Leader A.** How involved are dentists in preventing HPV-related oral cancer? Podium presentation at: APHA Annual Meeting and Expo, November 4, 2015, Chicago, IL.

Harris D. Population health: the primary opportunity facing the U.S. Healthcare system. Presented at: ASHP Conference for Pharmacy Leaders, October 20-15, 2016, Chicago, IL.

Leader A, DeArmas E. Did you Tweet from an iPhone or Android? Examining differences in how HPV vaccine is discussed by platform. Poster presented at: APHA Annual Meeting and Expo, November 1, 2015, Chicago, IL.

Leader A, DeArmas E. "Elite users" on Twitter: Examining key features for crafting future HPV vaccination communication campaigns. Podium presentation at: APHA Annual Meeting and Expo, November 2, 2015, Chicago, IL.

Leader A, DeArmas E. Using a novel software program to improve Twitter data collection methods. Roundtable presentation at: APHA Annual Meeting and Expo, November 3, 2015.

McIntire RK. Purchase of loose cigarettes by adult smokers in Philadelphia: individual correlates and neighborhood characteristics. Poster presented at: APHA Annual Meeting and Expo, November 1, 2015, Chicago, IL.

McRae JM, Varga S, Vegesna A, Alcusky M, Hegarty S, Keith S, Del Canale S, Lombardi M, **Maio V.** Potentially inappropriate medications in the elderly and associated outcomes: what can the US learn from a retrospective Italian cohort study? Presented at: American Managed Care Pharmacy Nexus, October 2015, Orlando, FL.

JCPH PUBLICATIONS

Alcusky M, Ferrari L, Rossi G, Liu M, Hojat **M, Maio V.** Attitudes toward collaboration among practitioners in newly established medical homes: a survey of nurses, general practitioners, and specialists. *Am J Med Qual.* Published online before print July 30, 2015, doi: 10.1177/1062860615597744

Luppatelli M, **Alcusky M,** Aristei C, Bellavita R, Jereczek-Fossa B, **McAna J,** Showalter T, **Maio V.** Adjuvant and salvage radiation therapy after prostatectomy: investigating beliefs and practices of radiation oncologist. *Brit J Radiol.* 2015;88(1055):20150587. doi: 10.1259/bjr.20150587. Epub 2015 Sep 22.

Nash DB. A leap in the right direction. *MedPage Today.* October 22, 2015

Nash DB. Does a 'stick' work without a carrot? *MedPage Today.* November 9, 2015.

Nash DB. Information blockade ahead! *MedPage Today.* December 17, 2015.

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