

Population Health Matters

Spring 2016 | Vol. 29, No. 2

EDITORIAL

Quarterly Publication

Primary Care: The Good, The Bad, and the Truly Ugly

This year will mark the 35th anniversary of my graduation from the University of Rochester School of Medicine and Dentistry in Rochester, NY. The occasion fills me with ambivalence. On the one hand, I take great pride, of course, in this important accomplishment and all of the training and work that has followed. On the other hand, I am troubled by the current state of my chosen clinical specialty, namely primary care—general internal medicine. What I see is the good, the bad and the truly ugly!

I gave up inpatient hospital-based care nearly eight years ago, after assuming the deanship of our College of Population Health, but I still see patients in our faculty general internal medicine ambulatory practice. Of course I'm not as busy as my full-time clinical partners, but I like to think that I can still make a difference in the lives of certain patients. In fact, at 60 years of age, I'm among the oldest full-time, campus-based primary care general internists on the faculty at Jefferson.

Some of the good that I see is the "change being driven by delivery system reforms emanating from Washington, including the meaningful use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; numerous sections of the 2010 Patient Protection and Affordable Care Act (ACA), and key portions of the Medicare Access and CHIP Reauthorization Act (MACRA), signed into law in April 2015.¹ Taken together, HITECH, ACA, and MACRA have completely changed the face of primary care – in my view, for the better.

The ACA, in particular, is completely transforming primary care with major

investments in enhanced reimbursement for primary care community health center expansion and partnership with multiple payers for the transformation of clinical practice, driven largely by the creation of patient-centered medical homes (PCMHs). These new entities "offer the possibility of refining the structure of transformation." They highlight "up-front supplemental payments for care management, as well as shared savings financial incentives as two key elements of more successful PCMH interventions."² In addition, federal funding has been augmented by state governments, private payers, and non-profit and philanthropic organizations.²

Finally, primary care doctors are learning to "apply the right resource in the right setting to care for patients." For example, "fee-for-service medicine typically utilizes physicians to care for patients regardless of their need. But in a risk managed environment, physicians provide the most value when they work at the top of their license, while lower level contributors, such as nurse practitioners, physician assistants, social workers, pharmacists, and even health coaches, can take on some of the tasks typically assumed by doctors."³ It appears that we are making good progress toward a complete restructuring of what it means to be in primary care practice in 2016.

While this transformation to a PCMH structure is underway, the "bad" is the murky evidence that we are actually on the right road! According to Chokshi and others, "the Agency for Healthcare, Research, and Quality synthesis report of 14 grants to study

Primary Care: The Good, The Bad, and the Truly Ugly.....	1
PFAC: Embracing Our Most Valuable Resource - People.....	2
Health in All Policies: Understanding Public Health at the State Level.....	4
Advance Care Planning.....	5
2016 Population Health Colloquium Highlights.....	7
Encouragement and Uncertainty: On the Interview Trail '16.....	9
Interview with SKMC Student David Hoang.....	10
In The News.....	11
Population Health Forums.....	12

Announcements & Upcoming Events

<i>Community Care of North Carolina Receives Inaugural Hearst Health Prize</i>	6
<i>Grandon Society Members</i>	6
<i>Introducing On Demand Virtual Information Sessions</i>	9
<i>JCPH Presentations</i>	14
<i>JCPH Publications</i>	14
<i>Interprofessional Care in the 21st Century</i>	14
<i>Upcoming JCPH Forum features Health Commissioner, Dr. Thomas K. Farley</i>	15
<i>Hearst Health Prize Call for Submissions</i>	15

Continued on page 2

primary care transformation revealed few overarching pearls. Instead, the success of transformation depended on context. External recognition as a PCMH-certified practice alone was seldom sufficient as a marker of meaningful transformation, from the patient's perspective.⁴ It appears to me that we are losing sight of the ultimate goal, which is an improvement in the individual patient's experience and clinical outcome. We are burdened by too many measures and a mindset focused on "checking the box" to receive a marginal increase in reimbursement. Experts like Millenson and Berenson¹ call into question the entire movement toward patient-centered care. They, too, bemoan the growing list of measures and support my contention about the weak evidentiary basis pointing us in the correct direction.

However, the truly "ugly" is another matter. In the 35 years since my graduation, the core content of both undergraduate and graduate medical education has changed only modestly. Yes, at the GME level, duty hours propel house officers from the building at set times, and yes, modern-day interns and residents hardly ever spend the night in the hospital, but the fundamentals are unchanged.

Specifically, in a world characterized by public reporting of outcomes, we still

devote modest resources to educating the next generation of physicians about their most important responsibility, namely, providing safe care to patients. The modern house officer learns little about the system basis of care, and is exposed only tangentially to the core tenets of performance improvement.⁵ Most UME programs are still structured as two years of memorization in the classroom, with outmoded teaching technology and two years of an apprenticeship in various parts of the inpatient setting. Little exposure is given to leadership training, improvements in teaching, and related lifetime skills that will be necessary for an effective primary care practitioner far into the 21st century.

Nonetheless, I have a good deal of hope for the future of primary care. For example, I am very impressed by our primary care colleagues working with new delivery models, such as [IORA Health](#), a Massachusetts-based startup company with more than \$48 million in investor backing, which is "breathing life into the way consumers can connect to their healthcare team."⁴ We've had the privilege of hosting IORA's founding CEO, Dr. Rushika Fernandopulle, at the College of Population Health. I'm also impressed by the work of [ChenMed](#), based in Florida and other parts of the Southeast. "Their model

includes having longer and more frequent patient visits, providing free transportation to patients, and placing an emphasis on cultivating a physician culture around relationship building and the desire to be accountable for outcomes."² Finally, I am enthusiastic about the future of primary care, as I believe that "new care models, including virtual visits, retail clinics, and urgent care centers, and technology-enabled specialist consults will force a rethinking of what constitutes primary care. Longitudinal patient relationships and a disease prevention-oriented mindset must remain at the core of primary care practice. Quality metrics, which primary care doctors generally find unsatisfactory, must be streamlined around that core."² I want to remain a vital part of the ongoing discussion about which quality metrics makes sense to primary care doctors as the future belongs to those physicians who are participating in this transformation. Just imagine what the next 35 years of primary care practice might look like for our younger colleagues!

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PFAC: Embracing Our Most Valuable Resource – People

One of the most powerful tools for practice improvement can be found seated in the chairs of the patient waiting room. In this era of patient centeredness, it is critical that patients are not only involved in their care, but that their ideas on improving every aspect of their healthcare experience

are heard, considered, and implemented. The Institute of Medicine defines patient-centered care as care that is respectful of and responsive to the individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.¹

The Department of Family & Community Medicine (DFCM) at Thomas Jefferson University (TJU) recognizes the importance of not only taking the patient's thoughts and concerns into consideration, but putting them into action. In February of 2014, Jefferson's DFCM organized

Jefferson's very first Patient and Family Advisory Council (PFAC).

A Patient and Family Advisory Council links patients and families with members of the healthcare team to provide guidance on how to improve the patient experience. Patients and their families are invited to serve on this committee to ensure that their comments, point of view, perspective and experience may be heard and integrated into the care they receive.² The mission of this committee is to ensure that all patients receive the highest level of quality service and patient-centered care as well as an exceptional patient experience. Jefferson has a similar [Patient and Family Advisory Council](#) for inpatient care at the hospital.³

The DFCM's PFAC started with a planning committee consisting of representation from the full spectrum of the healthcare team: physicians, nurses, medical assistants; front desk, billing, and phone room staff as well as administration. After doing much research on how other institutions around the country have put together their own PFACs, our planning committee created a timeline and began to discuss how to start recruiting patients.

We asked members of the healthcare team, via email and during weekly meetings, to identify patients that they felt would be good representatives for PFAC. We also created and displayed flyers in the patient waiting room and on bulletin boards in every exam room. We received many inquiries and conducted phone interviews using a membership application we created. In addition to obtaining the patient's name, address, etc., the patient is asked why they would like to become a PFAC member, their areas of special interest, and what related experiences they may have to share. The applicant must then sign the application, agreeing that: 1) the info given is correct and given voluntarily; 2) agree to abide by the volunteer policies and guidelines of PFAC; 3) must keep confidential all information gained, directly or indirectly,

concerning a patient, physician, or any other person; 4) authorize the staff of PFAC to discuss the patient's participation on PFAC with associated clinical care staff, including nurse and/or social worker, if applicable. Our main concern was to be sure we formed a diverse group of people that well represented our patient population. After careful screening, we achieved this result, and ended up with a dedicated group of people that truly want to make the patient experience at TJU's DFCM excellent.

The PFAC has been meeting every other month since September 2014. These are 2-hour breakfast meetings that include 15 patients and 10 DFCM faculty and staff members. The Planning Committee meets every week for one hour. The initial meeting consisted of icebreakers and an explanation of patient access and patient flow in the office. Every patient member asked important questions related to patient flow and access and offered advice on how to help the patient population understand these topics. This opened up a theme where at subsequent meetings we did a "virtual patient visit" beginning from making the appointment (phone room) to the closing of the visit.

We have implemented several changes since the launch of our first PFAC meeting in September 2014. New signage on registration desks is helping patients navigate where they need to go. Rejuvenation of an outdated website is reintroducing our patients to their healthcare team. A new and improved patient brochure has been introduced to answer all questions patients may have and to let them know when their health caregiver is seeing patients. Currently, one of our PFAC members is translating the brochure into Spanish; addressing language barriers is always on the agenda of every PFAC meeting. We now have a greeter at the front entrance of the practice to welcome patients upon their arrival and to address any questions and concerns they may have. On the horizon are more education materials and



Patient greeter Shirley Beckett

monitors providing appropriate medical education. We are also planning a patient appreciation week in the spring.

Although we have made great strides, we have much more to do. Our patient team is on a 2-year rolling membership and it is now time to start recruiting again. We need to expand our patient constituency to be more diverse and fully-inclusive, one that is welcoming to all persons. When we started this committee in 2014, we weren't sure if we would have a dynamic group of people that formed a constructive team. But what we have learned is that each member of the council is passionate about sharing ways in which we can improve the patient experience given their own unique thoughts, ideas and experiences. Everyone feels comfortable speaking their mind and they all bring something different to the table. By working together to improve Family and Community Medicine at Jefferson, I believe PFAC has begun to feel like "family" – we honestly care about one another – and that's what healthcare is all about.

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Health in All Policies: Understanding Public Health at the State Level

On March 31st, 2016, the Public Health Policy and Advocacy class had the opportunity to visit the [Pennsylvania Department of Health](#) and meet caucus members at the state capitol in Harrisburg, PA. This enlightening trip allowed us to apply what we learned about policy in the classroom to a real venue.

At the Department of Health, [Dr. Karen Murphy](#), the Secretary of Health for the PA Department of Health, welcomed us and discussed health issues that had been prioritized for legislative change. Dr. Murphy explained how the opioid abuse epidemic was a huge concern for our state. She emphasized that 7 people die per day from prescription drug use. Dr. Murphy discussed possible expansions of the [2014 Act 139](#) where first responders were allowed to carry and administer a lifesaving prescription drug called Naloxone to overdose patients while providing immunity from prosecution to those who initially reported the overdose to authorities. Ideas for expansion included making Naloxone more readily available to the public, which ideally would decrease deaths due to opioid overdose.

Dr. Murphy encouraged students to ask questions and addressed various subtopics such as the implementation, feasibility and enforcement of these ideas. It was exciting to apply our classroom knowledge of critically thinking and developing solutions to complex public health issues into a real and powerful venue. Policy creation and adoption are powerful tools used to effect change. This exposure to the cross between public health and law was an invaluable experience.

The rest of the presenters followed the same format. The presenters were as follows: Robin Rothermel, Director, Bureau of Communicable Diseases; Dr. Glenda Cardillo, Public Health Physician, Bureau of Community Health Systems; Dr. Sharon Watkins, Director of the Bureau of Epidemiology, Jeffery Backer, Division Director, Bureau of Public Health Preparedness; Tomas Aguilar, Director, Bureau of Health Promotion and Risk Reduction, then finally Dr. Loren Robinson, Deputy Secretary for Health Promotion and Disease Prevention.



Below photo. Back row left to right: Alyssa Sipes, Nate Ford, Spencer Mitchell, Junaid Yasin, Tomas Aguilar, Director, Bureau of Health Promotion Risk Reduction, Adam Carroll, Jeffrey Backer, Director, Division of Planning and Operations, Bureau of Public Health Preparedness; Randy Aviado, Vincent Basile, Joshua Clark; Tom Nowland, Kevin Clark, and Charlotte Cosgrove. Front row left to right: Dr. Sharon Watkins, Director, Bureau of Epidemiology; Robin Rothermel, Director, Bureau of Communicable Diseases; Nour Cheikhali; Ashley Asencio; Katie Jarrell; Natasha Bagwe; Connie Choi; Kerona Sharpe; Dr. Loren Robinson, Deputy Secretary for Health Promotion and Disease Prevention; Christina Downing, Brianna Williams, and Martha Romney.

Dr. Loren Robinson was energetic and insightful and ended our trip to the Department of Health on a high note. Many appreciated the story of her journey expanding her desire to heal as a physician to effecting impactful improvement in health for the masses. Dr. Robinson then took the time to encourage our group to continue on our public health path and was a refreshing cap to the Department of Health portion of the trip.

The second portion of the trip included a meeting with Whitney Krosse, the Executive Director for the House Health Committee (R) Caucus, and with Clarissa Freeman, Executive Director of the Public Health and Welfare Committee in the Senate Minority Caucus. These two individuals did a wonderful job of expressing the importance of continuing to learn how to translate health science into meaningful policy. They emphasized how much a group like ours is part of a health community that helps to inform and supplement their understanding of pertinent health issues that her law degree doesn't fully cover. It emphasized how critical it is for knowledgeable individuals from different fields such as health, law and economics to share information

between disciplines.

Overall, this trip was an eye opener to the expansiveness of public health and how it reaches a variety of fields to collectively improve the health of the public. We are thankful to all those who met with us and to Professors Martha Romney and Dr. Robert Simmons for providing such an impactful learning experience. And to learn the meaning of "health" in all policies.

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Advance Care Planning

By the year 2030, approximately 20% of the population in the United States will be 65 or older.¹ Given this reality, more attention has been devoted on ways to provide quality care and control costs at end of life. Despite advances in care and changes in health care delivery, the percentage of Medicare expenditures in the last year of life have remained largely unchanged over the past two decades.² Significantly more than any other developed country, the U.S. spends roughly 30% of all Medicare costs (almost \$180 billion dollars in 2014) on Medicare beneficiaries in their last year of life.³

Given this finding and other data demonstrating poor end-of-life care in this country, the Center for Medicare and Medicaid services (CMS) proposed and passed a new Medicare reimbursement policy that includes separate payments to physicians for counseling patients on advance care planning. "For Medicare beneficiaries who choose to pursue it, advance care planning is a service that includes early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is right for them," according to CMS.⁴ Under the proposal, beginning in January 2016, the Medicare physician fee schedule would include two new Current Procedural Terminology (CPT) codes for advance care planning – one would cover the first 30 minutes; the other, any subsequent 30-minute blocks of time.

With the growth of specialized palliative care in hospitals and an increase in utilization of hospice among Medicare enrollees, especially those with cancer, this new focus is increasingly prompting clinicians to engage in care conversations earlier in the course of illness.

Advance care planning, defined as 'a process of communication between

individuals and their healthcare agents to understand, reflect on, discuss and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions'⁵ is thought to increase patient and family satisfaction with care as well as prevent overtreatment at end of life. Previous studies have shown discussions at end of life are associated with lower rates of patient anxiety and depression as well as less aggressive care.⁶ Specifically, this multi-site, prospective, longitudinal cohort study included 638 patients with advanced cancer and their informal caregiver, with trained interviewers talking with patient and caregiver about care. They assessed whether patients had spoken about their goals of wishes, "Have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?" Overall only 37% of patients or caregivers reported having conversations about their goals for care; however, those that reported engaging in these conversations were significantly ($P \leq .001$) more likely to accept that their illness was terminal (52.9% vs 28.7%), prefer medical treatment focused on relieving pain and discomfort over life-extending therapies (85.4% vs 70.0%), and have completed a do-not-resuscitate order (63.0% vs 28.5%).

Much conflicting data exists on whether simply completing an advance directive alone actually changes care outcomes or if patient's wishes are followed in an urgent medical situation. Additionally, there may be nothing harder in medical care—cognitively, technically, or emotionally—than talking to patients, especially younger ones, about dying and thus advance care planning. Bringing up the topic, guiding the conversation to stay focused on the issues and clinical options, and ultimately reaching decisions are not naturally occurring skills. Rather, they require training, cultivation, and practice.

If the major barrier to engaging patients about end-of-life care is physicians' self-defined lack of skill, knowledge and comfort to engage in these conversations, money is unlikely to be the right catalyst. However, removing any and all barriers, including financial, is potentially a step in the right direction. Further research is needed to establish how best to educate providers, remove barriers, and empower patients and family members to best engage in their care in order to improve end of life care in this country.

At Jefferson, the Palliative Care Team is engaged in both inpatient and outpatient activities to both increase patient and provider comfort and familiarity with advance care planning. In addition, the [5th Annual Palliative Care Symposium](#) will be held Friday, June 3, 2016. This interprofessional program is designed to improve the quality and delivery of primary palliative care to all patients and their families with serious, life-threatening illness by acquiring skills and strategies for inter-professional practitioners who care for these patients.

If this is a topic of interest, many on-line sites are designed to empower patients, families and providers to engage in these discussions. For more information visit:

[The Conversation Project](#)

[PREPARE](#)

[Engage with Grace](#)

[Death Over Dinner](#)

[Making Your Wishes Known](#)

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Continued on page 6

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Community Care of North Carolina Receives the Inaugural Hearst Health Prize

The winner of the \$100,000 Award for Excellence in Population Health was announced that the Population Health Colloquium on March 8, 2016. Community Care of North Carolina (CCNC) was recognized for its work on care transitions for Medicaid beneficiaries in North Carolina. Led by C. Annette DuBard, MD, MPH, the CCNC team was able to show measurable improvements in the rates of hospitalizations and readmissions throughout North Carolina.

Finalists in the inaugural competition included the Centering Healthcare

Institute and Jersey City Medical Center – Barnabas Health (Wealth from Health Program). All finalists presented posters at the colloquium and were recognized at the award ceremony.

Look for the next call for submissions in **May 2016**: www.Jefferson.edu/HearstHealthPrize.



The winner of the Hearst Health Prize, Dr. DuBard of Community Care of North Carolina with Dr. Nash and Hearst Health President & CEO, Dr. Gregory Dorn. Photo by: Roger Barone

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Contact Alexis Skoufalos at 215-955-2822 or Alexis.Skoufalos@jefferson.edu

2016 POPULATION HEALTH COLLOQUIUM HIGHLIGHTS



Panelists left to right: Arthur Lazarus, MD, MBA; Stephen A. Martin, Jr, PhD, MPH; Karen Murphy, PhD, RN; Rita Numeroff, PhD; and Bill Winkenwerder, Jr, MD, MBA



Hearst Health Prize finalists left to right: Colleen Senterfitt, CNM, MSN, Centering Healthcare Institute; Winner, Annette DuBard, MD, MPH, Community Care of North Carolina; and Susan Walsh, MD, FACP of Jersey City Medical Center-Barnabas Health



Dr. Nash interviewing Dr. Jeffrey Brenner and Dr. Katherine Schneider.



Dr. Dorn, President & CEO of Hearst Health during the Hearst Health Prize award ceremony.



Dr. Nash interviews Jandel Allan-Davis, MD.



Allyson Schwartz



Dr. William Copeland

All photos by Roger Barone

THE SIXTEENTH



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Encouragement and Uncertainty: On the Interview Trail '16

"That's great, but help me understand how any of this is relevant to an intern at the bedside." This was not the reply I was hoping for after explaining my passionate interest in patient safety and population health during a recent Internal Medicine residency interview. Fortunately, this awkward reception proved to be an outlier. As a 'non-traditional' medical student with past work experience in health policy and an expressed interest in population health, I found my resume received a broadly positive reception on the interview trail. Indeed, during my dozen interviews, I found program directors boasting about quality improvement and patient safety nearly as often as fellowship matches and new hospital towers.

Medical students are increasingly aware that the practice of medicine is changing; future doctors will be more accountable for the cost and quality of care delivered. In light of this ongoing disruption to the industry we will soon be joining, students are looking for residency programs that will equip us with the skills and experience to effectively function in an 'Accountable Care' future. Although enthusiasm for training in population health management, quality improvement, and patient safety will certainly vary by individual, most applicants expect to gain a basic level of competency in these areas from prospective residencies. For example, opinions were unanimous among the applicants I spoke with on the interview trail that fully functional EMRs that allow residents to track and analyze data on their own performance is a must. For emerging physicians, completing residency without gaining facility with an EMR would be tantamount to entering independent practice without knowing how to manage hypertension.

Interview days provide applicants with a unique opportunity to evaluate programs. I found that speaking with current residents often yielded more actionable information than hours of online research. This in-person evaluation is especially important given the dearth of objective data applicants have to compare programs. American Association of Medical Colleges (AAMC) [FREIDA Online](#)[®] database, American Board of Internal Medicine (ABIM) board pass rates, and fellowship match lists were pretty much all the comparable data I could find on programs. Unfortunately, FREIDA data is spotty and self-reported by programs. Fellowship matches are obviously of limited use to applicants not interested in specializing, and ABIM board pass rates are limited to three-year rolling averages that are suspiciously updated each year just after the Match. The American College of Graduate Medical Education (ACGME) collects a large amount of data on residency programs, but this information is generally confidential and not released to the public.

In an effort to gain more data about the programs I will be entrusting my professional life to, I searched performance data from the [Leapfrog Group](#) and [Medicare's Hospital Compare](#). My thinking was that a hospital that is dangerous for patients or has significantly poorer outcomes than its peers is probably not somewhere I want to train. I found data on readmissions, hospital-acquired infections as well as overall safety ratings. The results were interesting and sometimes deviated sharply from my subjective impression of programs. Nevertheless, these data are hospital-specific and insufficiently granular to judge individual residency programs. So, like most applicants, I assembled my Match list based mostly on my 'gut' feeling about programs.



Roderick Thompson

As a soon-to-be physician who is optimistic about a safer, more accountable healthcare future, it was encouraging to see residency programs give quality improvement, patient safety and evidence-based medicine top billing on interview days. However, at a time when evidence and transparency in medicine are ascendant, it seems incongruous that applicants to medical residencies must make such an important decision with so little hard data. If residency programs want to prove they can adequately prepare emerging physicians for an 'Accountable Care' future, a great place to start would be improving transparency and data availability for applicants.

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Roderick will begin his residency in Internal Medicine this June at Kaiser Permanente Medical Center in San Francisco.

INTRODUCING ON DEMAND VIRTUAL INFORMATION SESSIONS!

Designed to meet the needs of busy prospective students, nationally and internationally, JCPH now offers virtual information sessions that can be accessed at any time. Information sessions are available for all programs including: Population Health, Public Health, Health Policy, Applied Health Economics and Outcomes Research, Healthcare Quality and Safety, and Healthcare Quality and Safety Management.

For more information visit: Jefferson.edu/PopulationHealth

Interview with SKMC student David Hoang:

The academic path that sparked a journey beyond the walls of clinical care

Describe your academic background.

I actually started at Jefferson in 2008 and did the combined degree program, which is an 8-year program. I did the first two years, the preclinical years in the medical school, and then I started my PhD in Biochemistry. I did four years of research and then did my thesis defense in August of 2014 when I basically completed all the requirements for the PhD degree. My specific area of research was in prostate cancer biology with Dr. Marja Navalainen, who was with the Kimmel Cancer Center at the time. After finishing my research, I returned to medical school to finish the last two clinical years.

I've always been the kind of person that likes to impact health care from a larger perspective. I realized that the day in and day out of being a clinician is very rewarding, but the impact there is less than what you might get through larger avenues, such as research or development of a drug or a therapy that may potentially reach a larger population. That's what really drove me to go that route.

What motivated you to enroll in the elective, "Business of Medicine" at Weill Cornell Medicine?

While working on my PhD, I was fortunate to connect with a few alumni of Jefferson who had migrated over to industry and I found their perspectives pretty interesting. I wanted more exposure to that; this internship was an opportunity to get that exposure in a condensed timeframe.

This internship was part of a 2-month course. Through a professor at Weill Cornell, I was connected to [Huron Consulting Group](#). They have practices in healthcare as well as life sciences. I was in the [life sciences](#) practice and my job consisted of day to day interacting with a number of clients in the pharmaceutical and biotech industry. The length of the internship was the same length of the course.

What did you work on at Huron?

One of the projects was in lung cancer, and I got exposed to the cutting edge of what is going on right now in the field in terms of therapies. Part of my job was to try to predict where the field is going within the next 10 years, which was really fascinating to me. I had to take the current knowledge and extrapolate out to the future treatment paradigms. That kind of work was very intellectual and pulled on both research and clinical skills.

I really enjoyed the people at Huron, they were fantastic, and it was an interdisciplinary environment. People came from many different backgrounds, and the majority did have a business background of some sort.

What did you learn that you didn't anticipate learning?

I learned how a business or large organization functioned. This for me was a step in a totally new direction. I'm used to being in the trenches. But there was an organizational aspect, and part of that was learning how to communicate with people at all different levels – from the board down through different departments and operational levels. That to me was a new experience. I realized how many people actually have to get mobilized to move a new idea forward, launch a new product, or change direction.

How do you think you will use this experience in your career?

In the short-term, I do have an opportunity as soon as I graduate in June with another company, doing similar work that I did at Huron. In the future, I would like to be in a senior leadership position at a pharmaceutical or biotech company.

Would you encourage other MD students to participate in similar courses and internships?

Yes, any medical student that has any type of interest in anything outside of direct clinical practice could benefit from something like this. I think there's a lot of



David Hoang

flexibility in these types of opportunities in terms of getting the type of experience desired by the student.

As you embark on this new journey, what are some of your reflections on your time at Jefferson and your career path?

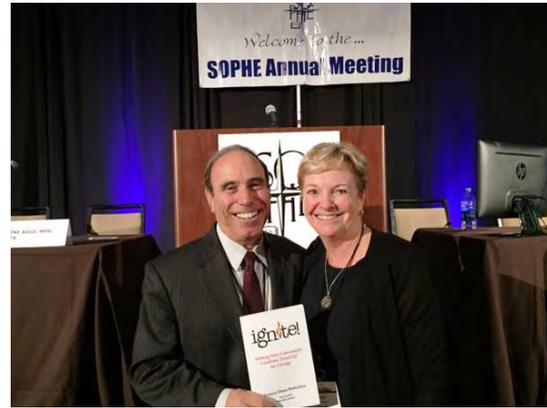
This hasn't been the most direct pathway. I enjoyed my time at Jefferson a great deal in all the different facets that I've experienced. Many times your career path doesn't unfold linearly, and there's nothing wrong with that. Sometimes students are anxious about having everything lined up, but my advice to younger students is that you don't necessarily need to have that in place. Sometimes the best way to go is to let it unfold naturally.

Looking at the past eight years, I really like this new direction Jefferson is going. There has been a true interdisciplinary push and I think Dr. Klasko has done a lot to move it in that direction. I see many efforts to connect between different departments, and implement new initiatives, and realize as an organization, that we all are involved in the mission of improving health and to get there we need to truly work as a team.

IN THE NEWS



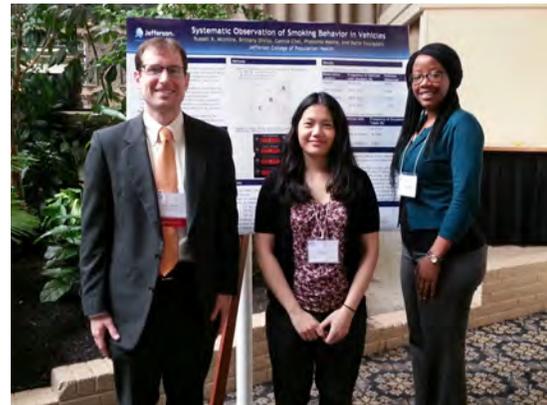
Dr. Simmons with Katherine Puskarz, MPH at SOPHE's 67th Annual Meeting.



Distinguished SOPHE Fellows reunion - Dr. Simmons and Dr. Fran Butterfoss.



JCPH and Jefferson Pediatric Dental Medicine at Philadelphia Science Festival Explorer Sunday for Aspiring Health Professionals.



Dr. Russell McIntire, with MPH Students Connie Choi, and Phatsimo Masire presented a poster at the Pennsylvania Public Health Association Annual conference.



JCPH MPH Students had the opportunity to meet with the esteemed Dr. Vivian W. Pinn at the recent Jefferson Women's Networking event. Photo left to right: April W. Smith, Tara Ketterer, Dr. Pinn, Denine Crittendon, Kerona Sharpe and Alia Salam.



JCPH's David Glatter (on left) received a special partnership in philanthropy award.

Using Electronic Health Records and Nursing Assessment to Redesign Clinical Early Recognition Systems

Eric V. Jackson, Jr, MD, MBA

*Director, Health Care Delivery Service
Associate Director, Value Institute
Christiana Care Health System
January 13, 2016*

The 2016 Forum season kicked off with an interesting presentation on innovative tools and interventions used in improving quality and safety led by [Dr. Eric V. Jackson](#), Associate Director of the [Value Institute](#), and Director of Health Care Delivery Service at Christiana Care Health System. Dr. Jackson oversees the integration of clinically connected pragmatic implementation science for all the service lines within Christiana Care.

First established in 2011 by Robert Laskowski, MD, the Value Institute was initially driven by the framework of the [Triple Aim](#). The Institute serves as a multidisciplinary research center focused on discovering solutions that improve the experience, efficiency and effectiveness of health care for patients and providers.¹ The Value Institute is comprised of 4 centers:

[The Center for Health Care Delivery Science](#)
[The Center for Organizational Excellence](#)
[The Center for Outcomes Research](#)
[The Center for Quality and Patient Safety](#)

Dr. Jackson set the stage by discussing studies related to early warning scores that alert the clinical team to patients whose condition is beginning to deteriorate and discussed the importance of cognitive aids that serve as enhancements to decision making. He outlined ways in which Christiana leveraged EHR and predictive system-wide surveillance, through early detection of deterioration, clinical transformation, readmission reduction, ICU collaboration, and palliative care. "Hospitals are big bags of data," stated Jackson, and asked, "how do we make sense of it?" He emphasized the importance of leveraging EHR and IT to detect early symptoms of adverse events. Knowing what tool works depends on how things operate organizationally within an institution, and the priorities of that institution.

Dr. Jackson described the strategic aims influencing Christiana's Early Warning Score (CEWS) which fall into three major themes: optimal health, exceptional experience, and organizational vitality. CEWS is described as an integrated trigger tool that detects early signals of adverse events 24 hours before they occur. CEWS includes predictive performance, IT infrastructure, workload integration, and Nursing Screening Assessment (NSA). The pilot study showed

that perceived workload did not increase, interface with physicians improved, and overall the assessment was useful to evaluating a patient's condition.

[Discrete-Event Simulation \(DES\)](#) is computer simulation that models a system as a discrete sequence of events. Each event occurs at a particular instant in time and follows a specific time distribution. Dr. Jackson explained optimization of implementation strategies, which are centered on the ability to predict unexpected physiologic deterioration of patients, together with DES allows the system to enhance: staff and scheduling, resource and workflow, capacity planning management, and patient flow.

The overall findings as described by Dr. Jackson are: patient rescue is a complex interdependent system that requires an integrated approach; CEWS provided strong predictive capability to detect early signals of RRT (rapid response team) activation; electronic NSA statistically improved predictive performance; and frontline line providers should be encouraged through system design to become champions of early warning assessments.

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1. Christiana Care Health System. Value Institute Overview. <http://www.christianacare.org/valueinstituteoverview>

What Does Population Health Mean for Public Health?

James W. Buehler, MD

*Professor, Health Management and Policy
Dornsife School of Public Health
Drexel University
February 10, 2016*

Fresh from his former position as Health Commissioner for the City of Philadelphia, Dr. James Buehler spoke about the connections between public health and population health at a recent Forum. Dr. Buehler is currently a Professor in Drexel's Dornsife School of Public Health, where his interests are centered on improving public

health systems and services, and in particular the interface between public health and healthcare systems, and the shared objective to advance population health. Dr. Buehler previously served as Commissioned Officer in the U.S. Public Health Service at the Centers for Disease Control and Prevention and was a faculty member of the Rollins School of Public Health at Emory University.

Dr. Buehler first raised the broad question – What determines health? He outlined numerous factors including genes, behaviors, norms, opportunities, access,

prevention, treatment, socioeconomic status, public health department, and physical environment. He struck a chord with the audience by sharing compelling information about the high rates of poverty in Philadelphia and the connections to premature death. He explained that aspirations of health providers to improve the health of populations will be modulated by the social context.

Dr. Buehler shared an overview of the mission, vision and services of the [Philadelphia Department of Public Health \(PDPH\)](#). The domains covered by the

PDPH include environmental health, air quality, infectious disease prevention and control, chronic disease, maternal, child and family health, medical examiner's office, laboratory, and health care services. PDPH is important in developing and implementing policies, programs and services, informed by evidence. Critical to how PDPH functions are partnerships with numerous non-governmental, universities, hospital, community based organizations, business, and other governmental agencies. The scope of care and services is city-wide populations; targeted populations; and safety-net services.

Buehler went on to describe examples of population-level interventions: a targeted educational campaign aimed at reducing the risk of cardiovascular disease; a policy-driven citywide cigarette tax; the launch of new farmer's market; and a special program

that engaged high school students in preparing healthy meals.

Looking at the national picture, Buehler believes that the public health landscape is being reshaped by developments such as [Meaningful Use](#) and [Affordable Care Act](#), which are aimed at transforming healthcare by promoting population health. "This is a very exciting, dynamic and fluid time to think about that relationship between public health and healthcare," states Buehler. Buehler explains that public health has a particular stake in Meaningful Use, as it offers the potential for more timely and complete population health monitoring. Buehler also pointed to population health aspirations that are illustrated in CMS's Accountable Health Communities announcement as an example of the push for healthcare providers to be more involved in the communities where

patients live. Buehler also described the importance of Community Health Needs Assessment (CHNA), an ACA mandate, and Collaborative Opportunities to Advance Community Health (COACH), a regional program comprised of hospital, public health, and community stakeholders.

He concluded by describing a CDC-funded [PDPH program](#) focused on public health actions to prevent obesity, diabetes, and stroke. The program includes learning collaborative with local Federally Qualified Health Centers and health system-affiliated practices; support for diabetes prevention for low-income residents; support for community health workers for improved patient outreach and assistance; and collaboration with partners to enhance HIT and population health management software.

Community Health and Development: New Avenues in Partnership and Financing

Donald Hinkle-Brown
CEO and President
The Reinvestment Fund
March 16, 2016

Dr. Nash introduced the March Forum speaker, [Donald Hinkle-Brown](#), by raising the question, "how can we use reallocation of resources to improve the real estate infrastructure to support health?" This, Nash stated, is certainly aligned with our mission in "health is all we do" and viewing housing as a key determinant of health.

Donald Hinkle-Brown is the CEO and President of the [Reinvestment Fund](#), a catalyst for change in low-income communities whose mission is to build wealth and opportunity for low wealth people and places through the promotion of socially and environmentally responsible development. Hinkle-Brown is recognized as an expert in mission investing and capacity building through his work developing new programmatic initiatives, raising capital and creating new products that improve opportunity, equity and health for underserved people and places.

Mr. Hinkle-Brown first explained that equity and social justice is really what initially drove the work of the Reinvestment Fund and the creation of the community development financial industry. From an equity

perspective, the community development problem is really a health problem. For example, Hinkle-Brown points out that nearly one-fifth of all Americans live in low-income neighborhoods that offer far fewer opportunities for healthy living than residents in adjacent, higher wealth communities.

The increased focus on social determinants of health also drives the work and mission of the Reinvestment Fund. The opportunity for improved health is connected to the quality of homes, schools, jobs, food and neighborhoods. The Reinvestment Fund works to build opportunities through capital (grants, loans, equity investments), knowledge (information, policy, analysis), and innovation (products, markets, and strategic partnerships).

Mr. Hinkle-Brown described in detail the operational function of the Fund which consists of organized people, money, capacity, and data. Their clients include government, philanthropy, and private organizations. The Fund is an intermediary both in terms of capital and data and that has helped stakeholders across the country develop a framework for community investment. "We view ourselves as a *think bank*," states Hinkle-Brown. An example of one of the early initiatives of the Reinvestment Fund was their investment in access to healthy foods and grocery

stores. Their role as a leader in healthy food financing served as a national model for others embarking on similar efforts.

The Reinvestment Fund is part of the Collaborative for Healthy Communities, an initiative designed to provide capital for community health centers, including Federally Qualified Health Centers (FQHC). They have partnered with the Public Health Institutes to align health and community development; and they have built the federal [Healthy Food Financing Initiative \(HFFI\)](#) with [The Food Trust](#) and [PolicyLink](#) in an effort to support projects that increase access to affordable food in communities.

Hinkle-Brown explained the Reinvestment Fund is helping hospitals and providers realize the health benefits of community development by focusing on the components necessary to improve health in low-income communities. Hinkle-Brown concluded by discussing Invest Health, a collaborative program with the Robert Wood Johnson Foundation created to help mid-size cities attract capital, build partnerships through different sectors, improve health outcomes and use data as a driver for change.

To access recordings and slides of Population Health Forums visit [Jefferson Digital Commons](#).

JCPH PRESENTATIONS

Cooper M. Harm across the board. Presented at: Delaware Hospital Association, February 3, 2016, Georgetown, DE

Cooper M. Quality improvement: science and innovation. Presented at: Yale University for first year medical students, February 5, 2016, New Haven, CT.

Cooper M. 14th Annual Safety Summit (host), Connecticut Hospital Association, March 24, 2016, Wallingford, CT.

Cooper M. Leadership panel for Women's History Month. Panel presentation at: Frank H. Netter School of Medicine, Quinnipiac University, North Haven, CT.

McIntire RK, Coffman, R, Rizvi A. Systematic observation of smoking behavior in parks and private vehicles. Presented at: National Public Health Week, College of Physicians, April 4, 2016, Philadelphia, PA.

McIntire RK, DiVito B, Choi C, Masire P, Youngdahl K. Systematic observation of smoking behavior in parks and private vehicles. Poster presented at: Pennsylvania Public Health Association Annual Conference, April 7, 2016, Lancaster, PA.

Simmons R. Developing and communicating advocacy messages at the state government level. Presented at: Association of Schools and Programs of Public Health Annual Meeting, March 20, 2016, Arlington, VA.

Simmons R, Puskarz K, Harris D. Population Health: linking health care and public/community health, opportunities for health educators. Presented at: Society for Public Health Education (SOPHE) 67th Annual Meeting, March 30, 2016, Charlotte, North Carolina.

Simmons R. Training health educators to serve as catalysts to enhance health literacy: changing our healthcare system and educating consumers. Presented at: Society for Public Health Education (SOPHE) 67th Annual Meeting, April 1, 2016, Charlotte, North Carolina.

Simmons R. Can strategies to improve cancer literacy work for young and middle aged adults? Presented at: National Association of Chronic Disease Directors Expert Meeting on Cancer Prevention in Early Adulthood, April 13, 2016, Decatur, Georgia.

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Nash DB. Why hospitals can't learn to 'fly'? *MedPage Today.* March 23, 2016.

Nash DB. A practical conundrum. *MedPage Today.* April 21, 2016.

POPULATION HEALTH FORUM

WHAT WILL IT REALLY TAKE TO IMPROVE POPULATION HEALTH?

Featuring

Thomas A. Farley, MD, MPH

Health Commissioner, Philadelphia Department of Public Health

June 8, 2016

8:30 am – 9:30 am

Bluemle 105/107

Details and registration [click here.](#)



IN PARTNERSHIP WITH



\$100,000 Hearst Health Prize Call for Applications

The Jefferson College of Population Health (JCPH), in partnership with Hearst Health invites you to apply for the Hearst Health Prize for Excellence in Population Health. The winner will receive \$100,000 cash prize in recognition of outstanding achievement in managing or improving population health.

The prize was created to help promote promising new ideas in the field of that will help to improve health outcomes, and thus proliferate best practices more rapidly. The goal is to discover, support, and showcase the work of an individual, group or organization that has successfully implemented a population health program or intervention that has made a measurable difference.

To learn about eligibility, criteria, and the application process visit: Jefferson.edu/HearstHealthPrize

Questions? Email HearstHealthPrize@Jefferson.edu

A promotional poster for a conference. The background is a night view of the Benjamin Franklin Bridge in Philadelphia, with city lights and a blue sky. The text is overlaid on the image. At the top, 'SAVE THE DATE' is written in large, yellow, sans-serif capital letters. Below that, in white text, it says 'Jefferson Center for Interprofessional Education cordially invites you to our 5th biannual conference'. The main title of the conference is 'Interprofessional Care for the 21st Century: Redefining Education and Practice' in white. The dates and location are 'October 28 & 29, 2016 | Philadelphia, PA'. A black box with red text on the right side says 'Abstract Submission Deadline EXTENDED to 6/3/2016!'. At the bottom left is the Jefferson logo with the tagline 'HEALTH IS ALL WE DO' and 'HOME OF SIDNEY HIMMEL MEDICAL COLLEGE'. At the bottom right is the URL 'Jefferson.edu/JCIPE/2016conference'.

Population Health Matters

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