

Population Health Matters

Spring 2017 | Vol. 30, No. 2

EDITORIAL

Quarterly Publication

Buried Treasure

My wife and I are downsizing—selling our comfortable suburban home of 29 years for a townhome. In the process of cleaning out nearly three decades of record keeping, files, and photos, I have uncovered some buried treasure!

The yellowed Xerox paper is fraying and the black and white photo is truly embarrassing, but I kept a complete copy of my application to the University of Rochester School of Medicine and Dentistry dated August 12, 1976. Of course this is long before the advent of the personal computer and the internet. It appears as though the form was typed on my Smith Corona typewriter, and I made carbon copies along the way. Some younger readers may need to consult a middle-aged colleague for a translation of this paragraph.

Several aspects of this archaeological discovery stand out, and I wanted to share those relevant parts and provide some background and historical context. I attended a very large public high school on the south shore of Long Island, NY, with a graduating class of more than 650. I was fortunate to gain admission to Vassar College in the second fully co-educational class after Vassar determined not to merge with Yale in 1968.

At Vassar I was essentially a double major with a primary concentration in economics and then I fulfilled all of the typical pre-medical requirements. As such, my “science GPA” was good, but my overall exposure to any advanced classes in the life sciences was negligible. In other words, while my academic record was good, my deeper understanding of the sciences beyond the minimal pre-medical requirements was scant. Applying to a top tier medical school

like Rochester was certainly what could be considered a “reach,” especially back then. However, the main message today is not my college academic record, but the essay that I wrote over 40 years ago this summer.

Please indulge me and join me for a look back at a moment in time. What follows, nearly in its entirety, is my “personal statement” for gaining entrance to the University of Rochester School of Medicine and Dentistry.

Personal Statement

Our healthcare delivery system will be faced with increasingly complex problems as we enter the 21st century. Today, unfortunately, the medical world is under attack on many fronts for the poor distribution of its practitioners and the inaccessibility, expense and inefficiency of the care delivered. These problems are compounded by the virtual explosion in biomedical knowledge that we have witnessed in the last two decades.

In order to effectively plan and develop our health delivery system, the medical sector, I believe, must continue to train clinicians who involve themselves in the scientific as well as the economic and community affairs of medicine. As the pace of technological change accelerates, physicians and scientists will be at the forefront, interpreting and hopefully utilizing these changes for the betterment of man. However, one must always be willing to learn about new procedures and discoveries while building upon the accomplishments of the past. Simply, physicians must be perennial students.

Buried Treasure.....	1
Reflections Over the Decades – 45 Years in Public Health.....	2
On the Front-Line: Understanding Philadelphia’s Homeless Populations Through the Point-Time Count.....	4
SE PA “Collaboratory” to Address Social Determinants of Health.....	5
Implementing a Hepatitis C Screening Program.....	7
Intermountain Healthcare Receives 2017 Hearst Health Prize.....	9
Jefferson Designated Baby-friendly Hospital.....	9
Thomas Jefferson University Primary Care Population Health Research Fellowship: A New Partnership.....	10
From Health Policy to Population Health: Impressions and Highlights of Recent Conferences.....	11
Third National Primary Care Ambulatory Patient Safety Conference on Research and Education.....	13

Announcements & Upcoming Events

Hearst Health Prize.....	9
Population Health Colloquium Highlights.....	14
Adjunct Faculty Positions Available.....	15
Population Health Forum Summaries.....	16
JCPH Publications.....	18
JCPH Presentations.....	19
In The News.....	19

Continued on page 2

The strenuous discipline of a medical education requires, I believe, total dedication to its principles. The foundation of these principles is built with a lifetime of moral, educational and family values. The strengths of youthful idealism will enable me to face the exciting challenges of a medical education and its concurrent responsibilities.

My undergraduate science and economics training, together with summer work in both medical research and health care management, has strengthened the base on which I can vigorously pursue a medical education. I enjoyed my responsibilities as a Student Fellow and my tenure on important Student Government and academic committees. Summer work at widely recognized medical centers has greatly heightened my enthusiasm for medicine.

While a medical education remains my primary goal, I have been extremely interested in combining my medical training with a sound management background. As health maintenance organizations mature, and as the government's role in financing medical care increases, the demand for specially trained physicians becomes axiomatic.

In the summer of 1974 I completed an administrative internship at the Long Island Jewish-Hillside Medical Center (now called [Northwell Health](#)), under the preceptorship of Mr. Arnold Goldstein, Deputy Director. This 10-week program, sponsored jointly by Long Island Jewish and the American University Programs in Hospital Administration (AUPHA), enabled me to view virtually all of the activities in a modern medical center. My rotation took me from the boiler rooms, through the operating room suites, to the executive management committee meetings. In addition, I spent part of my rotation at Long Island Jewish-Queens Hospital Center and the numerous mental health outreach programs on Long Island.

My economics advisor at Vassar encouraged me to pursue my interest in the economics of healthcare delivery. Courses in financing, accounting, labor relations, and basic economic theory are all directly related to my career goals. The academic environment at Vassar enabled me to do research for term papers in health-related topics. My independent work, as indicated on my official transcript, represents some of the political, sociological, and economic facets of healthcare delivery.

Thus, I believe that my lifetime dedication, personal drive, education, and work experiences have all combined to give me confidence in my ability to help meet the health challenges of Americans in the years ahead.

Heartfelt? Surely! Prescient? Maybe. By whatever measure, it was a thrill to uncover this buried treasure and to review my personal commitment to the issues that fully occupy my energies today more than 40 years later. How grateful I am to be at Jefferson and to have the humbling experience to help build and then lead the nation's first [College of Population Health](#). I feel very lucky to have had the ability to pursue my life's passion, and hope to see the growth and improvement that is so vital to our country's economy and the wellbeing of our citizens. Thank you for sharing in that work and joining me on a brief trip down memory lane.

David B. Nash, MD, MBA

Dean

Jefferson College of Population Health

David.Nash@Jefferson.edu

Reflections Over the Decades – 45 Years in Public Health

As I complete my 45th year in public health here in the U.S. (the last 10 at Jefferson), I have often been asked what has maintained my passion for public health as a career and profession. My response is three-fold: 1) the incredible work we do in public health to help people and their families live a healthy, productive and rewarding life where they work, study, and play, 2) the noble values we hold of social justice, human rights, and eliminating inequities and disparities, and 3) the enjoyment, affinity, and love we feel with our colleagues, working on shared goals to improve the lives of the people we serve.

Looking back over the past decade, so many thoughts come to mind. I recall the unusual beginning when I received a call from a faculty colleague at the [Drexel School of Public Health](#), (Wendy Voet, MPH), who casually mentioned she heard about an

open position for a public health program director at Jefferson. I didn't know much about Jefferson, except that it was the designated medical school for Delaware. I had also visited the campus a few years prior when I was at [Christiana Care Health System](#) and was referred to a physician in Family and Community Medicine at Jefferson to talk about public health and medicine. That doctor was James Plumb, MD, MPH (Director of Jefferson's Center for Urban Health) and the family doctor who referred me was Janice Nevin, MD, MPH (now President and CEO of Christiana). I hadn't thought about leaving Drexel but decided to inquire. Jennifer Ravelli, MPH, answered that call. She mentioned that Jefferson had a small Master of Science of Public Health (MSPH) program in their College of Graduate Studies, and that it was in the midst of an organizational transition and planning to hire its first full-time

program director. After a brief conversation about the program, its mission, students and faculty, and a little about my public health background, I asked about the application deadline. There was a long pause and finally Jennifer responded that the deadline was closing but if I could submit my application soon, it would be reviewed. I thought about submitting it by the end of the week, when Jennifer asked if I could submit an application . . . *immediately*. I submitted my application in the next hour. The next day, I received a call for a meeting with David Nash, MD, MBA, who at that time was the Chair of the Department of Health Policy at Jefferson Medical College. We met two days later at Suburban Station on a stormy spring day in 2007. We sat on a bench talking about Jefferson and its recently approved strategic plan by then-President Robert Barchi, MD, PhD to create a new School of Population Health. Dr.

Nash mentioned how the MSPH program would be an integral part and the signature program of this new school.

Initially, the MSPH program was located in the Jefferson College of Graduate Studies (JCGS). We re-designed the curriculum to an MPH and expanded the required credits from 38 to 40 and then to 42 to meet the Council of Public Health (CEPH) requirements for national accreditation. During this transition, I credit the following individuals for moving our program forward: James Keen, PhD; Gerry Grunwald, PhD, Dennis Gross, PhD, Robert Bartosz, Eleanor Gorman, Jennifer Ravelli, MPH and Lisa Chosed, MA. In 2008, Caroline Golab, PhD was hired and helped lead the organizational and strategic plans for the new school and provided tremendous support to get the MPH program accredited in 2009 as the new School of Population Health “opened its doors” to students.

There have been so many wonderful memories through the years. Some of the highlights for me included:

- The growth and development of the MPH program with new faculty and competency-based curriculum along with our outstanding students and alumni. It has been so meaningful to see our students grow as public health professionals and hear about their successes as alumni. I continue to be amazed by our students.
- Our collaboration with a wide range of public and private community organizations such as: the Philadelphia Department of Public Health; Public Health Management Corporation; Health Care Improvement Foundation; College of Physicians Section on Public Health; The Food Trust; Maternity Care Coalition; and the MPH Community Advisory Board. I am also very grateful for the many collaborators and partners within Jefferson, including the Department of Family and Community Medicine, and the Jefferson Center for Urban Health.
- Our professional meetings such as our monthly Forums, Population Health Colloquium, special professional meetings and events including our class nights, semi-annual JCPH faculty meetings and various professional presentations, our fun and joyous



Rob Simmons, DrPH, MPH, MCHES, CPH

holiday celebrations, social gatherings, community service projects, etc.

- Successful completion of two program accreditations with CEPH in 2009 and 2016, knowing the hard work put in by so many people.
- Collaboration with other universities on initiatives such as Community Driven Research Day, celebration of Public Health Week, partnerships with other graduate and undergraduate institutions and programs as formalized through our articulation agreements.
- Our collaboration with Philadelphia University, College of Architecture + Built Environment and their Design program, and their College of Science, Health, and Liberal Arts and various programs that will be linked with our MPH program. We have only been engaged with them for just over a year yet it feels that we have been *family* for a decade and of course, we will be family as a single university in the near future.

The future is very bright for the Jefferson College of Population Health and the MPH program. With new leadership under Associate Dean Billy Oglesby, PhD, MSPH, FACHE, and my successor Rosemary Frasso, PhD, MSc, CPH, and our great faculty, students, staff and alumni, the MPH program will reach new heights and take on increased importance and relevance in our region.

To add to this amazing time in my life, I honestly can't think of a more fantastic

pre-retirement send off than by being recognized by the Society for Public Health Education (SOPHE) with their highest award of Distinguished Fellow as well as College of Physicians of Philadelphia Section on Public Health and Preventive Medicine, 2017 Individual Recognition Award. I'm so touched and honored by these recognitions.

I want to thank everyone in the College and the University for an enjoyable and productive decade for me. In particular, I want to single out JCPH leadership, David Nash, Caroline Golab, Alexis Skoufalos, Neil Goldfarb, David Glatter and our program directors over the years for their dedication and support of public health and our program. A special thanks to our administrative staff over the decade who has helped make the MPH program and my job so much easier. And a sincere thanks to all our faculty, not solely those in our College, but colleagues like Rickie Brawer, Jim Plumb, Rich Pepino, and all our adjunct faculty from throughout Philadelphia.

Finally, I want to thank my wife, Roselena, who has been my *soul mate* and best friend for the past four decades as we begin our new journey, returning to her home (and mine) in Colombia.

Rob Simmons, DrPH, MPH, CPH, MCHES
Associate Professor
Program Director, Public Health
Jefferson College of Population Health
Rob.Simmons@Jefferson.edu

On the Front-Line: Understanding Philadelphia's Homeless Populations Through the Point in Time Count

Each year on a cold January night, hundreds move through the streets of Philadelphia on a quiet mission. They support the [Point in Time \(PIT\) Count](#), an annual effort to count the sheltered and unsheltered homeless persons in America's cities. Teams of volunteers set out in different "zones" to survey homeless individuals and connect them with resources. The data gathered provides insight on the extent of homelessness and ways to improve related services.

More than 250 volunteers participated in the January 26th [Philly Counts](#) event, including four from Jefferson's College of Population Health. Dr. Amy Leader, faculty member, and MPH students Madeline Brooks, Cordelia Elaiho, and Karla Geisse worked in part of Suburban Station from 4-7 a.m., where they conducted surveys and distributed care packages.

Madeline's Experience

The PIT Count opened my eyes to the simultaneous visibility and concealment of Philadelphia's homeless population. One need only walk down Market St. or Broad St. to pass several homeless individuals, yet here in Suburban Station at 4 a.m. were more than 100 people, congregated on benches or sleeping in secluded corners, who would dissipate with the morning commuter crowd. During the daytime no one would ever know about this station's "hidden" population.

The PIT Count took place on my 24th birthday. While interviewing individuals I encountered a man only three months younger than me. He revealed that he had previously been in and out of the foster care system. I reflected on the chain of events that brought me to Philadelphia for graduate school while this man had to take shelter in a subway station. Little separated us except for different circumstances – a deeply humbling realization.

That morning I also spoke with two individuals told me about the ways in which 'the system' had failed them. One woman angrily described outreach work as "passing the buck," while another man claimed that politicians would never care

about the homeless. While I knew that the data gathered from the PIT Count would help Philadelphia to alleviate its burden of homelessness, that meant little to those who already felt forgotten. Participating in the PIT Count reaffirmed my belief in the value of a population health perspective. We can address homelessness only by combining personal care with knowledge of the social and economic factors that allow it to continue. I'm proud to have been part of these efforts.

Cordelia's Experience

One hundred twenty-one: that was the number of homeless people we counted at Suburban Station the morning of January 26th, 2017. Some were awake, discussing life and other events. Many were sleeping, trying to catch a few hours of rest. When I signed up for Philly Counts I did not know what to expect. I did not expect to interview everyone with whom we came in contact, and on a relatively warm January night, I was not expecting so many people in the station. There was the added caveat that our newly elected President, Donald Trump, was in Philadelphia for the Republican Retreat and I was unsure if his presence would cause the relocation of the homeless. I have never participated in a Point in Time count before and I was grateful for the training provided by [Project HOME](#) and the leadership of Dr. Leader. For a few early morning hours, our team witnessed and shared in the experience of a diverse mix of people who were homeless and seemingly hopeless.

The most memorable conversation I had was with a young lady who seemed to have no support. She discussed how she felt so alone. She participated in last-resort measures in order to make it through the month. It was almost unbearable to hear her story. I wanted to sit with her and parse through how she got to be in this position and what her plans were going forward. It is easy to tell someone to work hard and push through. It is also easy to give advice and make suggestions, but many times, people just want a listening ear. They want to know that they matter as humans, not just as a project. This young lady wanted to know



Left to Right: Amy Leader, PhD, Karla Geisse, Cordelia Elaiho, and Madeline Brooks

that I understood some of the hardships she was experiencing.

The Philly PIT Count was incredibly shocking and moving. The number of homeless people at Suburban station was just a fraction of those without a home all over Philadelphia. It was a memorable night. I hope I was able to portray the compassion and care necessary.

Karla's Experience

As a population health student, I hear and read many statistics related to Philadelphia's challenging issues, including the amount of homelessness within the city. This does not really prepare you for the sight of a subway station that is filled with sleeping individuals surrounded by the belongings they can carry at four in the morning. As a part of the PIT event, our group surveyed and counted the homeless population in Suburban station beginning at four in the morning and ending around seven for a total of around 121 in Suburban Station during that time interval.

One particular conversation stood out for me with a woman I'll call "T". T had been homeless off and on for around a year, suffering from multiple mental and physical problems, coming from a broken home with unsupported veterans. However, she had a certain grace, dignity and pride, which I found exceptionally admirable. She spoke eloquently and was proud of her family's contributions to the nation. She also had much more energy than I did during the morning hours.

The experience was very eye-opening, especially as I commute through Suburban Station every morning when I come to campus. I had no idea of the extent of the migration in and out of these stations every morning, and I was told that they are typically more crowded during this time of year (not being so because of the warmer weather conditions). I was also very much surprised about the amount of resources available – there was a “hub” within Suburban Station itself,

handing out beverages and providing resources for shelter and medical care. It was very heartening to see the amount of passion for this cause. Especially at four in the morning.

Madeline Brooks
Madeline.Brooks@Jefferson.edu

Cordelia Elaiho
Cordelia.Elaiho@Jefferson.edu

Karla Geisse
Karla.Geisse@Jefferson.edu

The authors are students in the MPH program at JCPH.

JCPH STUDENT CAPSTONE PRESENTATIONS

Make sure to check out the latest student capstone presentations on [Jefferson Digital Commons!](#)

SE PA “Collaboratory” to Address Social Determinants of Health

Health policy experts have identified multi-stakeholder collaborations as effective – indeed necessary – strategies for improving population health, especially in communities with socioeconomic challenges.^{1,2} In southeastern Pennsylvania, COACH—Collaborative Opportunities to Advance Community Health—seeks to test a “collaboratory” approach to addressing the underlying social needs that give rise to poor health. COACH’s ultimate goal is to achieve measurable improvements in the population health of vulnerable local communities, thereby reducing the incidence of preventable medical interventions—such as hospital readmissions—caused in part by patients’ social circumstances.

Toward the end of 2014, final Internal Revenue Service (IRS) regulations³ authorized by the Patient Protection and Affordable Care Act (ACA) provided for greater collaboration in nonprofit hospitals’ community health needs assessments (CHNAs) and strategies implemented to address unmet population health needs. These regulations led hospitals, public health agencies, and community organizations in Greater Philadelphia to explore how they could work together to improve community health. As described in 2016,⁴ Department of Health and Human Services (HHS) Region III, along with [The Hospital and Healthsystem Association of Pennsylvania \(HAP\)](#), convened the initial meetings to consider opportunities for such collaboration. The official launch of COACH in September 2015 was the end result.

During 2015, HAP formally recruited hospital and health system participants, invited the participation of public health department representatives, and engaged [The Health Care Improvement Foundation \(HCIF\)](#) to facilitate the collaborative effort. Community organizations and stakeholders began joining COACH in mid-2016 (see Table 1 for current list of participants and stakeholders).

COACH participants view the effort as a “collaboratory”—a respectful, evidence-driven environment where relevant research findings, outcomes from new models of care, and emerging best practices can be identified, tested, and evaluated. COACH provides an opportunity for participants to:

- Engage in shared learning
- Strengthen the partnerships necessary to address social determinants of health
- Build stronger relationships with patients and communities
- Align with the population health vision of thought leaders and policy makers, as well as local, state, and federal public health improvement efforts

In addition to revised IRS regulations supporting hospital and health system collaboration on joint CHNAs and implementation strategies, recent policy approaches have promoted more

coordinated, multi-stakeholder approaches to community health improvement. Widespread dissemination and adoption of collective impact⁵ and the Robert Wood Johnson Foundation’s “[Culture of Health](#)” have provided partners with common language and frameworks to guide collaborative planning and action.

In response, hospitals in communities as diverse as the [Lehigh Valley in Pennsylvania](#), [King County in Washington](#), and [Washtenaw County in Michigan](#) have worked together on joint CHNAs. However, pursuit of joint implementation strategies to address shared community health needs have to date been much less common. Drawing on the example provided by the [Healthy Chicago Hospital Collaborative](#), COACH sought to be an “early adopter” of implementation strategies shared among a group of hospitals and health systems, in partnership with public health and community stakeholders, in southeastern Pennsylvania.

As the COACH facilitator, HCIF developed and implemented a yearlong structured process for exploring collaborative strategies to address unmet needs emerging from local hospital and health system CHNAs. HCIF support included:

- **Facilitation.** Preparation, delivery, and follow-up for collaborative convenings, including 10 in-person meetings.

Continued on page 6

Table 1. COACH Participants and Stakeholders

Hospital and Health Systems	Public Health Stakeholders	Community Stakeholders
Children’s Hospital of Philadelphia Einstein Healthcare Network Holy Redeemer Health System Jefferson Health (including Abington Jefferson Health and Aria-Jefferson Health) Mercy Health System Temple University Health System University of Pennsylvania Health System	Montgomery County Health Department Pennsylvania Department of Health Philadelphia Department of Public Health U.S. Department of Health & Human Services, Region III	Benefits Data Trust Center for Hunger-Free Communities, Drexel University Coalition Against Hunger Delaware Valley Regional Planning Commission The Food Trust Health Federation of Philadelphia Health Partners Plans Keystone First Philabundance Philadelphia Association of Community Development Corporations Share Food Program United Way of Greater Philadelphia and Southern New Jersey

Continued from page 5

- **Outreach and Engagement.** Regular one-on-one communication with participants to gather information and elicit feedback. Engagement of community stakeholders as collaborative participants.
- **Prioritization.** Development and implementation of methods and matrix tools for prioritizing health needs to address collaboratively.
- **Research.** Comprehensive research on best practices to inform development of shared implementation strategies.
- **Synthesis.** Development of a draft implementation strategies document and a specific proposal for a healthy food access pilot.

Through this process, participants identified healthy food access as a high-priority need for vulnerable populations in the region. In late 2016, COACH hospitals and health systems collectively adopted this strategy:

In coordination with partners in the region, implement a healthy food access pilot that 1) institutes screening for food insecurity through a validated two-question survey tool administered in the clinical setting; 2) tests interventions to improve healthy food access and processes for referral to community resources; and 3) tracks and shares common impact measures.

Key reflections on the first year:

- Synthesis of hospitals’ first-round CHNAs and discussion of the [health impact pyramid](#) helped participants realize the importance of pursuing “upstream” strategies with potential for greater impact.
- Building trust among hospital and public health participants and identifying areas of focus before engaging with community stakeholders provided for effective group dynamics and more targeted stakeholder recruitment.
- Getting the right mix of consensus-building versus timely progress was a tricky trade-off. Meetings sometimes focused on participant-driven decision-making at the expense of moving more quickly to conclusions and a plan of action. By more aggressively leveraging participants’ mutual respect, HAP and HCIF likely could have helped the collaborative settle sooner on its shared implementation strategy.

Nearly 18 months into the COACH collaborative, results include:

- **Sustained engagement.** HAP and participating hospitals and health systems recently committed to the resources and staff support need to support the next 18 months of collaboration.
- **Better relationships.** Strong attention to process and transparency created

an environment that fostered open sharing of questions and concerns. As a result, hospital, public health, and community participants have a better understanding of and respect for one another’s expertise, experience, and challenges, which serves as a strong foundation for collaboration.

- **Shared implementation strategies.** COACH hospitals and health systems have documented their intent to implement the food access pilot in selected clinical practices.
- **The start of COACH’s first collective action.** COACH has established initial workgroups to develop the food access pilot’s framework for food insecurity screening and referral, facilitate better identification and connections to appropriate food resources, and explore interventions for directly addressing food needs in clinical settings to be tested through the collaborative.

COACH has provided hospital, health system, public health, and community stakeholders with an efficient, cost-effective method of evaluating emerging models and best practices aimed at improving population health for vulnerable, lower-income communities.

Poised to undertake its first effort in this arena, the group will commit the resources and energy necessary to give the healthy food access pilot its best chance of achieving an impact. At the

conclusion of the 18-month pilot, the COACH group will evaluate its return on investment.

For COACH hospitals and health systems, this first foray into adopting and pursuing a shared strategy as part of ACA-required community health implementation plans has sparked potential interest in conducting one or more joint CHNAs and implementation plans when planning for the next cycle begins in 2018.

Our city, state, and nation must improve the population health of vulnerable communities if we are to have any hope of advancing overall well-being while,

at the same time, reining in health care spending. Collaborative population health efforts such as COACH hold promise for achieving this difficult but necessary goal. Policy makers should encourage and evaluate such initiatives and related best practices to assess their effectiveness and promote successful models.

Susan Choi, PhD, CPHQ
*Senior Director, Population Health
Health Care Improvement Foundation
schoi@hcfonline.org*

Priscilla Koutsouradis
*Director, Public Relations
The Hospital and Healthsystem
Association of Pennsylvania
priscillak@dhvc.org*

Bradley Moore, MPH
*Project Manager
Health Care Improvement Foundation
bmoore@hcfonline.org*

Robert G. Shipp III, MSHSA, RN, NEA-BC
*Vice President, Population Health Strategies
The Hospital and Healthsystem
Association of Pennsylvania
rshipp@haponline.org*

REFERENCES

1. Prybil L, Scutchfield FD, Killian R et al. Improving community health through hospital-public health collaboration: Insights and lessons learned from successful partnerships. http://www.uky.edu/publichealth/sites/www.uky.edu/publichealth/files/Research/hospital-public%20health%20partnership%20report_12-8-14.pdf. Published December 8, 2014. Accessed April 16, 2017.
2. Health Research & Educational Trust. Creating effective hospital-community partnerships to build a Culture of Health. <http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf>. Published August 2016. Accessed April 16, 2017.
3. New requirements for 501(c)(3) hospitals under the Affordable Care Act. Washington: Internal Revenue Service. <https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act>. Updated July 29, 2016. Accessed April 16, 2017.
4. Brawer R, Plumb J. Non-profit hospitals and community benefit – what’s next? *Pop Health Matters*. 2016; 29(1):3.
5. Kania J, Kramer M. Collective impact. *SSIR*. 2011; 9(1):36-41.

Implementing a Hepatitis C Screening Program

Hepatitis C is the most common bloodborne disease in the US, with approximately 4 million people in the US infected and over 130-150 million infected worldwide.¹ Most infections are acquired from illicit drug use, with the most vulnerable population being individuals born between 1945 and 1965. About 75% of patients with Hepatitis C become chronically infected and, of those, about 30% develop liver cirrhosis with permanent liver damage. Worldwide approximately 700,000 deaths occur annually from Hepatitis C as a result of cirrhosis or liver cancer.² Previously, patients who wanted to eradicate the virus had to undergo treatments with a combination of medications that caused significant side effects; certain populations were excluded from treatment because of comorbid diseases. In October 2014, the Food and Drug Administration (FDA) approved Harvoni® (ledipasvir, sofosbuvir) after a number of impressive clinical trials which showed superior efficacy over

existing treatments.³ Harvoni® not only had a much higher rate of virus eradication, but it also had a much lower side effect profile. Availability of Harvoni® and some additional antiviral medications that have subsequently gained FDA approval, has renewed the push to identify patients with Hepatitis C so that they can take advantage of available treatments.

The Abington Health (AH) division of Jefferson Community Physicians is a network of outpatient primary care and sub specialty practices located in the Philadelphia suburbs. The network includes over 200 physicians who have continued to push further into value-based health care, which is defined as safe, appropriate, and effective care at a reasonable cost. In the summer of 2016, the AHP network administration was presented with a unique challenge: To quickly implement an extensive screening process for Hepatitis C. The network was able to meet the challenge

and increased the percentage of patients screened from 6% to >45% (Fig. 1) in a short amount of time by developing a systematic, thoughtful process. This project emphasized improving health care value by improving the clinical quality of the health system’s practices.

In 2012, the Centers for Disease Control and Prevention (CDC) recommended that all healthcare providers offer Hepatitis C screening to all patients born between the years 1945 and 1965.⁴ In 2014, New York became the first state to mandate that hospitals and primary care providers offer screening. In 2016, Pennsylvania passed Act 87, that employed the same screening requirements as the New York provision. The Act required all providers develop a plan by September 16, 2016 to screen these at-risk patients, a date that was only a few short weeks after the law was adopted. Abington Health took this

Continued on page 8

challenge head on and quickly developed a multi-disciplinary team to create guidelines and processes to address the mandate.

The team started meeting in August 2016 to meet the September 16th deadline and with an initial goal of identifying the major stakeholders. Included on the list were the administrators who would be held to the state standard through political and possible legal pressures; clinicians who would be responsible for discussing the rationale for the test, ordering the test, and discussing the results; and the informatics team who would have to assist in optimizing the electronic medical record. Patients were also identified as stakeholders who would need to have bloodwork drawn, may have a financial contribution for the testing, and may have difficulty with clinical decision making if they test positive.

The Hepatitis C team then set out to educate the stakeholders. The administrators were initially educated through conference calls and emails that included the specifics of the legislation. The team used clinical administrators to create a frequently asked question (FAQ) sheet for clinicians and a PowerPoint presentation that was presented at the monthly Physician Leader Meeting. The physician leaders were responsible for sharing this information with the other clinicians in their offices. As an integral part of the clinical team, medical assistants were also provided education about Hepatitis C and why there was a need to promote testing in the practices.

The team quickly realized that to initiate behavioral change they would not only have to educate the stakeholders, but they would also have to change the clinician's environment to make the initiative easier to implement. This is an area in which the Informatics department had a major role. They worked diligently to make sure that

the electronic medical record interface was conducive to making the screening process a success. An alert was placed into the system for any patient who met the criteria for hepatitis C screening. This alert was marked as red if not completed. Once the test was ordered, this alert would change to green so that the patient would not be asked again about screening. In an effort to meet the strict intent of the law, an electronic template was also created with language that documented that the patient was asked about their hepatitis C screening status.

The final piece of the group's effort was the formulation of outcome metrics. The Informatics team created three sets of categories. The first metric category was the number of patients who had the test ordered. The second category was the number of patients who had documentation that the test was completed. The third category, which is still being developed, is determining if the test was offered but subsequently refused by the patient. The results of the metrics were

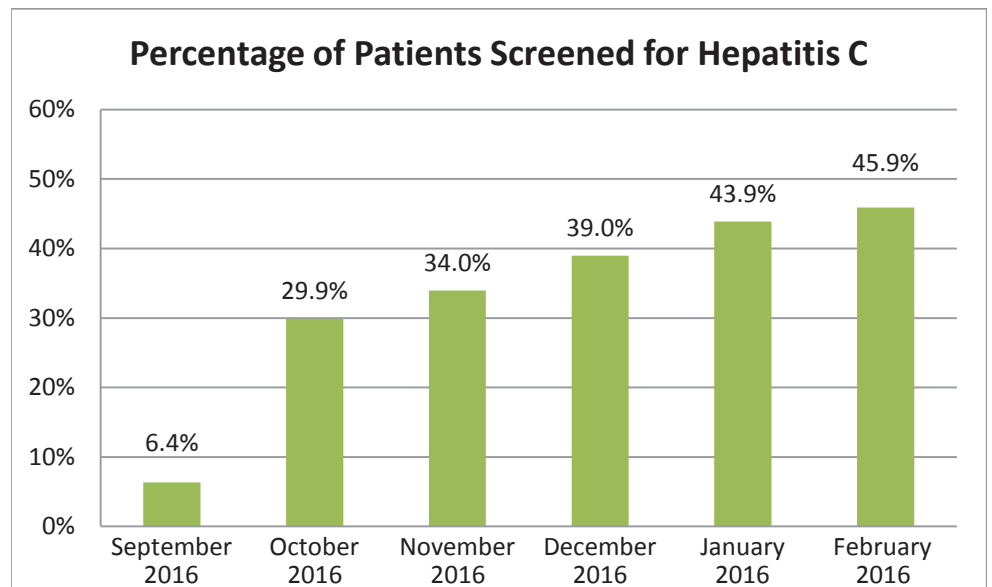
initially presented to the administration and then to the clinicians approximately every two weeks since the law went into effect to encourage further adoption.

While Abington Health Physicians has a long way to go to reach its goal of universal Hepatitis C screening for high risk individuals, they have already shown in a short amount of time that leading a well-coordinated effort can quickly lead to screening adoption even in a large complicated health system. The outpatient practices will continue to diligently pursue these screening goals and use this project as a template for the implementation of other large scale screening initiatives as the United States marches toward a health care system based on value.

Steven Spencer, MD, MPH

*Director of Population Health
Jefferson Community Physicians
Steven.Spencer@Jefferson.edu*

Figure 1



REFERENCES

1. World Health Organization. Hepatitis C Fact sheet. <https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm>. Updated July 2016. Accessed April 16, 2016.
2. Centers for Disease Control and Prevention. Hepatitis C FAQs for Health Professionals. <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#section1>. Updated January 27, 2017. Accessed April 16, 2017.
3. Afdhal M, et al. Ledipasvir and Sofosbuvir for Untreated HCV Genotype 1 Infection. *N Eng J Med*. 2014; 370:1889-1898.
4. Centers for Disease Control and Prevention. Viral Hepatitis. <https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm>. Updated October 15, 2015. Accessed April 16, 2017.

Intermountain Healthcare Receives 2017 Hearst Health Prize

The winner of the \$100,000 Hearst Health Prize for Excellence in Population Health was announced at the Population Health Colloquium on March 28, 2017. Intermountain Healthcare was recognized for its work on Mental Health Integration (MHI) in primary care. Led by Dr. Brenda Reiss-Brennan, the program used a collaborative and measurable team-based approach built upon systematic, evidence-based medicine, to help patients and their families manage the complexity of both mental and physical health. Over a 10-year period Intermountain was able to show

improvements in patient satisfaction and quality of care as well as reductions in healthcare utilization and costs. Watch Dr. Brenda Reiss-Brennan describe the program.

Finalists in the 2017 competition included the American Heart/American Stroke Association and California Maternal Quality Care Coalition. All finalists presented posters at the Colloquium and were recognized at the award ceremony. View highlights [here](#).



2017 Hearst Health Prize Winner, Brenda Reiss-Brennan, PhD, APRN, Director of Mental Health Integration, Primary Care Clinical Program, Intermountain Healthcare (center) with David Nash, MD, MBA, Dean, Jefferson College of Population Health (left) and Gregory Dorn, MD, MPH, President, Hearst Health (right)

The 2018 Hearst Health Prize Call for Submissions is now open! The deadline to submit is July 31, at 3:00 PM (EDT) / 12:00 PM (PT).

Jefferson Designated Baby-friendly Hospital

Jefferson University Hospital delivers roughly 2,000 babies a year and has recently been recognized locally, nationally and internationally for being a “Baby-Friendly Hospital.” By responding to both the needs of newborns and their parents, Jefferson is making the health and wellness of future generations a key priority.

Starting in 2009, when the Centers for Disease Control and Prevention (CDC) began monitoring the way in which hospitals promote breastfeeding, Jefferson’s Department of Nursing took a fresh look at the way the hospital trained staff to work with parents around the dietary needs of newborns. This work inspired the department to inquire about becoming a certified Baby-friendly Hospital by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) program, which is administered in the United States by Baby Friendly USA. The evidenced-based program’s goal is to achieve optimal infant feeding outcomes and mother-baby bonding. A committee was then formed comprised of pediatricians, obstetricians, nurses, case managers, lactation consultants, and nutritionists. The group was co-chaired by Kathy Sibre, Nurse Manager of Maternity; Terry O’Brien, Manager, Parent Education; Joanne Walko, Maternity Nurse and Lactation Consultant; and Edward Buchanan, Family Medicine Doctor.

The committee’s first step was to learn about the designation’s required [Ten Steps](#)

to Successful Breastfeeding, which include having a clear breastfeeding policy; ensuring that staff are properly trained in breastfeeding; educating parents about all of their child’s nutritional options; facilitating “rooming in” where by mothers and infants remain together 24 hours a day; offering breastfeeding support groups; and deemphasizing obstacles to breastfeeding, such as the use of a pacifier.

From 2014-16, Terry O’Brien helped to design new mandatory trainings for all nurses and doctors about the steps. She is a registered nurse who has spent her entire career at Jefferson working in patient education, labor and delivery, in the out-patient clinic, and mother and baby care since 1978. In an interview for this article, Terry explained, “In transforming Jefferson into a true Baby-Friendly Hospital, one of the biggest challenges that the committee identified was educating staff other than nurses about the importance of following the steps and insuring that mothers who choose to not breastfeed receive sufficient education for formula preparation. Our end goal is really to send parents and babies home with all of the information, confidence, and skills that are required to keep the baby healthy.”

Now, for the first hour after delivery, hospital staff support mothers in initiating and maintaining “skin to skin” contact with their newborns. This uninterrupted hour with the baby curled up at the mother’s chest allows moms to bond with their child,

stabilize the child’s temperature, calm the baby and to try to obtain the first breastfeed. Sleeping with the baby in the room helps moms and their families understand and interpret their child’s feeding cues.

Being a Baby-Friendly Hospital involves serious commitment from hospital leadership and from all departments that support women and children’s services. Not only is staff time spent on developing and implementing trainings, new policies, and preparing for a rigorous 2-day audit, but there are costs involved, such as not accepting free samples from formula companies.

Jefferson has also worked to make the enterprise Baby-Friendly for working moms who are employees. There are several classes and resources for new parents: a free breastfeeding Warm Line, a dedicated phone number for access to a lactation specialist; a free lunch time peer support group for new parents; free prenatal breastfeeding classes; a class for grandparents; and lactation lounges on all of the campuses (but not yet in every building). There is even a new



Continued on page 10

working mothers' group forming as a result of the Jefferson's Culture Jam, an employee engagement initiative.

On August 23, 2016, Jefferson received the prestigious baby-friendly designation.

Just two months later, Jefferson also became recognized by the State of Pennsylvania's Health Department and the Pennsylvania Chapter of the American Academy of Pediatrics through [Keystone](#)

[10](#), the state baby-friendly designation. Jefferson is also involved with local efforts around promoting breastfeeding. Since 2011, Jefferson has participated in a city-wide taskforce on breastfeeding organized by the [Maternity Care Coalition](#) and the City's Department of Public Health. The taskforce has been critical for professionals in learning about obstacles and opportunities for breastfeeding and for sharing concerns that other organizations other than their own have identified.

Jefferson is now working with Abington Hospital and other hospitals in the city to assist them with their designation.

Kate Clark, MPA
Assistant Director
Center for Population Health Innovation
Jefferson College of Population Health
Katherine.Clark@jefferson.edu

Thomas Jefferson University Primary Care Population Health Research Fellowship: A New Partnership

As our healthcare system experiences shifting cost pressures and a demand for a higher quality of care together with optimized patient experience, a need has grown for physician leaders who are trained and prepared to develop and implement population health strategies within complex health delivery systems. A recent partnership between the Thomas Jefferson University Department of Family & Community Medicine (DFCM) and the Jefferson College of Population Health (JCPH) aims to address this gap with a novel fellowship offering. This fellowship offers a 2-year Population Health Track¹ for its Primary Care Faculty Development Research Fellowship, open to Family Medicine, Internal Medicine, and Pediatric physicians. The fellowship is partially funded by a Health Resources and Services Administration (HRSA) Primary Care Training and Enhancement Award (principal investigator, Christine Arenson, MD, Chair of the DCFM). In July 2016, I was thrilled to become the inaugural full-time population health research fellow.

Convinced of the power of population-level thinking while completing medical school at the Lewis Katz School of Medicine at Temple University, I decided to become a family physician because of its big picture, holistic and preventive focus. During my residency training at Thomas Jefferson University, I found great satisfaction in ensuring that my patients' preventive health needs were addressed, and I continued to be impressed with the huge gaps and disparities in care that were often too late to prevent in the clinic. New models of care emphasizing upstream, proactive

management of populations spurred my interest. I wanted to equip myself in order to "change one population at a time" in addition to one patient at a time, as Mary Cooper, MD, JD and director of the JCPH Healthcare Quality and Safety programs, says. Finishing my final year as chief resident, I could not wait to begin.

The population health research fellowship combines the resources of the traditional DFCM primary care faculty development research fellowship with the resources of JCPH. Fellows work under the guidance of a mentorship team described in Table 1, led by Randa Sifri, MD. Effort is divided among master's level coursework, research, continuity clinic time, and other key conferences and experiences. Under the direct mentorship of David Nash, MD, MBA, Dean of JCPH, fellows participate in several health system quality and operational committees and population health conference opportunities, which have served to build experience in these environments and guide insight into the opportunities and challenges facing health systems. Exposure to the leadership and workings of the [Delaware Valley Accountable Care Organization](#), one of

the largest ACOs in the country, provides another distinct perspective.

Fellows may pursue one of several relevant degrees at JCPH,² or outside Jefferson. To strengthen my knowledge of the principles of high-value care and how to change physician behavior, I chose to pursue the [MS in Healthcare Quality and Safety at JCPH](#). Courses are 100% online and provide flexibility of schedule and networking opportunities with a diverse array of seasoned colleagues from across the country.

Under the research guidance of Dr. Sifri, Dr. LaNoue, and Dr. Rabinowitz, I am pursuing research interests of importance to our institution. Currently in the final planning stages, I am helping to lead a multidisciplinary team in the planning, implementation, and evaluation of a care coordinator-driven readmissions reduction pilot program for pneumonia patients. Reducing readmissions has become a recognized sign of quality, and has necessarily become a national priority with significant potential penalties for institutions that underperform as compared to their peers. This has served as a real world case study in which to apply important concepts of quality improvement learned in

Table 1. Key Stakeholders

Randa Sifri, MD	Fellowship Director, DCFM
Marianna LaNoue, PhD	Associate Fellowship Director, DCFM
Howard Rabinowitz, MD	Assistant Fellowship Director, DCFM
David Nash, MD, MBA	Dean of JCPH

the classroom. We will present our design and implementation process at the [2017 Annual Meeting of the Society of General Internal Medicine](#).

Additionally, I have had the opportunity to present a poster on the “Development of a Toolkit for Quality Improvement and Leadership Training for Residents and Students” at the [North American Primary Care Research Group Annual Meeting](#). This work reflected an ongoing effort to enhance standardized training in quality and leadership for trainees in our department through the use of a unique online learning platform.

I will continue to be involved in additional research projects moving forward, including an examination of ambulatory practice transformation efforts on quality metrics.

I am just over half of a year into the population health research fellowship, and its benefits have become abundantly clear. Providing immersion in an ideal environment for understanding health systems and population health management through a complement of research opportunities and valuable experiences, the Primary Care Faculty Development Research Fellowship-- Population Health Track will prepare leaders

for research, policy, and primary care and health systems leadership careers. I look forward to continuing my participation in the fellowship and in seeing it grow each year.

John J. Stoeckle, MD
Clinical Instructor
Faculty Development Research Fellow--
Population Health Track
Department of Family & Community
Medicine and Jefferson College of
Population Health
Thomas Jefferson University
John.Stoeckle@jefferson.edu

REFERENCES

1. Thomas Jefferson University. Department of Family & Community Medicine. Faculty Development Research Fellowship. http://www.jefferson.edu/university/jmc/departments/family_medicine/education/fellowships/faculty_research.html. Accessed 1/22/2017.
2. Thomas Jefferson University. Jefferson College of Population Health. Degrees and Programs. <http://www.jefferson.edu/university/population-health/degrees-programs.html>. Accessed 1/22/2017.

From Health Policy to Population Health: Impressions and Highlights of Recent Conferences

As program director for both the health policy and population health programs at the Jefferson College of Population Health, I look at the health landscape from two distinct vantage points. Health policy pulls back the curtain on the levers and mechanisms that govern the allocation of societal resources, the influence of public opinion and private interests, and the various junctures where change can and does occur. Population health is an expression of the more parochial interests of health care systems and providers searching for ways to improve health outcomes and reduce costs for the patients and communities they serve.

This duality in perspective to health was made plain to me after attending two important, but very different, meetings — the [AcademyHealth National Health Policy Conference](#) in Washington, DC and the [Institute for Healthcare Improvement's \(IHI\) Leading Population Health Transformation Seminar](#) in San Diego. I realized that we must reconcile the differences between these worlds and find ways to bring them together.

First, I'd like to share highlights from [AcademyHealth's](#) policy conference. It's clear to anyone not living off the grid or in a cave that health policy is undergoing rapid and extraordinary change. The recent election has

set in motion a fundamental realignment of the rhetoric of health policy and, to a lesser degree, its substance. The AcademyHealth policy conference featured a variety of speakers who described the context and contours of these changes.

Minority (Democratic) Leader Nancy Pelosi, and Senators Bill Cassidy (R-LA) and Tim Kaine (D-VA), painted starkly different pictures of the view from Capitol Hill. Senator Cassidy is also a physician and it's no surprise that he laid out his [plan](#), in partnership with Senator Susan Collins (R-ME), to replace the Affordable Care Act (ACA). Premised on the idea that the ACA will collapse, his Patient Freedom Act would keep consumer protections (lifetime caps, pre-existing conditions protection and coverage for adult children on a parent's plan until age 26) while giving the states more freedom to choose amongst a variety of models. Federal funding would be limited at the current level each state is already receiving for health care. Democrats Pelosi and Kaine argued for maintaining the ACA status quo, citing evidence of its success and the need for tweaks to address shortcomings rather than a radical do-over.

Many of the other presentations at the IHI meeting focused on the big policy picture and highlighted the complex interplay between

policy and health outcomes. It's clear that this is a boom time for health services research as the field scrambles to analyze the bewildering array of health policy proposals and initiatives. This energy is tainted with some dread as proposed budget cuts threaten key federal funding sources.

The IHI Population Health Transformation seminar program was a more intimate affair. Saranya Loehrer, MD, MPH, Head of the North America Region for IHI, and her team of seasoned health system administrators guided a group of health system professionals through a deep exploration of state-of-the-art population health practice. This was truly population health at the ground level.

Featured speakers, George Kerwin, President and CEO of [Bellin Health Systems](#) in Wisconsin; Al Kurose, MD, MBA, FACP, President and CEO of [Coastal Medical](#) in Rhode Island; Helen Macfie, PharmD, Chief Transformation Officer for [MemorialCare Health System](#) in Southern California; and L. Gordon Moore, MD, Senior Medical Director of Population and Provider Solutions for [3M Health Information Systems](#) shared stories of how to navigate the complex path from volume to value. They highlighted specific applications and development of

Continued on page 13

Population Health Colloquium

Thank you to our attendees, speakers, sponsors and exhibitors for making the 2017 Population Health Colloquium a success!

DIAMOND GRANTOR:



PLATINUM GRANTORS:



GOLD GRANTORS:



SILVER GRANTORS:



The Access Group®

BRONZE GRANTORS:



ADDITIONAL GRANTORS:



CO SPONSOR:



TUITION SCHOLARSHIP PROGRAM SUPPORTED BY:



MEDIA PARTNERS:



... AND SAVE THE DATE:

EIGHTEENTH POPULATION HEALTH COLLOQUIUM

March 19 – 21, 2018 • Philadelphia, PA

www.PopulationHealthColloquium.com



ACADEMIC PARTNER:



Continued from page 11

detailed action plans. For this audience of health system administrators and leaders, finances were a key part of the discussion as everyone was searching for ways to show the return for their investments in new people and technology. Data—how to analyze, apply and use it—was an important underlying theme, as well as how to engage community partners in population health initiatives that focus on keeping attributed patients healthy and out of the emergency department and hospital bed.

These back-to-back sessions were in some sense a mirror image of each other, an inside-out/outside-in look at the state of health care in the U.S. The policy action in DC is driving

much of the activity at the local level. Everyone in the healthcare sector has to be acutely aware of the impact policy changes are having and will have on their practice. They must respond to the changes while hedging their bets in case the status quo shifts 180 degrees.

The folks in DC have much to learn from what's happening out in the real world. The ACA, MACRA and other health laws have launched an unstoppable revolution that has radically changed how we will deliver health care in the future. The population health lessons learned from innovative health systems like those featured at the IHI Health Transformation seminar should be used to

inform national health policymaking. Even if they aren't, the folks in DC must recognize that the movement toward population health is unstoppable. The nation is holding health systems accountable for the health of the populations they serve like never before. There is no going back.

Drew Harris, DPM, MPH

*Program Director, Health Policy and Population Health
Jefferson College of Population Health
Drew.Harris@Jefferson.edu*

Third National Primary Care Ambulatory Patient Safety Conference on Research and Education

On February 23 and 24, 2017, I had the pleasure of attending the "Third National Primary Care Ambulatory Patient Safety Conference on Research and Education" held in Bethesda, Maryland. The conference was sponsored by the Agency for Healthcare Research and Quality (AHRQ). AHRQ, a division of the United States Department of Health and Human Services, is the leading advocate and financial supporter of research and education promoting safer, higher quality healthcare in this country. The meeting brought together over 100 healthcare professionals from across the country, including physicians, nurses, physician assistants, pharmacists and trainees. While patient safety in the hospital (inpatient) setting has long been studied, it is notable that patient safety in the ambulatory (outpatient) setting is now coming to the forefront of national attention.

The presentations covered a broad spectrum of patient safety issues. I will focus my comments on the subject matter of the two plenary session speakers—[Dr. David Bates](#), Chief of the Division of Internal Medicine of Brigham and Women's Medical Center and Medical Director of Clinical and Quality Analysis of Partners Healthcare; and [Dr. Nancy Elder](#), from the Department of Family and Community Medicine at the University of Cincinnati. Their presentations provided a broad overview of the present and future state of the field.

In his talk, "Ambulatory Patient Safety: A Global Perspective," Dr. Bates emphasized the many safety challenges of primary care—including limited time with patients (the average outpatient visit is 12 minutes), frequent interruptions, and patients who frequently leave with unanswered questions. More specifically, he went into detail concerning what he perceived as the four key areas impacting patient safety in the ambulatory setting: follow-up post hospital discharge; medication safety; follow-up of abnormal tests; and ambulatory surgery. He provided extensive detail of the correlation of these safety issues and medical malpractice claims. He concluded by stating that while there is still lots to learn about safety outside the hospital, the magnitude of the problem appears to be as least as big as in the inpatient setting, with a key area being delayed and missed diagnoses, especially of cancer.

Dr. Elder spoke on "The EHR in Patient Safety and Medical Errors—The Good, The Bad, and The Ugly." Her presentation on electronic health records was timely, given that the percent of office-based physicians using any EMR (electronic medical record)/EHR system at the end of 2015 was 86.9%.¹ She reviewed the initial hopes for EHRs, which included less paperwork, easy access to records allowing better care coordination, faster more accurate prescriptions, and fewer unnecessary tests and procedures, among others. The reality has been more complicated, with both

improvements and problems. The problem areas center on two main processes; entering and retrieving information, and communication and coordination. The process errors have impact across the clinical spectrum, including: 1) Medication and prescription errors—wrong drug/dose/formulation (juxtaposition errors from drop-down menus, rolling options lists "clicking" on unintended choices, auto-population errors where system suggests a drug from first few letters, which might be clicked inadvertently). 2) Testing errors—wrong tests ordered (for similar reasons as medication and prescription errors). 3) Diagnostic errors—resulting from problems of routing results between/among physicians and other providers, and decrease in use of letters/direct communication between physicians about patients because "it's in the EHR."

It is hoped that ambulatory safety issues will continue to receive this kind of attention as hospital lengths of stay decrease and procedures continue to shift to the outpatient setting.

Richard Jacoby, MD

*Director, Jefferson University Physicians
Ambulatory Performance Improvement
Clinical Associate Professor
Jefferson College of Population Health
Richard.Jacoby@Jefferson.edu*

REFERENCES

1. Centers for Disease Control and Prevention. National Center for Health Statistics. <https://www.cdc.gov/nchs/fastats/electronic-medical-records.htm>. Accessed April 17, 2017

POPULATION HEALTH COLLOQUIUM HIGHLIGHTS



MPH Students Denine Crittendon and Laurie Donoris enjoying the Colloquium.



Joseph Coughlin, Founder and Director, MIT AgeLab, Massachusetts Institute of Technology.



Dr. Nash with Philips Team



The Future of Clinically Integrated Networks Dinner Program (left to right) Stephen Klasko, MD, MBA, President and CEO, Thomas Jefferson University and Jefferson Health; David Nash MD, MBA; and Michael Dowling, President and Chief Executive Officer, Northwell Health



Population Health Leaders Panel. Left to right: Anthony Wehbe, DO, MBA, FACOI; Terri Steinberg, MD, MBA; Mary O'Dowd, MPH; Saranya Loehrer, MD, MPH, and Madeline Biondillo, MD



The Philadelphia Mummers provided the entertainment!



2017 Hearst Health Prize Finalists

Left to right: David Nash, MD, MBA; Elliot Main, MD, Medical Director, California Maternal Quality Care Collaborative (finalist); Brenda Reiss-Brenner, PhD, APRN (winner), Mental Health Integration Director; and Michelle Bolles, MCHES, Vice President, Programs and Operations, Quality and Health IT, American Heart/American Stroke Association (finalist); with Gregory Dorn, MD, MPH, President, Hearst Health.



Adjunct Faculty Positions Available (100% online)

The Jefferson College of Population Health (JCPH) is recruiting adjunct faculty to teach in its online graduate programs. Founded in 2008 as the nation's first College of Population Health, JCPH offers graduate degree programs in population health, public health, health policy, applied health economics and outcomes research, healthcare quality and safety, and operational excellence. Recent growth in all of these programs has created a need to add additional adjunct faculty. Adjunct faculty with the following expertise are needed:

- Healthcare Finance & Reimbursement (US-based)
- Healthcare Finance & Economics (International)
- Healthcare Organization & Delivery (US-based)
- Healthcare Organization & Delivery (International)
- Health Law & Regulatory Issues (US-based)
- Health Law & Regulatory Issues (International)
- Health Economics
- Economic Modeling in Healthcare
- Simulation in Economic Evaluation
- Measuring Subjective Outcomes in Health Research
- Methods in Outcomes Research
- Organizational Development & Change in Healthcare

For a list of course descriptions, please click here: <http://jcph.link/Courses-JCPH>

Qualifications

Students in the College's online programs are experienced professionals working in all aspects of healthcare. Their average age is in the mid-40s and most already possess a terminal degree (MD, PharmD, PhD, DPM, etc.). Consequently, faculty teaching in our graduate programs must have extensive experience applying the concepts of his/her chosen field in order to provide illustrative examples, answer detailed questions, and offer expert insight to an already well-educated student body. In addition, adjunct faculty should possess at least a master's degree (doctoral degree preferred), have prior experience teaching graduate courses (executive education, professional development, and continuing education allowed), and have experience or interest in teaching graduate courses asynchronously 100% online.

Expectations

Courses are designed so that students spend approximately 10-12 hours per week reading assigned materials, viewing recorded lectures, engaging in online discussions, and completing assignments for each course. Adjunct faculty spend approximately the same amount of time each week engaging with students in discussions, answering questions, and grading assignments (more time may be needed to grade larger assignments). The courses are taught asynchronously because students log in from around the world, so there are no set meeting times.

Application & On-Boarding Process

The College has created an online webinar to help answer questions about becoming an online adjunct faculty member. After prospective faculty complete the webinar, they are engaged in an on-boarding process that includes training on how to operate the Blackboard learning management system, use course authoring tools, shadowing existing faculty, and continuing education support.

**To begin the application process, please visit:
<http://jcph.link/educators-orientation>**

For more information, please contact Dr. Billy Oglesby, Billy.Oglesby@Jefferson.edu

POPULATION HEALTH FORUMS

Population Health in Your Own Backyard: The Delaware Valley Accountable Care Organization at Age 3

Katherine A. Schneider, MD

*President and CEO
Delaware Valley ACO
January 11, 2017*

The 2017 Forum season was kicked off by Katherine Schneider, MD, President and CEO of Delaware Valley ACO (DVACO). Dr. Schneider is nationally known for her work in the field of accountable care and patient engagement. She oversees the strategic direction and ongoing administration and management for all aspects of DVACO, the region's largest ACO with over 650 primary care physicians and over 107,000 Medicare fee-for-service beneficiaries.

Dr. Schneider humorously began her presentation by sharing her pet peeve – which is the misuse of the term Accountable Care Act vs. Affordable Care Act.

Dr. Schneider shared a definition of an ACO as a group of providers (with emphasis on primary care physicians) who agree to collaborate. An ACO works through identifying the population, which may be through attribution or selection of primary care physicians, and purchases an insurance product which drives selection of the ACO network as preferential for care. Also identified are the annual costs of care and quality

targets. These costs and targets may be based on trend vs. self, or trend vs. market; insurance premium received; and annual costs. Providers in an ACO will receive some fee-for-service payment as well as added revenue for financial and quality targets met.

DVACO is a joint venture of Jefferson University and Hospitals, Main Line Health, and Magee Rehab, and operates under the Medicare Shared Savings Program (MSSP) through an agreement with the Centers for Medicare and Medicaid Services (CMS). Its purpose is to enhance the quality of health care and reduce the growth rate of health care costs by acting as a convener, accelerator, and provider of the foundation needed to assist its participating members to transition from a fee-for-service model. The work of DVACO is generated by stratification (predictive modeling), transitions of care, and direct referrals.

Dr. Schneider emphasized that “value-based care is here to stay.” Despite challenges and uncertainty that we might be facing, and regardless of the environment, access to care and value-based care will always be the mission. DVACO has truly positioned itself with brand recognition and it seems to have a head start, which is a big advantage.

Dr. Schneider discussed the issue of “risk”

and stated as providers, they will be asked to take on more risk related to insurance and performance. She explained that they do not currently have downside risk. “Risk is not just about insurance risk,” states Schneider. Risk also includes operating risk, infrastructure risk, and issues such as data and cyber security.

It is important to reframe overutilization and waste reduction as safety and patient-centeredness and a way to get to the heart of the clinicians in the room, explains Schneider. Schneider states that we want to not just save money, but avoid harm and improve health outcomes.

DVACO lives in a complex, rapidly evolving IT environment. Dr. Schneider emphasized that there is no “technology magic button” or quick fix for interoperability challenges. Underlying systems and work flows must be configured to support fee for value (from fee for service). Though big data is very attractive, small data may glean important findings. Patient engagement cannot be limited to an app.

As Dr. Schneider concluded, she summarized data on ER visits, discharges, and readmissions, comparing DVACO's impressive results to collective averages of ACO's nationwide, she stressed the ACO is about the “care.”

The Longevity of Population Health

Susan L. Freeman, MD, MS, FACPE, FACE

*President, Temple Center for
Population Health
CMO, Temple University Health System
Vice Dean, Health Care Systems, Lewis
Katz School of Medicine, Temple University
February 8, 2017*

“Population health will absolutely need to have longevity...population health is a business imperative and longevity is one of the best outcomes,” explained Dr. Susan Freeman as she began her Forum presentation. Dr. Freeman is the founding CEO and President of Temple Center for Population Health, LLC. She is also the Chief Medical Officer, Temple University Health System, Vice Dean of Health Care Systems and Professor of Clinical Medicine at the Lewis Katz School of Medicine at Temple University.

Dr. Freeman explored how the definition of population health is really very complex and, in her expanded view, longevity is a key component. The conceptual framework that she shared involves tackling large-scale social, economic, and environmental issues in a way that changes outcomes. Within this framework, it is important to examine why some populations are healthier than others while at the same time including policy development, academic agenda and resource allocation in the equation.

Dr. Freeman organized her talk into different themes and started out by sharing a framework of **population health as a clinical and business model** – a model she states is vital for population health to survive. Reimbursement promoting new healthcare delivery models and social programs that reward health outcomes rather than the volume of services are the cornerstone of

this model. She emphasized that the Triple Aim is inextricably linked to value.

Dr. Freeman spent some time talking about the **longevity of value**. The impact of ACA has been critical in bringing to life the shift from volume to value. The components of ACA (such as shared savings, value-based purchasing, readmissions reduction programs, ACOs, health insurance exchanges and Medicaid expansion) have been important to the longevity. Freeman explained that ACA created new pathways for connecting people to coverage and she described the impressive numbers of enrollees for Medicare, Medicaid, SCHIP and the Basic Health Program. She emphasized the importance of the role of CMS and the CMS Innovation Center, particularly as it relates to the success of ACA.

Despite the successes of ACA, Freeman doesn't feel that the Triple Aim has been fully achieved. Issues of disease burden, socioeconomic factors and social determinants of health, legacy systems, and interoperability are major challenges. She went on to describe data related to disease burden in Philadelphia, which includes high percentages of obesity, smoking, sexually transmitted infections, opioid related mortalities, and persons living below the poverty level.

Dr. Freeman then provided an overview of Temple Health and [*Temple Center for Population Health*](#) (TCPH). The goal of TCPH is to attain a sustainable, coordinated

model of health care delivery through clinical and business integration, community engagement, and a balance of medical and nonmedical interventions to promote high value care and healthy populations. The immediate focus has been on low-acuity admissions, high utilizers, post-acute care, ambulatory sensitive conditions, predictive analytics, and balancing the revenue cycle against the value proposition. As part of the overall structure, there is a strong emphasis on primary care, investment in infrastructure, value-based contracts, care transitions, and care reaching into the community using community health workers.

Dr. Freeman summarized her talk by discussing **longevity, high-value healthcare, and the future**. She does believe that the insurance market is likely to change and that Medicare may shift to all "Advantage" and Medicaid may shift to block grants and more control at the state level. She outlined various initiatives and themes which may play a big role in the longevity of population health such as consumerism, collaboration, academic mission, [*Healthy People 2030*](#), [*Public Health 3.0*](#) and ongoing efforts to improve access and quality to decrease disparities. Particularly important to the future is the [*21st Century Cures Act*](#), which provides funding to various research and healthcare initiatives including the [*Cancer Moonshot*](#).

Implementation Science from Practice to Research

Linda Fleisher, PhD, MPH

*Senior Research Scientist
Children's Hospital of Philadelphia
March 8, 2017*

Dr. Fleisher is a Senior Research Scientist at Children's Hospital of Philadelphia (CHOP); and Associate Research Professor at Fox Chase Cancer Center. She is also adjunct faculty at the Jefferson College of Population Health and the University of Pennsylvania.

Dr. Fleisher first provided some very important definitions to set the stage. Dissemination she described as a purposive distribution of information and materials. *Dissemination research* is focused on how this information is created, used, packaged, and transmitted and how effective the dissemination is. *Implementation practice* covers a specific set of activities designed to put in to practice. *Implementation science* involves looking at the factors that influence the full and effective use of innovations in practice; it's understanding the why and how.

Dr. Fleisher described the Conceptual Model for Implementation Research¹ which involves the core of implementation science as the center or anchor between the intervention and the outcome. It is important to examine the intervention is being implemented, who's doing the intervention, what kind of

training is involved, how successful is the implementation, and overall looking at the entire context of the implementation.

Dr. Fleisher referred to the work of Tabak et al.² who identified 109 models of implementation science and with exclusions ended up with 61 models. From this study it was found that many models focused on community and organization, while very few focused on policy.

She went on to describe some specific commonly used models such as the [*Consolidated Framework for Implementation Research*](#) (CFIR); RE-AIM Framework. Dissemination and implementation models are important to ensure inclusion of essential strategies; enhance interpretability of study findings; and provide systematic structure for development, management and evaluation of interventions. It is also important to look at de-adoption, Fleisher explains.

Dr. Fleisher's work has focused on health disparities, shared decision making, and in recent years digital health. She stressed implementation research and practice with a multi-disciplinary approach as being critical to the process. Dr. Fleisher described two community projects, the Body & Soul program, a healthy eating program that targeted African Americans in churches and the [*RCaDES*](#) (Reducing Cancer Disparities by

Engaging Stakeholders) initiative, as different examples of implementation science.

Dr. Fleisher also discussed an interesting, multi-level digital health initiative at CHOP. The idea behind this initiative is to accelerate the integration of effective and trustworthy mHealth interventions & tools into high quality patient care. She emphasized the importance of testing and mHealth tools, and understanding overall, current practice related to these technologies, both within your own institution and beyond. An external scan of other Children's Hospitals and mHealth was conducted from which valuable information was gleaned. She also discussed "mychoice" a web-enabled application used to address barriers to clinical trial participation in African American Cancer patients.

REFERENCES

1. Proctor et al. Implementation Research in Mental Health Services: an Emerging Science with Conceptual, Methodological, and Training challenges. *Adm Policy Ment Health*. 2009;36(1):24-34.
2. Tabak RG et al. Bridging research and practice models for dissemination and implementation research. *Am J Prev Med*. 2012; 43:337-350.

To view Forum slides and listen to audio recordings visit Jefferson Digital Commons: <http://jdc.jefferson.edu/hpforum/>

EDITORIAL BOARD TRANSITIONS

Best wishes to retiring editorial board members Dan Louis, Etienne Phipps, and Rob Simmons. We are very grateful for their many years of service on the board.

AHEOR Fellows Reflect

As the first year of our experience as Applied Health Economics and Outcomes Research (AHEOR) Fellows quickly approaches its end, it is a perfect time to reflect on our experience at Jefferson College of Population Health (JCPH). Here we have learned more than either of us could have imagined. We have grown both personally and professionally, and we thank our mentors for their guidance and all those who contributed to our development during our time here.

As AHEOR Fellows, conducting research is one of our primary responsibilities. As researchers in training, this is important because it allows us to gain a better understanding of what it means to be a researcher and to contribute to the field. This year we had the opportunity to pursue a wide variety of projects and work with an equally wide variety of collaborators in the process. We have participated in research describing disparities in breast cancer, examining refugee health, and evaluating aspects of the Italian healthcare system. Highlights included a project led by David analyzing opioid utilization patterns using claims data from partners outside the JCPH with hopes of painting a clearer picture of opioid use in a working age population; while Laurence worked on a cost-effectiveness analysis to evaluate the clinical and economic consequences of patients' non-adherence to aspirin.

Much of the fellowship involves conducting research, but there is a lot more to what we do as fellows at JCPH. One of our first experiences was attending the Population Health Academy, a week-long, intensive course which provides attendees with a foundation in population health. This was an amazing primer to the challenges we will face in an evolving healthcare system and to the problems that our research would seek to address over the course of our first year. Some of the most exciting experiences involved attending conferences including the Academy of Managed Care Pharmacy (AMCP) Annual Meeting and Expo, AMCP Nexus, and Real World Evidence and Market Access USA. Each provided unique educational content and great networking opportunities. Additionally, we both presented our research at each AMCP conference and will be presenting our research at the

International Society for Pharmacoeconomics and Outcomes Research (ISPOR) 22nd Annual International Meeting. We also served as judges for the local AMCP Foundation Pharmacy & Therapeutics (P&T) Competition held by Jefferson College of Pharmacy and Sigma Xi Research Day.

With Year 1 coming to a close, we look forward to another exciting year of learning and growth at our sponsor companies and we thank all



Laurence and David

those who have made this year such a great experience!

David Singer, PharmD, is an Applied Health Economics and Outcomes Research Fellow with Jefferson College of Population Health and Janssen Scientific Affairs, LLC. He is also currently pursuing an MS in Applied Health Economics and Outcomes Research. His second year will be spent at Janssen in Titusville, NJ.
David.Singer@jefferson.edu

Laurence Djatche, PharmD, is an Applied Health Economics and Outcomes Research Fellow with Jefferson College of Population Health and Novartis AG. She is also currently pursuing an MS in Applied Health Economics and Outcomes Research. Her second year will be spent at Novartis in East Hanover, NJ.
Laurence.Djatche@jefferson.edu

JCPH PUBLICATIONS

Banarjee ES, Herring S, Hurley KE, **Puskarz K**, Yebemetsky K, **LaNoue M**. Overcoming obesity: a mixed methods study of the impact of primary care physician counseling on low-income African American women who successfully lost weight. *Am J Health Promotion*. First published March 16, 2017. DOI: 10.1177/0890117117690853

Djatche L, Singer D, Heyer A, Lombardi M, Del Canale S, **Maio V**. How can we effectively engage physicians in the deprescribing process? *Am J Med Qual*. 2017. Apr 1:1062860617704899. doi: 10.1177/1062860617704899. [Epub ahead of print]

Dong Y, Alcusky M, **Maio V**, Liu J, Liu M, Chang C, Lai M, Gagne JJ. Evidence of potential bias in a comparison of β -blockers and calcium channel blockers in patients with chronic obstructive pulmonary disease and acute coronary syndrome: results of a multi-national study Accepted in *BMJ Open* 2017; 7:e012997 doi:10.1136/bmjopen-2016-012997

George BJ, Li P, Lieberman HR, Pavela G, Brown AW, Fontaine KF, Jeanson MM, Dutton GR, Idigo AJ, Parman MA, Rubin DB, Allison DB. Randomization to randomization probability: estimating treatment effects under actual conditions of use. *Psychol Methods*. 2017 Apr 13. doi: 10.1037/met0000138. [Epub ahead of print].

Harris D. Trump's proposed health spending cuts could wreak economic havoc. *Philly.com Health Cents*. March 29, 2017.

Koff G, Vaid U, Len E, **Crawford A**, Oxman D. Differences in utilization of life support and end-of-life care for medical ICU patients with versus without cancer. *Critical Care Med*. 2017;45(4):e379-e383.

McIntire RK, DiVito BM. An experiential service-learning project on observed smoking behavior to teach practical epidemiologic skills to MPH Students, Philadelphia, 2015. *Public Health Reports*. 2017;132(2): 392-396.

Nash DB. A sea change in the world of clinical practice. *MedPage Today*. Focus on Policy. April 29, 2017.

Nash DB. A vital but missing piece in the healthcare discussion. *MedPage Today*. Focus on Policy. March 31, 2017.

Nash DB. Regenerative medicine: a new perspective on a controversial topic. *MedPage Today*. Focus on Policy. March 3, 2017.

Powell RE, Lovett PB, **Crawford A**, **McAna J**, Axelrod D, Ward L, Pulte D. A multidisciplinary approach to impact acute care utilization in Sickle Cell disease. *Am J Med Qual*. First published May 2, 2017. DOI: 10.1177/1062860617707262

Singer D, Crawford A, Fortner G, Goldfarb N. Opioid and benzodiazepine utilization patterns across Multiple Employer Group Plans in Eastern Tennessee. *J Manag Care Spec Pharm*. 2017; 23(3-a), S102.

Varga S, Lombardi M, **Maio V**. Improving the Patient-Centered Medical Home (PCMH) Evaluation Process Is Essential to Foster the PCMH Movement. *Popul Health Manage*. 2017;20(1):1-2. doi:10.1089/pop.2016.0085

JCPH PRESENTATIONS

Djatche L, Gobe J, Chun G, Varga S.
Evaluating value-based frameworks used for relapse or refractory multiple myeloma regimens: ICER Report, ASCO Framework, and NCCN Evidence Blocks. Poster presented at: Academy of Managed Care Pharmacy Annual Meeting, March 27-30, Denver, CO. **Gold Winning Abstract!**

Singer D, Crawford A, Fortner G, Goldfarb N. Opioid and benzodiazepine utilization patterns across multiple employer group plans in Eastern Tennessee. Poster presented at: Academy of Managed Care Pharmacy Annual Meeting, March 27-30, Denver, CO.

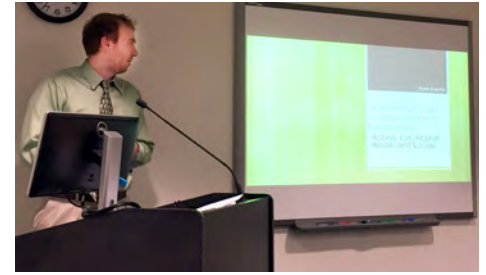
IN THE NEWS



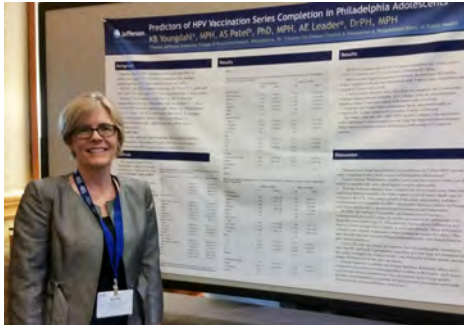
Capstones for the MS in Healthcare Quality and Safety Management program were presented at the recent American Association of Physician Leaders Meeting. Left to right: Jose L. Gonzalez, MD, JD, MSEd, Joan C. Ingram, MD, and Mark G. Davies, MD, PhD, MBA, CPE, FACHE with Billy Oglesby, PhD, MBA, MSPH, FACHE, Associate Dean, JCPH.



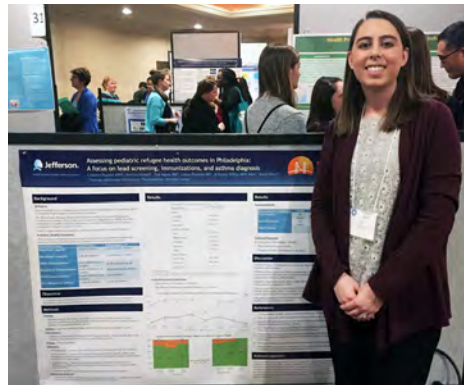
MPH Student Tashika Robinson was honored at the Support Center for Child Advocates 40th Anniversary Benefit Gala where she received the Andi Broad Distinguished Advocates Award.



Brian Kosciusko presents his MPH capstone.



JCPH Alum Karie Youngdahl, MPH presenting at the National Foundation for Infectious Diseases Annual Conference on Vaccine Research.



PhD Candidate and MPH alum Colleen Payton, MPH, CHES presented at the Pennsylvania Public Health Association Annual Meeting.



MPH Student Madeline Brooks' article, "Diabetes in Delaware: What's Social Support Got to Do with it?" was published in the Delaware Journal of Public Health.



Mital Kanzaria, MD, Jefferson Interventional Cardiology Fellow, PGY7 presenting his capstone for the Healthcare Quality and Safety Master's degree program.



Dr. Simmons is presented with the Distinguished Fellows Award by Dr. Frances Butterfoss at the Annual SOPHE Meeting.

Population Health *Matters*

Jefferson College of Population Health
Thomas Jefferson University
901 Walnut Street, 10th Floor
Philadelphia, PA 19107

EDITORIAL BOARD

Editor

David B. Nash, MD, MBA

Dean
Jefferson College of Population Health

Managing Editor

Emily J. Frelick, MS

Senior Project Director
Jefferson College of Population Health

Editorial Board

Lauren Collins, MD

Associate Director, Jefferson Center
for InterProfessional Education
Director, Jefferson Health Mentors Program
Assistant Professor
Division of Geriatric Medicine
Department of Family and
Community Medicine
Sidney Kimmel Medical College

Max Koppel, MD, MBA, MPH

Clinical Associate Professor of Urology
Department of Urology
Thomas Jefferson University

Juan Leon, PhD

Director of Online Learning
Jefferson College of Population Health

**Mary Lou Manning, PhD, CRNP,
CIC, FAAN**

Associate Professor
Jefferson College of Nursing

Ronald E. Myers, PhD, DSW

Professor
Director of the Division of Population Science
Department of Medical Oncology
Sidney Kimmel Medical College

Billy Oglesby, PhD, MSPH, FACHE

Associate Dean for Academic and
Student Affairs
Jefferson College of Population Health

Colleen Payton, MPH, CHES

Clinical Research Coordinator II
Department of Family and
Community Medicine
Thomas Jefferson University

Etienne Phipps, PhD

Director
Einstein Center for Urban Health
Policy and Research
Einstein Healthcare Network

Shoshana Sicks, EdM

Administrative Director
Jefferson Center for InterProfessional
Education

Randa Sifri, MD

Associate Professor
Director, Research Development
Director, Faculty Development Research
Fellowship Department of Family
and Community Medicine
Thomas Jefferson University

**Rob Simmons, DrPH, MPH,
MCHES, CPH**

Associate Professor
Program Director, Public Health
Jefferson College of Population Health

Alexis Skoufalos, EdD

Associate Dean
Strategic Development
Executive Director
Center for Population Health Innovation
Jefferson College of Population Health

Rachel Sorokin, MD

Chief Patient Safety and Quality Officer
Thomas Jefferson University Hospital

Steven Spencer, MD, MPH, FACP

Director of Population Health
Abington Health Physicians
Jefferson Health

**Richard G. Stefanacci, DO, MGH,
MBA, AGSF, CMD**

Lecturer, Jefferson College of
Population Health
Chief Medical Officer, The Access Group

901 Walnut Street, 10th Flr.
Philadelphia, PA 19107

Tel: 215-955-6969 Fax: 215-923-7583
Jefferson.edu/PopulationHealth