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GUEST EDITORIAL

Present At the Creation

Caroline Golab, PhD is Jefferson College of Population Health's Associate Dean for Academic and Student Affairs. In 2007, she was the consultant who conducted a feasibility study and developed the business plan for the new school. After the TJU Board of Trustees approved the proposal in 2008, she was asked to implement the plan. Dr. Golab is retiring later this year after nine years with JCPH. She was asked to give some reflections on what it was like to be "present at the creation" and what makes the College of Population Health unique.

It was a dark and stormy night. Well, almost. It was Halloween 2007 when the phone rang. "Can you meet me after work?" said the voice on the other end. "I want to make you an offer you can't refuse."

And that's how my journey into the world of Population Health began.

David Nash, MD, then Chair of JMC's Department of Health Policy, had just come from a meeting with TJU President Robert Barchi, MD, PhD. The University was concluding an intense 2-year strategic planning process. Jefferson was at a crossroads. If it wanted to maintain – and enhance – its reputation as a national leader in health care delivery, it would have to tackle the non-clinical issues that were making delivery increasingly difficult – cost, accessibility, quality, patient safety, medical error, chronic disease management, end-of-life care. For the industry in general, and for Jefferson in particular, confronting these issues was crucial to survival. Solving them, however, required a paradigm shift in our way of thinking, a shift that would place wellness and prevention at the core of our mission. As a major academic health center, how should Jefferson respond to this challenge? That was the momentous question Dr. Barchi posed to Dr. Nash on Halloween 2007.

When we met that evening over beer to take up the challenge, it became increasingly clear that the idea of a new school dedicated to what we now so easily refer to as "population health" was the only answer. The visionary in David Nash saw this so clearly. For more than twenty years he and other forward thinking Jefferson leaders like Richard Wender, MD, former Chair of the Department of Family and Community Medicine, had been voices in the wilderness, sending up cautionary tales about these issues to any and all who would listen. People were finally listening, but was a new school feasible? Financially viable? What programs would it offer? Who would teach the courses? Would we find students to fill the seats? Could we convince the traditional Jefferson Establishment to do something that had never been done before, anywhere in the country – establish a school dedicated to *population* health – not *public* health? Our conclusion: Build it and they will come.

And why did I agree to get involved? Throughout my career I have been involved in designing, building, revamping and rescuing the educational initiatives of various institutions (most likely the reason I was asked to take on this new mission). I am, by profession, a historian, someone who has spent a lifetime studying 19th and 20th century immigration and urbanization and the economic and technological forces that brought these two movements together across the cities of the world. In studying the migration of peoples, I find that each group, each migration, has a *pattern*, and that these patterns speak volumes. I look for *root causes* – the social and economic determinants – that propel these movements and determine why they happen, when they happen, and why someone ends up here but not there. I use big data to find the patterns, to secure the information that explains why my grandparents settled on the streets of Chicago rather than Baltimore, Minneapolis, Rio de Janeiro or Sydney. In all these ways, I am not very different from the epidemiologist who uses big data to study the spread of disease and who looks for patterns and causes. I was doing "population health" most of my life but didn't know it.

The beauty of starting something from scratch is that you can take the best practices proven elsewhere and make them your starting point. Like Captain Kirk, our secret mentor, we took our mission very seriously to "boldly go where no one has gone before." If I had to pick five things that make the Jefferson College of Population Health unique – and successful – I would offer the following:

1) *One-of-a-kind quality programming in health policy, healthcare quality and safety, applied health economics/ outcomes research and, of course, population health.* These stand-alone programs, many of them the first of their kind, aim for depth and real-world applications. Although they build on public health foundations, when we started these programs back in 2007, they were not seen as part of the established public health education model. (This is the primary reason why we opted *not* to become a School of *Public* Health.)

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2) *Student-focused use of asynchronous online learning.* Recognizing that the audience for our programs would be national, even international, an online format was essential. But we had to fight for it. The Jefferson Establishment initially viewed online learning as easy, insufficiently rigorous, and not up to Jefferson standards. In response, we used best practices identified by the Sloan Consortium and the national gold standard rubric *Quality Matters* to develop high-end online learning programs with small classes (15 students max) where the emphasis is truly on *learning*. Ratings in critical outcomes – student satisfaction, student learning outcomes, faculty satisfaction, interaction between faculty and students and students with students – are higher in our online courses than our face-to-face classes. Online courses, when done right, create a greater sense of community than the typical face-to-face classroom. Our online students tell us this all the time.

3) *Distinctive faculty models that stress teacher-scholars and practitioners.* Usually, faculty are hired for their content expertise and ability to conduct research and to secure funding for it. Promotion and pay increases depend on it. Their interest and ability to teach are secondary. We flipped this model: In JCPH, faculty are hired for their content expertise but evaluated for their teaching; promotion and raises depend on successful student learning. Following the Boyer Model, we guarantee our teacher-scholars 20% "protected time" so that they can enhance their classroom teaching with scholarship and practice experience. For our online programs, we rely on *practitioners*, working professionals who can share their personal experience with our students; they "teach" what they actually "do" in real life. These models, while conducive to real learning, are not the norm now, but will be in the future.

4) *Innovative approaches to research* that create real-world and real-time laboratories to study population health issues. In collaboration with Main Line Health's (MLHS) Lankenau Institute for Medical Research (LIMR), we established a Center for Population Health Research, directed by our faculty, to study health issues specific to the catchment area serviced by MLHS. In similar fashion, we have inaugurated a second research center through a collaboration with the 1889 Foundation and Conemaugh Health System in Johnstown, PA. While the former will study health issues related to both affluent suburban and underserved urban populations (cancer and diabetes, e.g.), the latter will focus on issues related to less affluent rural populations (e.g., opioid drug dependence).

5) *Rethinking student audiences and redefining "workforce development."* Students in our on-site MPH program (30% of our population) tend to be recent college graduates seeking a full-time (more or less) student experience that prepares them for first-time jobs/careers. In contrast, students in our online programs tend to be well-established working professionals, most often clinicians and healthcare executives, seeking education to cope with the accelerating changes transforming health care today. In our HQS programs, for example, 52% of students are over 50 and 87% are over 40; no one is under 30. Just as our academic programming favors established health and healthcare professionals, so does our definition of "workforce development." In our view, population health means putting public health together with healthcare delivery (ending the regrettable schism created by the *Welch-Rose Report* of 1915).[1] We take public health principles and practice directly to the medical establishment, both current and future, by encouraging Jefferson medical students to complete an MD *and* an MPH degree while at Jefferson and by working with medical school leaders to revise their curricula to infuse population health. We do this by offering monthly Population Health Forums, annual Population Health Colloquia, Grandon Lectures, Population Health Academies and other CME/CNE activities aimed at medical and healthcare professionals who otherwise would have no exposure to this material.

In retrospect, back in 2007 there was little argument about the idea of a new school. Everyone agreed the time was right. The controversy was in the *name*. We were strongly advised not to put *Population Health* in the title. "The term's a fad." "No one knows what it means." "It will be passé in two years. Jefferson will be a laughing stock."

Almost ten years later, no one is laughing. If imitation is the sincerest form of flattery, then we've started a trend – or, more aptly, a movement. The Universities of New Mexico and New England have established Schools of Population Health and more are coming soon. Countless others have formed Departments, Centers and/or Institutes that bear the name. Still more have added the term to their programming. We receive calls from around the country asking for help in getting started.

Most important of all, the advance to population health has caught the attention of the public health community – with a vengeance. From every program, department and school of public health in the country to leadership groups like American Public Health Association APHA), Association of Schools and Programs of Public Health (ASPPH), and the Council on Education for Public Health

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(CEPH), the dialogue over the meaning and "ownership" of population health has become intense, even combative. We are re-thinking Welch-Rose.

The historian in me likes to think that, in many ways, the Jefferson College of Population Health started it all. Our very presence was disturbing. We threw down the gauntlet and challenged the status quo. Now everyone is trying to find their place again. This, when all is said and done, may be the most important contribution that the Jefferson College of Population Health has made to U.S. health care. Resistance is futile. Live long and prosper!

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REFERENCES

1. Feldscher K. The birth of public health education. March 17, 2015. https://www.hsph.harvard.edu/news/features/the-birth-of-public-health-education/ Accessed August 1, 2016.