

Population Health *Matters*

Quarterly Publication

EDITORIAL

Converging on Quality and Safety

Certain recent events, both in Philadelphia and across the nation, have led me to believe that we are at the brink of an impending “convergence” in the quality and safety arena. This convergence is focused on two major national trends – the release of a critically important report entitled, *Teaching for Quality*¹ and the implementation of the Accreditation Council for Graduate Medical Education’s (ACGME) Next Accreditation System (NAS). Let me explain some of this jargon and review the components of this convergence.

In November 2013, Philadelphia was the host city for “Learn • Serve • Lead: Association of American Medical Colleges (AAMC) Annual Meeting.” Academics from around the country gathered in the city’s state of the art convention center to celebrate the accomplishments of the 141 academic medical centers and the nearly 500 members of the Council of Teaching Hospitals. The audience recognized that we are on the precipice of a new age; an age where these organizations will be pressed to make the transformational leap from measuring success not by the sheer volume of services delivered but instead tied to the clinical outcomes achieved (moving from volume to value).

Contemporaneously, the ACGME is poised to fully implement the Next Accreditation System (NAS) to oversee training for residents in seven specialties (ie,

emergency medicine, internal medicine, neurologic surgery, orthopedic surgery, pediatrics, diagnostic radiology and urologic surgery). In July of 2014, the NAS will be implemented by all remaining specialties and ultimately cover more than 9,000 medical residency programs throughout the country.²

The AAMC report, “Teaching for Quality” represents the culmination of nearly four years of work by a national steering committee that I had the privilege of participating in. The report, authored principally by one of the committee members, Dr. Linda Headrick, is envisioned as “a national collaborative faculty development initiative to insure the proficiency of all clinical faculty members in quality improvement and patient safety.”¹ The avowed goal of the initiative is to “insure that every medical school and teaching hospital in the United States has access to a critical mass of faculty-ready, able and willing to engage in role model and lead education in quality improvement and patient safety and in the reduction of excess healthcare costs.” In my view, this public policy represents a critical watershed event in the history of post-World War II medical education in our country.

The principle objectives of Teaching for Quality are to create and foster a

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foundational core of clinical expertise in quality and safety. The goal is to ensure that there are 3 distinct levels of faculty: those deemed **proficient** should be able to practice and teach quality improvement in the context of their everyday work; those at the next level will be **expert educators**, skilled in developing and delivering formal education and in assessing physician development; and an elite few would become **Masters** or **Scholars**, producing publishable research to advance the field in addition to their teaching. In a nutshell, every clinical department will be obligated to support a faculty career trajectory in the basic tenets of quality improvement and patient safety. Through this initiative, we hope to be able to educate a new generation of interns and residents in a way that will equip them with the necessary skills to practice value-based and population-based medicine.

The aims of the NAS are to “enhance the ability of the peer review system to prepare physicians for practice in the 21st century, to accelerate the ACGME’s movement toward accreditation on the basis of educational outcomes and to reduce the burden associated with the current structure and process-based approach.”²

As these two major trends converge, what will be the response of educators, policymakers, and other persons responsible for producing the practitioner of the future? Fueled in part by the national conversation about health reform and the move from volume to value, the scholarly literature has been filled with new research and a new “call to arms” to implement quality and patient safety curricula across the spectrum for all trainees.

For example, an entire issue of the *Journal of the Medical Association (JAMA)*, November 13, 2013) was recently dedicated to critical issues in US Healthcare. Within this special *JAMA* issue, national experts called for top-down review of quality measures³ and others called for a change in the toxic politics of healthcare.⁴ Still others⁵ called for a moonshot-like approach

to reduce healthcare costs. These leaders recognize that, while laudable, these goals can only be achieved with a new type of physician workforce.

I’m very happy to report that Jefferson Medical College (JMC) hopes to be at the forefront of this movement. In his recent *Dean’s Column*, Mark Tykocinski, JMC Dean, noted⁶ that “as a medical school we now have to take the ball and run with it. Our public trust is to make sure the next generation of physicians is facile with quality and safety concepts and tools. Increasingly, the regulators will mandate this. Training physicians in quality and safety is no longer optional.” From my perspective, all I can say with regard to Dean Tykocinski’s heartfelt column is Amen!

At the School of Population Health working in tandem with Dean Tykocinski, we have established a cohort of JMC faculty members who will join with us online to study the tenets of quality and safety and obtain a graduate-level certificate from our school. As some of our readers undoubtedly know, the JSPH offers an online Master of Science degree program as well as a Certificate program in Healthcare Quality and Safety. Our programs equip physician leaders with the tools, methods, knowledge and strategies for improving healthcare quality and patient safety.

We believe our graduates are prepared to identify, interpret and implement policies, care guidelines and regulations relevant to healthcare quality and safety. They will be able to apply quantitative and qualitative analytic skills to design, conduct and evaluate quality and safety measurement performance and improvement activities. They will be positioned to produce original research evidence to support change in the quality and safety measurement system. By training a cohort of faculty in the tenets of quality and safety and achieving a level of scholarship and research support, consistent with a leading medical school, we will then be in a position to tackle the NAS head-on.

To put this convergence into a broader context, it’s important to recognize the work of JMC and JSPH at the national level. Recently, medical educators have come to recognize that our current educational system is more a part of the problem than a part of the enduring solution. Educators “must also rethink their relationships with clinical environments so that the education of students and residents accelerates the transformation in healthcare delivery needed to fulfill our contract with society.”⁷ We are making an explicit connection between the implementation of quality and safety and the successful implementation of much needed healthcare reform.

In order to achieve this laudable goal, others have identified quality and safety pedagogic tracks within the learning environment. For example, at the University of Chicago – Pritzker School of Medicine, there is a four year scholarly track in quality and safety for medical students already well underway.⁸ Still others have queried academic Departments of Medicine to further understand the role of quality improvement and patient safety scholarship in the appointment and promotion process.⁹ Quality and patient safety has now become a bona fide, well-recognized component of scholarship and an appropriate career trajectory for young investigators.

I believe that this convergence is going to serve us well and will be the stimulus necessary to make Thomas Jefferson University’s approach to this challenge a potential national model. The School of Population Health looks forward to working with other health profession schools across the country as they seek innovative ways to tackle the convergence of Teaching for Quality and the NAS. I look forward to hearing from you as to how your organization is tackling this important challenge. ■

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Teaching Health Beyond the Walls of the Health System: JeffSTARS

Interview with Esther K. Chung, MD, MPH

Dr. Chung is Professor of Pediatrics and Director of JeffSTARS (Jefferson Service Training in Advocacy for Residents and Students) at Jefferson Medical College (JMC) and Nemours.



In the following interview, Dr. Chung discusses JeffSTARS, a program focused on teaching advocacy to medical students at JMC; residents in Pediatrics at at Jefferson and Nemours/Alfred I. DuPont Hospital for Children; and residents in Family and Community Medicine at Jefferson.

Describe the JeffSTARS program.

Jeff STARS is an advocacy program designed to move students beyond the medical model and the walls of the health system. It is essential to include the social determinants of health in medical education and training.

The program is set up as an outpatient rotation for 3rd-year medical students who are assigned to Jefferson. JeffSTARS incorporates the following advocacy components into the outpatient pediatric experience: a monthly advocacy journal club, weekly Advocacy Cafés, and community site visits. Similarly, pediatric and family and community medicine (FCM) residents on rotation in the outpatient practice also participate in the advocacy components. This allows for a rich and dynamic exchange of ideas involving trainees at various phases in their career development.

The JeffSTARS Advocacy and Community Partnership Elective allows self-selected 4th-year medical students and pediatric and FCM residents to participate in an intensive advocacy experience. This elective allows the students to spend 50% of their time with an advocacy organization in the community and to work on a mutually agreeable project. For example, I have 3 students in the 4th year who rotated recently: one student worked with the [Education Law Center](#) on a project related to lead exposure and its impact on child development; another student worked at [Planned Parenthood Southeastern Pennsylvania](#) on educating patients about the Affordable Care Act; and another student worked on a needs assessment with [Project HOME](#) as part of an effort to help expand pediatric services. Trainees in this elective also attend 15 seminars that cover topics from social determinants of health to working with the media.

You mention journal clubs and Advocacy Cafés, please explain those.

Monthly advocacy journal clubs serve as an opportunity to discuss current articles in the medical literature on health and health policy. The Advocacy Cafés provide weekly opportunities to discuss health topics and often include guest speakers from other organizations and educational institutions. Discussion groups have allowed students to have rich experiences not only with faculty,

but with each other and with visiting students. This includes students from Rwanda who visit Jefferson each year from the National University of Rwanda Medical School.

How is advocacy taught?

We learned that we had to meet the students and residents where they were in their training because they are developing their diagnostic skills and are often focused on one-on-one patient interactions. My colleague, Michael Campbell, JD, Visiting Assistant Professor of Law at Villanova University and a long-standing health advocate, has coined the terms, “big A” and “little a” advocacy. “Big A” advocacy focuses on community advocacy, while “little a” centers on one-on-one patient advocacy. Trainees often start out feeling that “little a” advocacy is more relevant to them, so we start there and eventually weave in more components of “big A” advocacy. Since the implementation of the JeffSTARS curriculum, there has been a cultural shift and both “a” and “A” advocacy have become natural parts of the Advocacy Cafés.

How many students and residents participate in the JeffSTARS program?

For the required outpatient rotation, approximately 4-6 pediatric and 1-2 FCM residents participate monthly. Generally, we host an additional 11 students during their

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pediatric clerkship every six weeks. That totals to roughly 70+ residents and 88 students per year. Our program is now in its 5th year.

What is the history and motivation behind the program? How did you get involved?

Early in my career, my approach to advocacy was from a researcher's point of view. I would look at a problem and conduct a research project and then in the background and discussion sections of a paper, I would speak about advocacy areas. From 2007-2009, I had the opportunity to complete a [Physician Advocacy Fellowship](#) (formerly Soros) with the [Institute on Medicine as a Profession](#) (IMAP) at Columbia University. In this fellowship, I worked with the [Maternity Care Coalition](#) on hospital, workplace and public program policies related to breastfeeding. Even though I had been practicing medicine for many years, and I had been very active in public health circles, working in a non-profit organization gave me a whole new perspective on advocacy.

I wanted to allow trainees to have similar opportunities, to get them outside of the walls of the hospital and not have to wait until they were established physicians. Students and residents have expressed verbally and in writing that they have learned new perspectives on health from the JeffSTARS program.

You have been the driver of this program from the beginning. How has this affected you professionally?

Being in the role of a faculty member, we are always viewed by trainees as role models and that puts some pressure on us to practice what we preach. Leading JeffSTARS has helped me to stay involved in advocacy efforts, and it has also opened up opportunities for me, it's a give and take. Being a partner with a community organization allows for close communication; therefore, if a community partner needs a physician to give testimony or to be a part of their campaign to speak on a major public health program, they may contact me. It is part of my job to model advocacy behaviors. On the other hand, the medical students and residents have a lot to teach the faculty and community organizations. They come from different and interesting backgrounds and are very willing to share their knowledge and opinions with others.

How is the program funded? Do faculty volunteer?

The program was initially funded through a grant from [Community Access to Child Health](#) (CATCH) and the [Community Pediatrics Training Initiative](#) (CPTI) of the American Academy of Pediatrics. The [IMAP](#), Advocacy Education and Training Initiative Grant really helped us to get established and to become institutionalized at Jefferson and Nemours.

Community sites and faculty volunteer to participate. We've had a strong commitment from the Department of Pediatrics at Jefferson and Nemours, the Department of

Family and Community Medicine, and the School of Population Health. Faculty have helped by volunteering to conduct seminars and lead Advocacy Cafés, and by offering support to students and residents. We have also included speakers from institutions and organizations outside of Jefferson, including Christiana Care, the Pennsylvania Chapter of the American Academy of Pediatrics (PA AAP), and numerous community partners.

Is there anything else you would like readers to know about the JeffSTARS program?

We are always interested in forging relationships with new community partners. We are also interested in expanding our program to include other Departments at Jefferson.

The JeffSTARS program continues to grow, and it has had a tangible and direct impact on patient care. Physicians are better able to advocate for their patients by accessing community resources like WIC and Early Intervention programs. The success of the program lies within the enthusiasm and energy of the medical students and residents, support from the medical school, the residency program, a terrific faculty, and amazing community partners. ■

For more information on the JeffSTARS program contact Dr. Chung at esther.chung@nemours.org or visit: <http://www.nemours.org/education/gme/pediatricresidency/advocacy.html>

Promoting HPV Vaccination through African American Beauty Salons

Salon-based health education programs are receiving increased attention because they engage trusted members of a community (stylists) in health promotion efforts.¹ Hair salons have long held special meaning for African American women, as they represent a place in the community where they can be pampered and receive care. Furthermore, the salon stylist is often considered a confidante, having long-standing relationships with her clients. A stylist can communicate health information in a way that is familiar, understandable and appropriate for her clients. Several studies have used beauty salons as a community health promotion setting and

stylists in the roles of natural helper or peer health Educator.²⁻⁵ In almost all studies, results have been favorable. Topics, aimed at reducing health disparities, have included breast cancer screening, HIV/STD prevention, diabetes education, fruit and vegetable consumption, and stroke prevention.

We designed a salon-based health education program to respond to alarmingly high rates of cervical cancer morbidity and mortality among African American women, who suffer almost twice the number of cervical cancer deaths as both White and Hispanic women.⁶ This disparity suggests chronic,

undiagnosed human papillomavirus (HPV) infection, coupled with low rates of cervical cancer screening. Despite the availability of a vaccine against HPV for both males and females, rates of vaccination remain suboptimal.⁷ Studies have documented a low understanding of the vaccines, coupled with public mistrust in vaccinations, provider hesitations to recommend the vaccine, and in some instances, geographic barriers to vaccination.^{8,9} Our study aimed to dispel myths and misinformation while educating women about the link between HPV and cervical cancer.

Central to the success of this effort was an honest and respectful engagement of African-American women in dialogue about cervical cancer, HPV, and vaccination. We recruited 10 predominantly African-American beauty salons in West and North Philadelphia and trained stylists in each salon to act as facilitators for client recruitment to in-salon health education sessions. We had two similar curricula for the education sessions, each customized to target specific populations of females: those ages 18-26 who were able to make their own vaccination decisions; and mothers or guardians (primary caregivers) of girls ages 9-17 years old. Females were eligible if they patronized one of the participating salons and had not (or their daughter had not) been vaccinated against HPV. Study evaluation consisted of baseline, post-intervention and one-month follow-up surveys to assess changes in knowledge, awareness and intentions to vaccinate against HPV. We also conducted debriefing interviews with the stylists at the end of the intervention to understand the successes and limitations of the study from their perspective. Participants were compensated with a \$40 gift certificate to use at the salon; the salons were compensated \$5 for each customer who enrolled in the study.

Over the course of 6 months, we enrolled 240 women in the study. Roughly 60% of the women were caregivers of girls ages 9 to 17, while 40% were young women ages 18 to 26; all participants were African American. A majority of caregivers and young girls were aware of HPV and the vaccine, but few personally knew of someone who had been vaccinated. At baseline, knowledge about HPV and its link to cervical cancer

was low, and few felt that they had enough information to make an informed decision about vaccination. After the health education intervention, knowledge significantly increased at post-assessment, and remained elevated one month later. At baseline, 33% of participants answered all of the knowledge questions correctly, while at post-intervention, that number rose to 75% and remained at 74% one month later. Intentions to vaccinate against HPV also significantly increased in both groups, as did intentions to talk to a health care professional about the vaccine. As this was a short-term pilot study, we were not equipped to measure longer-term vaccination behavior. Previous research suggests that people wait until their next scheduled provider visit to initiate vaccination, rather than schedule a separate appointment. Yet, an overwhelming majority of participants indicated that they shared what they learned with family or friends, therefore continuing the dialogue outside of the salon and into the neighborhoods.

The debriefing interviews with salon owners and stylists also provided useful insight for the study team. When the owners were asked why they chose to participate in the study, the most common response was that they felt that the information was important for women to know, and that women were not hearing the health information in other places. The stylists were pleased to bring the topic of HPV into the salon, where the environment was comfortable enough for the participants to ask questions. Many of the study participants were first-time customers to one of the salons, yet they expressed high levels of trust in the stylist who talked to them about HPV, despite

not knowing the stylist or having a long-term relationship with her. For example, among the young women who said that they were first-time customers to the salon, about 50% of them reported that they trusted the stylist “a lot”, despite meeting them for the first time.

The primary purpose of this pilot study was to assess the feasibility of delivering health-education messages to women through the venue of African American beauty salons. The study successfully achieved this goal, while learning significant lessons about how to most effectively deliver such an intervention. The researchers operated from a “meet-them-where-they are” perspective, engaging women at a time and place that is convenient (and credible) for them. In doing so, women learned from the brief intervention, and continued the dialogue with their family and friends long after the pilot had ended. Knowledge and attitudes towards HPV vaccination were positively and significantly changed and, in the future, lives may be saved because of it. ■

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Reflections from the International Union for Health Promotion and Health Education (IUHPE) World Conference on Health Promotion and Education, Pattaya, Thailand

Every three years the International Union for Health Promotion and Health Education (IUHPE) holds a world conference. This past August, the 21st World Conference took place in Pattaya, Thailand with a theme of “Best Investments for Health.” The conference drew over 2100 people from 80 countries and offered a unique opportunity for participants from many different sectors and cultures to share in a collaborative learning process.¹

Although supported by the Thai Ministry of Health, the conference was organized by the Thai Health Promotion Foundation (*ThaiHealth*), an independent state agency funded by a 2% surcharge tax on tobacco and alcohol. The Foundation, founded in 2001 has generated funds of approximately \$60 million

annually to support over 1000 Thai evidenced-based health promotion policies and activities across a range of multi-sectorial partners. The World Health Organization has recognized this unique private/public partnership to develop public health promotion planning, implementation, and evaluation initiatives through a stable government health earmarked funding mechanism.²

The conference embodied the unique spirit and philosophy of Southeast Asia with health defined and measured by physical, mental, social, and spiritual indicators of *health and happiness* such as the Gross National Happiness Index from Bhutan.³ That conference *spirit* was modeled through service and cultural experiences imbedded

into the conference. For example we were able to visit a local orphanage and school for deaf children.

I presented some of our local and national public health research and practice in health literacy and policy and advocacy at the conference^{4,5} but clearly learned much more from our international colleagues regarding true community engagement and health promotion that will not be soon forgotten. ■

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Population Health Certificate

Jefferson’s Graduate Certificate in Population Health is intended for current and emerging leaders who want to thrive under Health Reform and implement real world solutions. This 21-month long program includes 5 online courses: Population Health and Its Management; US Healthcare Organization and Delivery; Intro to Healthcare Quality and Safety; Chronic Illness Prevention and Chronic Care Management; and Intro to Health Economics and Outcomes Research.

Click the Dates Below to Register for Population Health Certificate Upcoming Online Information Sessions:

March 20, 2014

12:30 pm – 1:00 pm

May 22, 2014

12:00 pm – 1:00 pm

Can Color-Codes Help Us Make Better Snack and Beverage Choices?

In the past few decades obesity has risen dramatically in the US. Centers for Disease Control and Prevention (CDC) report that more than 35% adults in the US are obese.¹ Studies indicate that behavioral and environmental changes have primarily led to this increase in obesity; increases in caloric intake; bigger portion sizes; increased availability of fast food; greater intake of sugary beverages; unhealthy snacks rich in calories, fats, and sodium; and lack of fruits and vegetables in the daily diet.² Leading federal and private agencies have stressed the need to reduce obesity through public health policies designed to address this pressing issue.³ Reduction in obesity means a healthy community and a healthier workforce. **Healthy People 2020**, the national health promotion plan, recommends providing health promotion activities where people gather, such as schools and workplaces.⁴ These activities should include system and policy changes that make the *healthy choice the easy choice* for consumers, including snack and beverage items.

Vending machines are a major source of snacks and beverages in the environment, including schools and worksites. Studies indicate that vending machines typically carry energy-dense food, with high fat and sodium content, and sugar-sweetened beverages.⁵⁻⁶ While menu-labeling has evolved as a successful public health strategy for improving choices among food and beverages, point-of-purchase nutritional information is not available at vending machines.

Thomas Jefferson University and Hospitals (TJUH), a leading academic medical center in the Philadelphia area, has demonstrated its commitment to build a healthy community through its employee wellness program. In 2007, the organization signed Healthcare Without Harm's Healthy Food in Health Care pledge, a national initiative committed to improving the food environments in hospitals.⁷ Signing this pledge demonstrates a healthcare institution's commitment to food procurement policies

that are environmentally and socially responsible and promote good health choices among employees, patients and the community.⁸ According to Healthcare Without Harm, "hospitals throughout the country have begun to transform their food environments in a variety of ways by: creating healthy vending criteria; eliminating sugar-sweetened beverages from their facility offerings and increasing access to public drinking water; removing trans-fats from menus; shifting retail price structures to encourage healthy food selection; and last but certainly not least, by increasing the purchase of local and sustainable foods."⁸

In keeping with its commitment to this global initiative, Thomas Jefferson University Hospital's Department of Nutrition and Dietetics partnered with TJUH's Center for Urban Health and TriState Vending Company to create a point of purchase tool to facilitate healthier snack and beverage choices at vending machines throughout Jefferson's center city campus. This project, the *Choose Healthier Initiative (CHI)*, was spearheaded by an MPH student in the Jefferson School of Population Health as her Capstone project. To assist vending machine users in making healthier choices, CHI developed criteria that was used to group vending options based on caloric, fat and sodium content. Using nutritional information provided by the vending company and the criteria developed by CHI, each vending option was assessed and assigned to one of 3 color-coded groups: healthier choice (green); less healthy choice (yellow); and least healthy choice (red). A separate category was created for 'Nuts and Seeds' because they are a healthy food but are very high in calories (a lighter shade of green). Using these criteria, the initial review of the vending machine product mix for snacks revealed that only 15.4% of the snacks in vending machines across campus were healthy, 3.4% were nuts and seeds, 23.7% were less healthy and 57.45% were unhealthy choices. The product mix for beverages revealed that 12.50% of the beverages were healthy, 23.21% were less healthy and 64.29% were unhealthy beverages.

The intervention was pre-tested to ensure users understood the criteria and how to use the color-coding system. Pilot testing at 7 locations across Jefferson's campus was initiated to test the intervention's feasibility and impact on consumer purchases.

By the end of December 2012, all vending items were color-coded and signs explaining how to use color codes to make healthier snack and beverage choices were posted on the machines throughout the campus, including the university and hospital. The student researcher monitored the vending machines daily during the months of January and February 2013 to ensure intervention fidelity. Implementation issues (e.g. removal of color-coding signs, placement of items in wrong slots) were addressed promptly. TriState Vending provided baseline sales data for November and December 2012 and post-intervention data for January and February 2013. The baseline and post-intervention data for all the 7 locations were compared to assess the effect of the intervention on consumer purchases. Study results indicated a significant reduction in post-intervention sales of unhealthy (red) snacks. Additionally, there were increases in the percentages of healthier snacks and beverages sold. Sales data for the university and clinical locations were also compared. The results from the university locations revealed a 166.67% increase in the sales of healthier snacks. Clinical locations had a significant increase in the sales of healthy beverages. It is important to note that there was a significant reduction in the sales of unhealthy items despite the lack of healthier food choices in the vending machines. Improving the product mix to include more types of healthy food items could have the potential to increase the impact of the intervention.

A customer intercept survey was conducted to assess the effect of color codes on users' decision making related to snacks and beverage choices. A total of 35 surveys were completed and results showed that 51% of the respondents used color codes to select snacks and beverages; 94% of those who used color codes agreed that it helped them make a better choice.

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Given the positive outcomes, Jefferson is expanding the program to all vending machines in its Center City Philadelphia campus by January 2014. To sustain and institutionalize the program, future contracts with vending companies could include point-of-purchase color-coding as a required condition and an improved product mix to increase healthier choice options. This study demonstrated that point-of-purchase color-coding is a simple and inexpensive intervention that encourages users to make better choices. ■

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Ranita Chakrabarti conducted this initiative as her MPH Capstone Research project to complete her MPH at the Jefferson School of Population Health.

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Reflections from the Harvard Second Century Symposium of Transforming Public Health, and Association of Schools and Programs of Public Health (ASPPH) Annual Conference

The beginning of the year 2015 will mark the 100th anniversary of the infamous Welsh-Rose Report that created academic professional training in public health, originally funded by the Rockefeller Foundation.¹ For nearly fifty (50) years, academic public health training programs existed solely in independent *Schools of Public Health*. National academic accreditation of graduate programs in public health began in 1945 through the American Public Health Association. With the growth of academic public health education, an independent body, the Council of Education for Public Health (CEPH), was founded in 1974 to organize

and manage national accreditation of university public health training programs.²

An Association for Schools of Public Health (ASPH) was formed in 1953 to represent academic public health training institutions. Over the past sixty years, in addition to the growth of schools of public health, programs of public health within other Colleges, Schools and Departments in universities have proliferated and have become accredited by CEPH that now outnumber schools of public health by approximately 2:1 in the US. The ASPH recently expanded its organization to include accredited programs of public

health like Thomas Jefferson University's, MPH Program within its School of Population Health. Thomas Jefferson University's MPH Program joined the new organization, now called the Association of Schools and Programs of Public Health (ASPPH) this past August as a Founding Member of ASPPH.³

As the Director for our MPH program, I represented Jefferson at the first annual conference of the new ASPPH in Boston this past November prior to the American Public Health Association annual meeting. The three-day meeting was preceded by a special symposium held by the Harvard School

of Public Health which celebrated its 100 year anniversary of its collaboration with the Massachusetts Institute of Technology (MIT) for the formation of its school of public health. At Harvard, its President, Drew Gilpin Faust and School of Public Health Dean, Julio Frenk, presented its three year initiative that transformed its masters and doctoral level public health education and research programs and facilitated four national panels from the public health, science, and business education around the digital revolution and science of education, re-inventing the classroom, campus, and community, learning assessment for action and impact, and transforming the public health field.⁴ It was an incredible learning experience that will be shared with our university and school leadership, our advisory board, our faculty, and of course, our public health students.

The ASPPH annual meeting was a robust meeting of public health Deans,

Associate Deans, Program Directors and faculty representing over 70 universities.⁵ I participated in several council and section meetings in Health Policy and Management, Behavioral and Social Sciences, and Public Health Practice. The plenary sessions addressed topics such as financing a public health degree, public health leadership, embracing diversity in one's institution, academic public health practice, the ACA and Public Health: Massachusetts Example, and Big Data in Public Health. The concluding session was the ASPPH first-ever Board of Directors meeting where the By-laws were finalized and the expanded organization representing nationally accredited schools and programs of public health formally was constituted. Joining the ASPPH is a major commitment for Jefferson's School of Population Health and its MPH program. There are many potential advantages including joining the national public health application system, SOPHAS, expanding our influence and

opportunity for input into the changing field of academic public health education, increased grant and cooperative agreement funding opportunities, and increasing marketing of our program at a national level. This new organizational membership for Jefferson does come with a heavy financial and managerial time cost to be part of an expanded national organization for public health. We are now at the table with the large, nationally recognized, public health institutions such as Johns Hopkins, Columbia, Harvard, North Carolina, UCLA, and Michigan to name a few. Time will tell on its impact for our relatively new public health program. ■

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Population Health Academy

This five day academy is designed to prepare the next generation of health care leaders for the dramatic changes occurring in our nation's health system. Busy health system administrators and leaders will receive a solid foundation in the key domains of Population Health: US Health Care Organization and Administration: A Rapidly Evolving Environment; Population Health Management: Moving from Volume to Value; Health Economics; Data Analytics; Health Care Quality and Safety; and Prevention and Chronic Disease Management.

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Click the Dates Below to Register for Population Health Academy Upcoming Online Information Sessions.

March 20, 2014

1:00 pm – 2:00 pm

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1:00 pm – 2:00 pm

Discovering Solutions Hiding in Plain Sight

For many of our healthcare challenges, there *already* exist successful behaviors and practices *within our communities*. Utilizing a process that helps our communities discover these practices so that they choose to make them their own (or modify them to work in their unique context) can lead to improvements at a fraction of the costs of inventing something new, with a much higher likelihood of sustainable success.

This improvement framework is called Positive Deviance (PD). It was originally described in the 1950s when researchers identified that some very poor families had well-nourished children. This epidemiological finding became a method for stimulating change in the 1990s when researchers from Tufts University, Jerry and Monique Sternin, worked with villages in rural Vietnam where children were suffering from malnutrition.

The Sternins helped the villagers appreciate that there were a few well-nourished children in their village, even within the poorest families. They then facilitated a discovery process so the families whose children were malnourished could learn *how* the PD families were able to provide nutrition for their children. Any practice that even one family was unable to do because of barriers they faced was discarded and referred to as “TBU”- true but useless. The Sternins then helped the villagers acquire the skills to reliably incorporate the handful of truly PD practices into their daily lives. All were simple and virtually free practices. For example, one practice involved mixing into the staple of rice for children, the shrimps, crabs, and greens that adults added to their rice. Though most families initially felt these foods were inappropriate for children, years later researchers discovered that 85% of the children in these villages had become well nourished, and that the younger siblings born into these families had avoided malnourishment.¹

In 2006 the Sternins were invited to join a collaborative effort to explore how PD might contribute to solving intractable problems in healthcare. My current organization, Plexus Institute, brought new insights from science about change in complex systems, advances in network science, and a host of

other processes for engaging frontline staff in creative problem solving. What emerged is now being called Adaptive Positive Deviance (APD). Sometimes the behaviors that become successful are those that already exist, but that are not widely known within the community. This is classic PD. In other cases, the members of community take elements of what is working for their peers and modify them to fit their local context through a process of experimentation and learning (APD).

The initial APD work in healthcare focused on reducing MRSA (Methicillin-resistant *Staphylococcus aureus*) transmission within hospitals. Funded by the Robert Wood Johnson Foundation and in collaboration with the Centers for Disease Control and Prevention, six institutions (including VA Pittsburgh Healthcare System; Albert Einstein Medical Center, Philadelphia, PA; University of Louisville Hospital; Billings Clinic, Montana; Johns Hopkins Hospital and Franklin Square Hospital Center, both in Baltimore, Maryland) learned how to use APD. During this time, I was the Chief Quality Officer at Einstein and participated in the training. We learned how to facilitate “Discovery and Action Dialogues (DADs)”: 20 to 40 minute small group discussions designed to uncover PD practices, bring more people into the work, and foster action and ownership of the challenge of MRSA transmission by the front line staff. Other organizations focused on different interactive methods, like improvisation and role play, to highlight the practices that worked and uncover the barriers that were faced.

In a conversation with Curt Lindbergh, PhD (August 2013), it was revealed that the ultimate results of the initiative were impressive in 3 of the 6 hospitals, where sustainable reduction in MRSA infections of over 70% have occurred.¹ As opposed to many change initiatives which begin with an organization-wide focus, this work was initiated with pilot units and volunteer participation. It then evolved in an organic fashion, with progress occurring more in phases than by steady incremental improvement.² Changes in social networks also occurred during the initiative. As people asked and answered the question, “Who else needs to be involved?” the social networks of

people being viewed as resources regarding MRSA prevention got larger and denser- in other words, smarter.³ More people became involved in the work and more solutions were identified and created.⁴

For APD to be effective, leaders need to act differently. One of the common leadership responsibilities is to ensure that the organizational policies and procedures (which they helped develop) are followed. What if there are different behaviors that are occurring on the front lines that can lead to better outcomes? In many organizations, practices that deviate from policy are referred to as “workarounds” and are not supported and may even be suppressed. In an organization using APD, leaders must create the conditions to enable the continuous discovery of new behaviors that will lead to better results. Those discoveries will not come from the top of the organization, or from outside the organization, but rather from the front lines where the work is being done.

In addition to the MRSA initiative mentioned above there are other examples of successful application of APD to serious healthcare challenges. The dialysis unit at AtlantiCare in New Jersey reduced central line-associated bloodstream infections by over 50% through APD-guided improvements.⁵ In a conversation with Mark Munger (August 2013), Allina Health in Minnesota has significantly reduced post-operative pain as reported by patients using APD. A consortium of university hospitals in Canada has successfully utilized APD for a number of patient safety challenges.⁶ Billings Clinic, a Top 100 hospital recognized by Truven Health and Becker’s, has committed to APD as an organizational framework for change.

Let’s think about the goal of achieving the “Triple Aim,”- the point where optimal health outcomes, healthcare experiences, and reduced healthcare expenses intersect.⁷ Our improvement focus is typically on “opportunities” (poor performance) and “best practices” (what has worked for someone else somewhere else). What if we flipped this focus 180° and looked for our own PD practices? What is already working well for us, in our context? Are there any patients with multiple co-morbidities who seem to be doing much

better than expected? Are there any clinicians whose outcomes seem to be really impressive in areas where others are struggling? How are they accomplishing these results?

We need to create the conditions to connect the people with the problems -- the patients and the clinicians whose outcomes aren't optimal -- with those individuals whose PD practices enable them to achieve better results.

We need to ask that population of patients and clinicians, "What would it take for you to adopt these practices that are already working for these peers?" The population would then be choosing to adopt these behaviors because they've seen the benefits in their peers and they decide this can work for them, too. This process would not require new technology, new therapeutics, or other new inventions. It requires the time to convene people and

learn, and it requires trust. We need to trust in the PD process. We need to trust that the solutions already exist even though we may not currently be able to see them. They are waiting to be discovered and implemented by the people who need them the most. ■

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11th Annual Interclerkship Day on Patient Safety



Left to right: David B. Nash, MD, MBA, John Nance, Rachel Sorokin, MD, and David McQuaid at the 11th Annual Interclerkship Day on Patient Safety.

6th Annual Lee White Innovation Institute

Where Wellness Meets the Road: Taking Population Health from Theory to Practice

Health Care Leadership Network of the Delaware Valley

November 20, 2013

Organizations across all industries are working together to focus on the quality and cost of medical care in the United States. The nationwide mindset is shifting from interventions that can cure disease to prevention, wellness and chronic care management — work that requires tighter coordination across the continuum of care and a more active role for patients and caregivers. Payers are encouraging and supporting innovation in health care delivery systems, helping them adopt new technologies and methodologies to care for patients. Finally, economic necessity is motivating the government and the private sector to bend the health care cost curve, while achieving and sustaining better clinical outcomes.

To view a video recording of this program visit:
<http://jdc.jefferson.edu/leewhite/>



Grandon Society



Jefferson School of Population Health invites you to join the **Grandon Society**, a membership organization for individuals and organizations focused on advancing population health. The Grandon Society is designed for leaders throughout the healthcare sector who are dedicated to transforming the US health care system through collaboration, education and innovation.

Benefits of membership include exclusive member-only programs and events, a member e-newsletter, and early notice and special registration rates for JSPH conferences and events. Memberships are available for individuals and for organizations, with special rates for academic, non-profit and government institutions.

Become a member today and join us for our **Grandon Society** workshop on **April 9, 2014** from **9:45 am – 11:00 am**, immediately following the Population Health Forum. This interactive session will feature **Somesh Nigam, PhD**, Senior Vice President and Chief Information Officer of Independence Blue Cross.

For more information visit: http://www.jefferson.edu/population_health/GrandonSociety.html.

Questions? Contact Amanda Solis at (215) 503-6871 or amanda.solis@jefferson.edu

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Director, Camden Coalition
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The Colloquium is offering a **SPECIAL 1-DAY Registration for Wednesday, March 19th**, for those who wish to attend this portion of the program only.

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Population Health Forums

Population Health as a Corporate Strategy: The Value in Investing in Wellness

Dixon Thayer

Co-Founder, Chief Executive Officer
HealthNEXT

Ray Fabius, MD

Co-Founder, President
HealthNEXT

October 9, 2013

Dixon Thayer and Ray Fabius, MD of HealthNEXT presented a compelling overview of the factors influencing employee wellness and the subsequent outcomes benefiting the workforce, consumers, corporations, and investors. HealthNEXT is focused on making companies healthier by creating a culture and environment that helps employees achieve better health.

Thayer has held several leadership positions in large organizations during critical times of change. His expertise is focused on establishing and leading breakthrough strategies, high-performance leadership teams and tangible value creation. Fabius is a global physician executive who has served as a medical leader in academics, private practice, managed care, the health insurance industry, informatics, and the corporate-purchaser space. Fabius has written and lectured extensively on quality management, utilization management, network development, and the purchaser-payer-provider-patient/employee axis and eHealth.

Dr. Fabius presented on the broad, overarching value of investing in wellness. By using examples from key studies, he discussed corporate messaging; medical cost reductions; productivity gains; and employee engagement. Too often companies invest in wellness programs targeted to those who are unhealthy. Fabius explained that evidence shows that it is equally important to invest in healthy people. “Well people who stay well are less expensive over time,” states Fabius. He also explained the importance of preventing and limiting

disease progression: in other words, slowing down acute conditions before they become chronic or catastrophic.

Fabius emphasized that employers cannot focus on cost alone; they must look at “skill and will.” A motivated and well trained workforce affects health and productivity. He discussed presenteeism as a huge drain on the workforce and he identified a continuum of employee performance outcomes affecting the workforce and, in turn, costs. This continuum can begin with “not doing well while working” to “not doing work on work time” and a progression toward “lost to the workforce.”

Fabius also discussed the top drivers of lost work time, and identified sleep disorders, depression, and fatigue as major factors in presenteeism. Conditions affecting the highest costs for employers include depression, obesity, and arthritis.

Fabius summarized his presentation by highlighting ways in which behavioral economics can improve engagement. For example, providing rewards and/or taking away privileges; interventional surveys; rank comparison; and benefit plan enhancements. He emphasized the importance of building a culture of health and pointed out that once this is more ingrained into a system, incentives are not needed.

“Engagement drives amazing results,” Thayer explained as he continued the Forum session by delving further into the dynamics of C-Suite and employee engagement. Though

there is no single definition of employee engagement, it may include: total commitment and motivation; employee alignment with the company’s mission; and valuing the company, and being valued in return. Engaged employees are higher performers than less engaged employees, less likely to leave the company, are more innovative, more committed to customer satisfaction, and go the extra mile.

Why does employee engagement matter? Thayer cites the international Unilever LampLighter study which revealed that companies with high employee engagement saw improvements in net income growth, operating income, and earnings per share. Thayer explains that health care as a benefit is not necessarily the issue; the issue is how to engage employees in ways that make contributions greater or better than before. The link to health lies in the fact that the healthier the workforce, the greater concentration of top performers as opposed to middle or bottom performers. Health is a key driver that influences engagement, influencing a cycle of engagement, personal performance, and business performance.

Companies that are often listed as the “best companies to work for” have a common thread...a big investment in wellness. Thayer states companies that make a commitment to wellness do tend to out-perform other companies. In conclusion, the evidence continues to mount that having a healthy workforce provides a competitive advantage in ways that benefits employers and investors. ■

RESOURCES

1. HealthNEXT
2. The Link Between Workforce Health and the Bottom Line

Grandon Workshop

A special additional session of the Population Health Forum for Grandon Society Members

October 9, 2013

In this workshop, HealthNEXT principals Dixon Thayer and Ray Fabius, MD, continued to explore issues regarding employee wellness, and the impact on employers and investors, through a stimulating, interactive discussion. Thayer asked, “Why isn’t employee engagement and wellness a priority?” He identified a number of barriers including: the degree of comfort in the C-suite; lack of education regarding wellness; unclear return on investment vs. other uses of capital; and breakdowns in communications.

Thayer and Fabius explained that in order to effectively bend the cost curve, a critical mass of employers must be involved; further, it is extremely important to measure participation and monitor outcomes. Large self-insured employers become the focus of success stories, and can have significant influence on the community and other employers. Thayer and Fabius emphasized the marketplace solution as one major way to resolve the health care crisis.

The workshop participants engaged in a lively exchange regarding their own experiences and perceptions of wellness programs. Those who identified as “healthy” felt burdened by the idea of participating in a program that they didn’t necessarily need, but felt compelled to participate in order to reap the financial benefits. Others were glad to take the first step in a wellness program and were curious to see how it might grow and evolve.

The next Grandon Society Member-only workshop, “Innovation, Big Data, and Collaboration: Improving Population Health” will feature Somesh Nigham, PhD, Senior Vice President and Chief Information Officer for Independence Blue Cross. The workshop will take place on April 9, 2014 from 9:45 am -11:00 am.

The Role of Employers and Business Coalitions in Improving Health Care

Neil Goldfarb

President and CEO

Greater Philadelphia Business Coalition on Health

November 13, 2013

Neil Goldfarb presented at a recent Forum regarding the growing movement of business coalitions and their role in improving health care. Goldfarb is President and CEO of the Greater Philadelphia Business Coalition on Health (GPBCH), an employer-led non-profit organization established in 2011 with the mission of developing best practices for maintaining a healthy workforce, and ensuring that when employees do need health care it is safe, high-quality, and affordable. Goldfarb was previously Associate Dean for Research in the Jefferson School of Population Health where he focused on healthcare quality and value. He also served as Director of Ambulatory Care Improvement for the Jefferson faculty practice plan.

Goldfarb began his presentation by pointing out the drivers of the high cost of health care and identifying the problem of achieving “value” for the dollars spent. He discussed the

historical context of value-based purchasing strategies which have included a number of components such as: collecting and publicly reporting information on quality and costs of care; redesigning benefits to promote high-value services; payment reform and provider incentives (pay for performance); consumer education; and promotion of employee health and productivity.

GPBCH falls within the umbrella of [The National Business Coalition on Health](#), a member organization dedicated to value-based purchasing of health services through public and private purchasers. There are 52 coalitions throughout the US representing over 7,000 employers. Some of these coalitions are geared toward transforming their local markets, and that’s where Goldfarb feels that GPBCH can play a role. This is the first time that the Philadelphia region has had such a coalition, which currently consists of 30

employer members, representing 350,000 covered lives in the region, and 32 affiliates.

Goldfarb feels it is important to identify best practices for keeping employees healthy and productive in their workplace while recognizing that employees will in fact need quality health care, regardless of wellness programs that might be in place.

GPBCH’s work largely is conducted through 5 member work groups: Member Education; Primary Care; Transparency; Value-based Insurance Design; and Employee Health and Well-being.

Member education has included a number of workshops and conferences on various topics including: diabetes; patient-centered medical homes; patient safety initiatives; best strategies for employee wellness; and health care innovation.

A great deal of activity takes place in the employee health and well-being space. The coalition serves to help members learn from one another and create new initiatives. GPBCH has formed the Diabetes Prevention Learning Collaborative which is a part of the [Philadelphia Health Initiative](#). Members are currently developing a region-wide corporate challenge in conjunction with the American Heart Association. Goldfarb emphasizes the need to create the culture of health and awareness.

Primary care is of particular concern to the Coalition. Goldfarb wants to ensure that employers and employees have access to information about primary care provider quality, and while Patient-Centered Medical Homes (PCMH) appear to improve coordination and quality, the Coalition recognizes that not all high-quality practices have achieved PCMH designation. A HEDIS-based metrics for employer tracking of

primary care utilization is in development, and a primary care thought leader summit is planned for the future. Goldfarb is also concerned about understanding the service coordination between worksite clinics, retail clinics, urgent care centers, and traditional primary care.

There is a trend toward value-based insurance design (VBID) and realigning plans to encourage use of high value benefits. GPBCH is in partnership with the Philadelphia Department of Public Health and the Jefferson School of Population Health to work on a value-based insurance design for smoking cessation, blood pressure, and lipids. Another project involves the development of an employer-based pilot study of the need for VBID and its potential impact. GPBCH will be working with benefits consultants and health plans to discuss the challenges and strategies for VBID implementation.

Goldfarb is committed to ensuring that the issue of transparency is at the forefront of the employer agenda. He described the work of the [Leapfrog Group](#) which is focused on collecting and reporting data on hospital safety. He believes this is critical in ensuring that both employers and employees have access to and understanding of quality health care. “When information is made public, hospitals accelerate the rate of change,” states Goldfarb. With a regional roll-out in progress, GPBCH will create educational tools to help the employer to educate the employee or consumer about Leapfrog. Goldfarb further explained, “we want to drive transparency at all levels of the healthcare system.” ■

For more information on GPBCH contact Neil Goldfarb at ngoldfarb@gpbch.org

A Continuous Quality Improvement Approach to Organizational Cultural Competence

Cheri Wilson, MA, MSH, CPHQ

Program Director, Culture-Quality-Collaborative

Faculty Research Associate

Department of Health Policy and Management

Johns Hopkins Bloomberg School of Public Health

Hopkins Center for Health Disparities Solutions

December 11, 2013

December’s Forum featured Cherie Wilson, a Faculty Research Associate in the Department of Health Policy and Management in the Johns Hopkins Bloomberg School of Public Health, Hopkins Center for Health Disparities Solutions (HCHDS). This is a National Center of Excellence in Health Disparities Research designated by the National Institutes of Health, National Institute on Minority Health and Health Disparities. She is also the Program Director for the Culture-Quality-Collaborative (CQC) and the Clearview Organizational Assessments-360 (COA360). The Culture-Quality-Collaborative (CQC), a project within the HCHDS community engagement core, is a network of 16 leading healthcare organizations across the United States that is working in conjunction with HCHDS faculty and select cultural competency consultants to share ideas,

experiences, and solutions to real world problems that arise as a result of cross-cultural interactions that hinder the elimination of disparities in healthcare.

Ms. Wilson’s presentation began with a video clip entitled ‘Where are you from?’ which demonstrated for the audience the importance of recognizing the human desire to ‘put things in boxes,’ or place people in categories. Ms. Wilson went on to warn of the deleterious impact of these assumptions within healthcare.

Many definitions of cultural exist, and Wilson shared her preferred definition: *A developmental process that evolves over an extended period of time.*¹ She presented cultural competency as a continuum, with individuals, systems, and organizations at

various levels of awareness knowledge and skills.

Setting the context for an understanding of cultural competency and health care, Wilson highlighted the changing demographics of the United States, Pennsylvania, and the city of Philadelphia. According to the 2010 US Census, 12% of US residents are foreign born; while in Pennsylvania it is 5.7% and in Philadelphia it is 11.6%.² She pointed out that 20.6% of US residents speak language other than English in the home; in Pennsylvania it is 10% and Philadelphia is 21.0%.²

Ms. Wilson also went over several federal and state mandates relating to culture and healthcare, including the National Culturally and Linguistically Appropriate

Services Standards (CLAS) in Health and Health Care the Affordable Care Act. She warned, however, that simply changing a policy is not enough. Healthcare professionals must be educated on this cultural shift, and must progress along the cultural competency continuum.

Making the business case for cultural competency, Ms. Wilson first discussed the economic consequences of health

inequalities. She explained how poor patient experiences, readmissions, increased length of medical encounters; increased risk of litigation; and time spent with activities that are not reimbursable, are factors that contribute to increased cost and reduced profitability. Ms. Wilson summarized her presentation, by describing [Clearview 360](#), a web-based tool used to which is a web-based tool assess of a healthcare organization's cultural competency, and offer tailored

interventions and solutions for the user. The assessment is not meant to be a one-time survey; this type of quality improvement is meant to exist in a cycle, meaning that there is always a re-assessment after the initial assessment, as health equity is an evolving process. Improving health disparities reduces cost while improving the health of minority and/or non-English speaking populations, which are two undeniable desirable outcomes. ■

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