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EDITORIAL

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Raising All Boats: Part II

The Jefferson College of Population Health (JCPH) continues in its leadership role as a key national thought leader with regard to the emerging fields of graduate study in healthcare quality and safety, population health, and health economics and outcomes research. Nearly a year ago, the editorial “Raising all Boats”¹ described an important meeting in New Orleans, nestled inside the annual meeting of AcademyHealth, where the Deans of emerging schools and colleges of Population Health were working together to standardize the curricular framework for this new discipline. JCPH was the sponsor of that special session, and this piece describes a subsequent panel on related topics at the Society for General Internal Medicine (SGIM) annual meeting in Denver, CO.

SGIM is arguably the nation’s most prominent national organization for general internists who practice mostly in academic medical centers. Having joined when it was still called, **SREPCIM** (Society for Research and Education in Primary Care Internal Medicine) at the recent SGIM meeting in Denver, one of us (Dr. Nash) proudly sported a badge noting that this was his 35th anniversary meeting!

While academic longevity is interesting, it certainly is not the core reason for this editorial! Rather, we write to share our excitement that our competitive application to present a special session within the SGIM annual meeting, was accepted by their leadership. In the narrative that follows, we will set the context for the SGIM Annual Meeting, and why we felt it was so important to bring together leaders in the JCPH journey to certify and accredit graduate programs in healthcare quality and safety (HQS).

As of September 2017, there were 12 stand-alone graduate programs in healthcare

quality and safety in the U.S. and Canada: four of them started just a few months prior to that date. In response to the significant growth in academic programs in HQS, and the rise of professional development programs in this space, program directors representing these academic institutions met in Philadelphia in the early Fall of 2017 to discuss developing an accreditation framework for stand-alone graduate programs in HQS.

The Commission on Accreditation of Healthcare Management Education (CAHME) was identified to serve as the accreditation partner given the complimentary nature of HQS with healthcare management, and the existing relationships that most partnering institutions already had with CAHME to accredit their academic degree programs in healthcare management. Following the same development process that CAHME undertook nearly 50 years ago for healthcare management education, the group agreed upon a “certification to accreditation approach.”

Simply put, nearly a year ago, under JPCH’s leadership, one of us (Dr. Oglesby) brought together all of the stand-alone graduate programs in HQS in the United States and Canada. They have subsequently committed to a deep self-evaluation with the goal of becoming certified in healthcare quality and safety under the auspices of a major national accrediting body.

With this accomplishment in mind, our team submitted the aforementioned proposal to SGIM, which was accepted at their annual meeting. We noted in the application

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process to SGIM that general internists, among others, are being called upon to assume leadership responsibilities related to healthcare quality and safety as the delivery system moves from one based on the volume of services delivered to the value generated by those services. The goal was that our panel, nested within the SGIM annual meeting, could stimulate the national conversation regarding career trajectory in quality and safety, with a special emphasis on self-evaluation, measurement, and the road toward accreditation. The leadership of SGIM agreed, and our panel had solid attendance during the meeting in Denver.

Dr. Nash was joined in Denver by Anthony Stanowski, DHA, FACHE, the President and CEO of CAHME, who gave a brief overview of its history and current operations. Dr. Stanowski did an excellent job outlining the evolution of CAHME, most especially in the last decade, and why their board of directors felt that accrediting programs in quality and safety was so central to their future mission.

Also participating in the panel were the directors of two current graduate programs, including Annette Valenta, DrPH (University of Illinois) and Sue Feldman, RN, MEd, PhD (University of Alabama) who presented updates on each of their programs. Given that the SGIM meeting had an additional focus on the role of information technology, Drs. Valenta and Feldman emphasized this aspect of their unique curriculum, and how general internists might become strong advocates for the merger of health information technology, and improvements in healthcare quality and safety.

Certainly, general internists are not the only leaders in the HQS movement, but having the privilege of presenting at a major national scientific meeting with a competitive submission process is further evidence of the growth of academic credibility for the 12 stand-alone graduate programs in HQS. This also represented another leadership opportunity for JCPH to “raise all boats”, not just for colleges of population health, but for the curricular champions at 12 other graduate schools

focusing on the need to improve education in quality and safety.

Looking toward the future, we believe that, Jefferson’s leadership role in population health (and HQS as a core component), will serve the delivery system well and will continue to contribute to improving the health of our citizens.

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From Classroom to Curriculum: Population Health Onboarding in the Real World

Newly hired clinicians transitioning into roles that independent practicing primary care providers must absorb a great deal of new information while assuming responsibility for their patient panels. Acclimating to the variety of payer programs, organizational accountabilities, and patient care activities can be a considerable challenge for newly minted providers and requires network support. The onboarding of new physicians into an ambulatory care network is a critical time for imprinting the organization’s cultural norms and priorities as well as nurturing their confidence. In an effort to facilitate this transition and foster a learning environment, the Jefferson Community Physicians (JCP) division of Jefferson Health developed a hybrid population health overview course with problem-based learning as part of the onboarding process.

Jefferson College of Population Health’s (JCPH) doctoral program in Population

Health includes course work in Teaching and Learning principles and execution, which laid the groundwork for developing the Population Health Overview Program described here. Congruent with JCPH’s encouragement of students to incorporate real-world experiences into learning opportunities, the need for a pragmatic population health onboarding program was identified through this connection. The program was developed utilizing the resources and support provided by JCPH faculty in collaboration with the local clinical leadership team.

The Population Health Overview Program employs adult learning principles and techniques to convert theoretical concepts and knowledge into actionable steps for busy practitioners. Lindvang & Beck (2015) summarize four categories of learning: First Order, which is factual knowledge; Second Order, which is reflexive knowledge to solve

concrete problems; Third Order, which is the creative form of problem solving where new perspectives and questions are assimilated; and Fourth Order, which is ‘world’ knowledge at a social evolution level. Curriculum in the Population Health Overview Program builds upon each level and culminates with problem-based learning exercises (Table 1). For instance, learners in the program complete a patient case vignette assignment from a reflexive knowledge perspective in Module 2 and build upon this this during Module 3 from a more experiential perspective. This holistic application of knowledge and skills aims to guide more interconnectedness between providers’ workflows and patients’ outcomes while enabling them to take ownership of population health care delivery with each subsequent case vignette.

The Population Health Overview Program kicks off with a learner self-assessment

Table 1.

Learning Principle	Defined	Application in program (activity)	Learner Feedback
First Order	Factual knowledge	Each module's lecture and reading materials target acquiring the foundational knowledge of each topic Example: Week 1 contained readings about the National Quality Strategy (NQS) and the Week 1 lecture described all of the payer programs we currently are participating in.	"Week 1's lecture was a great overview of the material. I had attended a meeting earlier about CPC +, but this presentation was much more effective and easier to understand."
Second Order	Reflexive knowledge to solve concrete problems	Each of the modules had assignments and activities that required the synthesis of facts in order to complete the activity. Example: Patient case vignettes were introduced in the second module and using during the third module. During the in-person session, Population Health Jeopardy also aided in cementing key learning objectives.	"I think it would be helpful to have a concise list of the care gaps we at JCP are being asked to close. This would be useful for providers and staff and promote closure of those gaps."
Third Order	The creative form of problem solving where new perspectives and questions are assimilated	Each of the online modules contained a discussion board whereby attendees were asked to respond to reflective questions about their practice in relation to these population health topics. Example: In module 1, providers were asked to consider how, individually, they could advance the national population health agenda in their community.	"I learned the most during week 2's quiz and practical application; consider adding more of these vignettes and less of the long readings which I found difficult to incorporate in to practice. 100% of learners rated their proficiency in describing to a colleague the variety of payer programs in place at JCP as Very Good or Outstanding on the final course evaluation.

in order to gauge their level of familiarity and confidence in the material about to be presented. The Program itself is divided into three separate modules and aims to accomplish three learning objectives. Module 1 familiarizes learners with the current national health care climate and describes key components of the various payer programs in which JCP is participating. Module 2 answers the question 'how are we evaluated' by reviewing quality metrics for which all network primary care providers are held accountable. Fourteen electronic clinical quality measures (eCQMs) are reviewed in depth, along with metrics to track the successful achievement of payer and enterprise goals. Both of these modules are facilitated through narrated PowerPoint presentations and by directing learners to readings that underscore the key theoretical underpinnings. This content review aims to illustrate the scope and diversity of population-based health care delivery to prepare clinicians for what they will experience at JCP. Module 3 is a demonstration of how to properly document the population health

assessments and interventions using vendor-established, certified workflows in the electronic medical record (EMR). This live, in-person session builds on the patient vignettes to mirror clinical scenarios learners will face in their respective practices, while the course leaders demonstrate how to accurately document that patient encounter.

To date, the Population Health Overview Program has been piloted with the Jefferson Community Physicians at the Abington campus with the intention of rolling this curriculum out next at the Aria campus. Learners in the pilot group have completed course evaluations, and have provided feedback on content, structure, and activities, which will be used to help shape future iterations of this program (Table 1). Recognizing that this program could benefit the entire primary care interprofessional team, the pilot group recommended expanding the target audience and modules to encompass other disciplines such as Medical Assistants, Office Managers, and Care Managers. Additional opportunities for growth of this program are also being

explored including using an abbreviated version as a continuing education module for seasoned providers, in an effort to help keep them abreast of fluctuations in payer program requirements and EMR changes. Holding true to the initial focus of this program, subsequent iterations will continue to be learner-centric and utilize problem-based learning techniques.

**Special acknowledgement to Juan Leon, PhD, Director Online Learning, Jefferson College of Population Health for his guidance and mentorship in learner-centric curriculum development.*

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Jefferson Health Begins Its Comprehensive Primary Care Plus Journey

The [Jefferson Health System](#) is a large health enterprise in the Philadelphia Metropolitan area, composed of 14 hospitals, that employs hundreds of primary care physicians in more than 100 primary care practices. In 2017, Jefferson Health embarked on an exciting new journey to transform its outpatient practices. As part of the [Affordable Care Act](#), the [Center for Medicare and Medicaid Services \(CMS\)](#) created [The Innovation Center](#). The Center was set up to test innovative payment and delivery system models that may show promise for maintaining or improving the quality of care in Medicare, Medicaid, and the [Children’s Health Insurance Program \(CHIP\)](#), while slowing the rate of growth in program costs. The original [Comprehensive Primary Care \(CPC\)](#) program was initiated in 2012 with a grant from the Innovation Center. The purpose was to explore whether outpatient quality outcomes could be achieved through improvements in infrastructure in outpatient practices. After some promising early outcomes, CMS decided to move forward with the second phase of the project, entitled [Comprehensive Primary Care plus \(CPC+\)](#). Nationwide approximately 3,000 primary care practices and 13,000 clinicians were chosen to take part in CPC+ in the fall of 2016. Sixty-one owned Jefferson Health primary care practices and 3 affiliated sites were chosen as part of this group to take part in the CPC+ program and benefit from this 5-year program.

Each office practice at Jefferson Health chose one of two tracks, with an almost equal distribution of the two types across the enterprise. Track 1 was chosen by practices that were able to meet minimum requirements, while Track 2 was chosen by practices that were farther along in their transformational journey. While the program is sponsored by CMS, the structural reforms provided have to improve the care provided for all patients in a practice -- including those with commercial insurance. Regardless of the track, the program is designed to change how patients are managed in order to improve the clinical quality, health care costs, and patient experience. There are five specific domains that need to be addressed to remain in the program (Table 1).

Table 1. Program domains

Access and Continuity	Requires that practices engage in activities such as 24-hour patient access and assigning care teams to patients. Practices must also offer electronic visits and expanded office hours beyond traditional times.
Care Management	Requires stratification of the entire population into different risk categories based on their clinical condition. High-risk patients, who are more likely to have poor health outcomes, are required to take part in a comprehensive care management program.
Comprehensive Coordination	Includes formulating discharge follow-up planning and using behavioral health services to improve health outcomes.
Patient and Caregiver Engagement	Requires the formation of a patient family advisory council (PFAC) to involve the patient in feedback about the transformation process occurring in the practice. This domain also supports creation of self-management tools for patients with high-risk conditions.
Planned Care Population Health	Ensures the practice is analyzing payer reports including the CPC+ feedback reports that are provided quarterly by CMS. The practice is obligated to schedule a weekly care team meeting with a focus on quality health improvement.

Timing of the CPC+ program was advantageous for Jefferson Health as it continues to integrate the expansion of different campuses into its growing health system. It was paramount for the system to coordinate its efforts across all of its campuses to further the integration journey, so a centralized structure was formulated to act as the control center. The central structure included key administrative and clinical leaders from the respective campuses to facilitate a central strategy with local control of implementation. A CPC+ project director was hired to oversee the entire project and ensure standardization and communication amongst the campuses.

A Jefferson population health retreat early in the process led to the formation of several subcommittees to meet the CPC+ requirements. The integrated behavioral health committee, whose role is to create a centralized approach to behavioral health, will equip current and newly hired practice-embedded behavioral health specialists with the tools to improve the health of patients whose

chronic diseases are adversely affected by their underlying psychosocial ailments. The Care Management Committee is working diligently to ensure that there is a standardized plan to address the high-and rising-risk patients, who are not only the most vulnerable but are also the most costly in the system. The Quality Committee is working to ensure the successful reporting of the electronic clinical quality metrics (eCQMs) that are required to be reported to CMS as part of the CPC+ requirements. Finally, the Primary Care Innovation Committee is ensuring that a portion of the granted funds are spent at the local practices on innovative ideas that will not only improve care but also improve the satisfaction and efficiency of the clinicians providing the care. The Innovation Committee has proposed additional positions that will help the system reach quality goals: documentation scribes and advanced medical assistants who will allow clinicians to spend less time documenting the visit and more time providing expert clinical decision making based on the patient’s medical problems. Additionally, Ambulatory

Pharmacists will assist in improving the quality of medical management of patients with complex and low-value medication regimens, as well as to enhance the use of high-value medications.

As outlined above, the first year of the CPC+ program has seen some incredible success in formulating structure and

process that have moved the integration of Jefferson Health's primary care practices in a positive direction. Strategic planning for the future has focused on meeting specific financial and quality goals. As the program progresses, the mandate is that it will move beyond process and get to a place of improved health care value as well as improved patient and provider satisfaction.

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Hospital Community Benefit: What is it, why is it important, and how could it be more effective?

Nonprofit hospitals achieve and maintain their official nonprofit status through undertakings aimed at promoting the health of their communities, referred to as community benefit activities. Among the categories of community benefit designated by the Internal Revenue Service (IRS), over 85% of overall hospital expenditures fall under direct patient care, including financial assistance programs, shortfall from Medicaid and other means-tested government programs, and subsidized local health service. The remaining 15% of hospital community benefit funds are applied in domains including medical research, health professions education, and community health improvement services.¹ In 2011, hospitals reported over \$62 billion in annual community benefit investments,² and annual per capita community benefit investments have been shown to exceed combined annual state and local health department spending.³ Non-profit hospital community benefit investments have the potential to positively impact the health of communities across the country, yet a number of factors, including lack of clear mechanisms for accountability or inter-hospital cooperation, may limit the effectiveness of these expenditures at improving the health of local populations.

The community health improvement services (CHIS) category, which is explicitly defined as activities or programs carried out "for the express purpose of improving community health," has the

greatest potential to address upstream determinants of health.⁴ However, this category has historically accounted for a small portion of overall hospital community benefit expenditures, with estimates ranging from 4-8% of overall community benefit spending.^{2,3,5} This is notably lower than expenditures in direct patient care categories.³

In recent work, our team explored allocations of community benefit expenditures and compared this to local health needs from 23 nonprofit hospitals and health systems across the five-county greater Philadelphia region. We performed this work with the concept that there may be opportunity to better maximize community benefit through coordination of investments across hospitals, especially in a dense, urban region. Two manuscripts have been generated by this work.^{6,7} In the following, we summarize our findings, and provide recommendations for next steps to increase community benefit impact.

Understanding What Communities Need and How Hospitals Allocate Their Expenditures

The Affordable Care Act (ACA) mandates that, every three years, nonprofit hospitals perform a community health needs assessment and establish an implementation strategy to address identified needs. We performed a qualitative content analysis to understand

regional health needs and related initiatives outlined in the implementation strategies as reported by each of the Philadelphia nonprofit hospitals. Access to primary care and services for substance abuse were identified as community health needs by all of the Community Health Needs Assessments in Philadelphia County, but only half of the hospitals reported a plan to address these community needs. In addition, while dental health, mental health, insurance coverage, and pharmacy and drug costs were among the most frequently reported community needs, these domains were very rarely included in hospital implementation strategies.

Coordination of Nonprofit Hospital Community Benefit Investments

In this work (currently in press), we explored local community benefit spending patterns, specifically characterizing spending allotments in CHIS. We analyzed hospital-published Community Health Needs Assessments (CHNA) as well as Internal Revenue Service tax filings from 23 nonprofit hospitals and health systems across the five-county greater Philadelphia region. The urban core of Philadelphia County had higher rates of poverty, more non-White residents, lower average educational attainment and higher overall community need than the surrounding suburban counties. However,

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while hospitals in Philadelphia County reported far higher overall community benefit expenditure, they reported significantly less spending on CHIS as compared to surrounding suburban counties, both as a proportion of their total community benefit spending and as an absolute dollar amount.

Recommendations to Maximize the Impact of Community Benefit Spending

While the hospital community benefit has tremendous potential for impacting and improving regional health, our work has demonstrated substantial gaps between community need and community benefit expenditure. In order to maximize the impact of the hospital community benefit, we propose the following priorities:

1. Improve regional coordination between hospitals that serve overlapping communities
2. Establish a mechanism for hospital accountability to ensure that identified community health needs are being addressed in a community-centered manner, and that evidence-based approaches are being employed to address those needs.
3. Expand hospital reporting requirements to include measures assessing the effect of community benefit-funded

programs on local community health. While current policies demand reporting of monetary inputs for community benefit investments, there is no expectation for reporting outcome measures. Measures might vary by region, and hospitals should be able to select outcome measures most relevant to the documented needs of their community. Examples might include measures of rates of immunizations supported by community benefit funding, or number of individuals provided access to job training programs, or number of pregnant women connected to insurance coverage through community benefit supports.

4. Increase transparency within CHNA implementation strategies, including information on how hospitals prioritize which needs will be targeted, what hospitals have identified as specific goals and objectives regarding their CHNA, hospital dollars invested per program, people served per program, and any other relevant outcomes

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Student Perspectives on Hotspotting: What it takes to improve care for “high utilizer” patients

Introduction

“Hotspotting” is an emerging method aimed at improving care and reducing costs by identifying “high utilizers” or patients with complex chronic conditions who over use emergency departments and inpatient hospital care. The Interprofessional Student Hotspotting Learning Collaborative promotes collaboration and interprofessional team-based learning among the various health and social service professions for these complex patients. The program addresses social determinants of health through patient interactions, home visits, accompaniment to providers’ offices/hospital visits, and navigation of community resources.

Last year, the [Jefferson Center for Interprofessional Practice and Education \(JCPIE\)](#) was selected as one of four national Student Hotspotting hubs by the Camden Coalition of Healthcare Providers, Association of American Medical Colleges, Primary Care Progress, Council on Social Work Education, National Academies of Practice, and American Association of Colleges of Nursing. As a hub, Jefferson has scaled up its hotspotting program to include eight interprofessional teams in addition to hosting twelve teams from regional institutions, playing an integral role in propelling this national movement for caring for complex patients forward. Interested students throughout Thomas Jefferson University apply to the program and participate in small teams of four to six interprofessional students.

The following summary describes the Hotspotting observations and experiences of two 2017-18 student participants, Jessica Shipley (Nursing) and Meghan Bresnan (Pharmacy).

Jessica’s experience

One night while working as a nurse extern at Jefferson, I saw a text from our student Hotspotting team: “Our patient has been admitted from the ER, can someone come talk with her?” I volunteered to go after my shift, and that was when I met “Mary” for the first time.

For most people, landing in the emergency room is a frightening, singular event. For our client, as with other high utilizers

of healthcare, being picked up by an ambulance every few months had become routine, and we wanted to know why. Earlier that month, team members had visited the elderly woman, living alone with some assistance, and described her as having a flat affect with signs of cognitive decline. But the person I saw in the hospital that night was alert, sociable, and engaged, although anxious to get back home after a stimulating day in the ER. Since the doctors couldn’t guarantee her safety home alone, she had been admitted for an overnight stay until a caregiver could pick her up. She didn’t understand this. Waiting until the nurse left the room, she turned to me. “Can’t you just call the ambulance to take me back home?” she asked. That’s when I understood what an important role social isolation was playing in our client’s health. Home alone and anxious about her symptoms, she knew that the ambulance was only a reassuring phone call away.

By joining our patients as they navigate the health system, students can observe smaller moments like these that provide clues about high utilization otherwise missed somewhere between a doctor’s appointment and a trip to the ER. Our interprofessional team from medicine, nursing, occupational therapy, pharmacy, and public health can then compare insights from different points of view. After following up with another home visit, we discussed how our patient’s unmet social needs were leading to serious medical problems, as well as avoidable visits to the ER triggered by anxiety, confusion, or even loneliness. We shared this information with our advisors and our patient’s physician, suggesting a few changes.

As for what it’s like to “do Hotspotting”, all I can say with certainty is that it’s complicated. The program’s organizers prepare us for ambiguity in a complex patient’s situation and urge us to resist the impulse to fix it, suggesting we simply get to know the person instead, using a trauma-informed approach. These patients have been let down by the system and sometimes all we can provide in our short time together is a first step back towards a healthier routine.

I’m proud to say that after months of meetings, case conferences, and home

visits, we have a few small wins – a change in our client’s treatment plan and a regular follow-up with a trusted social worker – that feel like huge victories. At the beginning, I never imagined I’d be thrilled by such tiny, incremental steps. Now I see how these slight shifts can correct course over time and make a difference not just in health outcomes but in saving system resources and costs as well. This is a memorable lesson as I begin my own nursing practice and it reminds me to celebrate progress wherever I find it.

Meghan’s experience

It was very easy to make the decision to participate in Student Hotspotting because I wanted to be able to help identify “super-utilizers” and see what I could do as a student pharmacist to ensure the number of hospital admissions decreased by increasing the health of my patients. While it was easy to say yes to participating, it was also stressful stepping into an advanced role beyond just being a student pharmacist. I knew I was going to be visiting the homes of different patients and performing medication reconciliations and would potentially be faced with situations I did not know how to necessarily handle. I remember being beyond nervous to call my first patient and set up a time to meet at her apartment because I was honestly afraid of rejection, but she turned out to be the nicest woman and was more than happy to have my team come to her home and meet her.

Our first roadblock with our patient came when I called her to confirm our visit a few days after originally reaching out, and she did not remember agreeing to the visit. For a moment I didn’t know what to say because I did not want to alarm her, so I asked her again if it was okay for us to come over and she kindly agreed. Luckily, when we went to our first visit, she remembered I called her the previous day; therefore, what I thought was a major roadblock turned out to be a case of forgetfulness. Throughout our original visit with our patient we became more and more comfortable asking her questions about her previous hospitalizations, but our biggest source of information was our patient’s nurse aide. She was able to

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detail every reason for our patient’s recent hospitalizations, which was helpful because we soon discovered our patient was diagnosed with mild dementia which was affecting her ability to recall recent events.

Throughout this entire experience so far, not only did I have my team to work with to help our patient, but I was also working with our patient’s primary care physician. I was able to speak to the physician to obtain

more background information, to get the full picture of how we could approach such a complex situation. Overall, Student Hotspotting has showed me how taking care of a patient is way beyond prescribing medications and checking on a patient’s physical well-being. There are so many social and mental factors that contribute to a patient’s overall health that are sometimes forgotten in the usual day to day practice of medicine which need to seriously be considered if a clinician wants to treat their patients to the best of their ability.

[Click here to watch Jefferson students describe their Hotspotting experiences.](#)

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Defining Population Health Use Policies for a Regional Health Information Exchange

Regional health information exchanges (HIEs) primarily aim to improve healthcare by facilitating clinicians’ access to information about their patients from electronic health records maintained by other providers¹ or from claims records maintained by insurers. This might include information on diagnoses, medications, test results, or care encounters.¹ In addition, information in HIEs can be used for multiple population health applications.^{2,3,4} For providers and insurers, this might include improving the completeness of data for performance monitoring and quality improvement or for assuring the delivery of recommended services.^{2,3} For public health agencies, this might include improving disease monitoring systems or supporting linkages between clinical and public health services.^{2,4} Incorporating population-level uses into HIE operations requires consideration of governance and policy questions that are distinct from those that underlie direct clinical applications. During 2016-2017, HealthShare Exchange (HSX), a regional HIE centered in Philadelphia, PA,⁵ initiated such efforts by convening a workgroup that included representatives from member organizations (hospitals, insurers, accountable care organizations, clinicians, community health centers) and the public health field (a list of participants is available at <https://www.healthshareexchange.org/hsx-population-health-workgroup>). In this article, we summarize the key issues that arose in these deliberations and the strategies the workgroup identified to address them, with the aim of providing a resource to other HIEs interested in adding or expanding population health activities.

Table 1. Examples of scenarios used to develop population health use policies for a regional health information exchange.

Healthcare uses	A consortium of providers participating in a neighborhood health improvement project seeks to characterize patients who use ED services excessively in order to formulate interventions.
	An individual provider is interested in assessing and improving cancer screening rates among her patients.
	A primary care practice is interested in better understanding birth outcomes within its patient population, including infant birthweights and maternal post-partum visits.
	As part of its periodic community health needs assessment, which is required for maintenance of not-for-profit status, a hospital seeks to assess the prevalence of hypertension among Asian people residing in its service area (a population that is insufficiently represented in a local community health survey).
Public health uses	A metropolitan health department endeavors to assess the prevalence of obesity by selected demographic characteristics across the city, based on body mass index calculations derived from height and weight measurements recorded in medical records, in comparison to other methods for obtaining such measures.
	A healthcare provider wishes to submit mandated reports to a health department on certain infectious diseases and immunization services.
	As part of an outbreak investigation, a local public health department seeks to assess the extent of the problem in order to inform its response.

HSX is an increasingly mature HIE serving the greater Philadelphia metropolitan area and the Delaware Valley region, including southern New Jersey.⁵ Participants include large hospital and healthcare systems, insurers, primary and specialty care providers, accountable care organizations, behavioral

health providers, and post-acute-care entities.⁵ HSX policies and procedures have been defined through “use cases” that describe the purpose, scope, and terms of specific data uses, such as automated retrieval of information when patients are seen in hospital emergency departments and

Table 2. Examples of scenarios used to develop population health use policies for a regional health information exchange.

Topic	Question(s)
Definition of population health	What distinguishes population health versus patient care uses of an HIE?
Applicability of federal regulations that protect research participants	Are population health uses of an HIE research? Is institutional review board (IRB) review and approval required?
Data access and data-use agreements	Should users have access to individual-level patient/client data with or without identifying information versus data on numbers of patients in different classification strata (i.e., aggregate data)? Should users have access to information regarding the identity of providers who had seen population members? Should data extracts be released to analysts for use outside HSX, or should analysts be required to work onsite at HSX or to access HSX data via a secure channel? Would the user be restricted from accessing data for patients with HIV or mental health diagnoses? Could HSX members obtain data only for those with whom they have an ongoing provider or insurer relationship?
Potential conflicts between the interests of payers and providers	What is the boundary between performance assessment for informing service improvement versus informing reimbursement incentives or rates?
Project approval and transparency	How would proposed population health uses be approved? What requirements would analysts have to share findings?

notifications to primary care providers when patients are discharged from hospitals or emergency departments.⁶ The growth of HSX has been enabled by a shared recognition among members of its utility for improving patient care, attention to data security and data-use policies, and trust engendered among users by their participation in governance and policy committees.

In examining potential population health uses of HSX and its data from healthcare and public health perspectives (Table 1), the workgroup identified multiple questions (Table 2) that set the agenda for its deliberations. The resolution of these questions is summarized in the remainder of this article.

The workgroup **defined population health uses** as queries that seek to **characterize a group of patients** (e.g., those under the care of a particular provider, enrolled in a particular health plan, with a particular diagnosis or health risk, or residing in a particular geographic area), regardless of whether those queries prompt follow-up with individuals.

For example, characterization of persons diagnosed with hypertension would be a population health use, which might inform improved prevention services or outreach to those whose blood pressure was not well controlled. Envisioned population health uses reflected insurers' interests in improving care coordination and quality for their members, providers' interests in improving their care quality and outcomes, and public health entities' interests in monitoring and protecting the health of populations within their purview. HSX can enhance capacities to address these needs because its data repository includes information about patients or clients that is maintained in record systems outside members' individual systems and because it allows geographically-based queries. Such population health uses are distinct from clinical uses where queries seek information about an individual patient or client.

Population health data users would include HSX members or authorized governmental public health agencies. Because the scope of population health uses is to inform services or functions directly connected to

users' responsibilities and not to develop more generalizable knowledge, the latter objective being a defining attribute of research in Federal regulations that protect research participants,^{7,8} the workgroup concluded that **population health uses were not research** and thus not subject to institutional review board approval and oversight. This conclusion, which was affirmed by HSX legal counsel, was also based in part on the analogy between proposed population health uses of HSX and investigations in public health practice that are classified as "nonresearch."⁹

Questions regarding the level of data granularity that should be provided to analysts and procedures for granting analysts access to HSX data (Table 2) consumed considerable attention. The group resolved that data should be provided **at a level of detail necessary to address a proposed query**, but not beyond, under terms specified in data-use agreements that protect confidentiality and data security. Depending on the nature of specific requests, as exemplified in Table 1, data would be provided in ways that are also **commensurate with a user's established relationships** to patient or client populations, **adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule**,¹⁰ and **compliant with other state and federal regulations** that govern uses of personal health information. For example, in the scenario involving a primary care practice interested in assessing birth outcomes within its patient population, the practice has established relationships with patients who might have delivered at multiple hospitals. Thus, the HIE would provide patient data from those hospitals. In addition, a proposed analysis might require individual-level data to explore risks for adverse outcomes, and needs for patient follow-up might be recognized that would require access to patient identifiers. In the scenario where a hospital is conducting a community health needs assessment using data for people residing in its defined community service area, the population of interest would likely include a mix of people who are or are not its patients. In that situation, hospital analysts would be provided data that does not include personal identifiers, and, as in any instance where de-identified individual-level data are provided, the data-use terms would prohibit analysts from making any effort to re-identify persons

Continued on page 10

represented in the data. If that same hospital were interested in assessing the prevalence of HIV within its service area, HSX would provide aggregate counts of persons living with HIV but would not provide analysts with individual-level data because of special protections surrounding personal-level HIV data under Pennsylvania state law.¹¹ In the scenario where a local health department seeks to assess the prevalence of obesity communitywide, aggregate counts of the number and percentage of people who are obese, would likely be provided; although, HSX staff effort would be needed to conduct the analyses and prepare the tabulations. For people who elect to opt-out of having their personal health data exchanged through HSX, only de-identified data would be provided for any project.

The workgroup also determined that all population health projects would be **subject to approval and oversight under existing policies and governance procedures of the HIE.**⁶ For example, HSX member-contract terms prohibit payers from using data derived from the system to leverage contract negotiations with providers. The terms

also **prohibit any member from using HSX data for market analyses.** The workgroup recognized that, in some instances, the distinction between data that could be used for performance management (an accepted population health use) and prohibited uses might be ambiguous. It concluded, though, that HSX member organizations were unlikely to engage in prohibited data uses, given the spirit of collaboration among them that had created and sustained the exchange and their commitment to transparency regarding planned population health uses.

Ultimately, the workgroup recognized that population health data uses by HSX members and public health authorities were sufficiently distinct to require the development of separate use case documents for each. These documents, which address the workgroup's resolution of the critical questions in detail, were approved by the HSX board in July 2017 and are available online (www.healthshareexchange.org) along with other HSX policies.^{6,12,13} Going forward, an informal user group will be established to share insights and experiences and to foster best practices for population health uses of HSX data.

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Massachusetts Housing and Shelter Alliance Receives 2018 Hearst Health Prize

The winner of the \$100,000 Hearst Health Prize for Excellence in Population Health was announced at the Population Health Colloquium on March 20, 2018. Massachusetts Housing and Shelter Alliance (MHSA) was recognized for its successful Home and Healthy for Good program, a permanent supportive housing program addressing chronic homelessness, and overutilization of acute care and emergency care, by removing barriers to housing. Individuals are provided with their own home where they can maintain sobriety, find employment and achieve other health and life goals. The program was able to show reductions in the utilization of emergency services and an increase in the placement of adults experiencing chronic homelessness into permanent housing. Watch MHSA Executive Director, Joe Finn describe the program.

The two other finalists for the 2018 Hearst Health Prize were each awarded \$25,000.

They are listed below in alphabetical order:

Cincinnati Children's Hospital Medical Center (CCHMC) for their All Children Thrive (ACT) Learning Network, an initiative which is focused on population-based improvements aimed at reducing infant mortality, reducing days that children spend in the hospital, and ensuring that children thrive by being school-ready at age five and reading proficiently by the third grade. Watch the video.

Nurse-Family Partnership (NFP), a national maternal and child health program that changes outcomes for the most vulnerable moms and babies in poverty. NFP provides



Robert Kahn, MD, MPH, Cincinnati Children's Hospital Medical Center (finalist); Joe Finn, Massachusetts Housing and Shelter Alliance (winner); David Olds, PhD, Nurse Family Partnership

each expectant mom with a personal nurse to help her have a healthy pregnancy, improve her child's health and development and set goals to become economically self-sufficient. Watch the video.



HEARST HEALTH
prize

IN PARTNERSHIP WITH
Jefferson College of Population Health



Jefferson
Philadelphia University +
Thomas Jefferson University

2019 \$100K Hearst Health Prize Call for Submissions Open!

The Hearst Health Prize, in partnership with the Jefferson College of Population Health, is now accepting applications for the 2019 award. The winner will receive a \$100,000 prize, with \$25,000 awarded to up to two finalists, in recognition of outstanding achievement in managing or improving population health. The goal is to discover, support and showcase population health programs that have made a measurable difference. For more information, visit Jefferson.edu/HearstHealthPrize. Submission deadline is **Thursday, August 9, 2018, 3:00 PM EDT/ 12:00 PM PDT**. For questions, please email HearstHealthPrize@jefferson.edu.

Disease Specific Chronic Care Management for the Underserved Population

More than 30 million Americans are currently living with diabetes.¹ Each year, an additional 1.5 million are newly diagnosed.² Diabetes has a major impact on people who live with the disease, their family members, and society as a whole. Not all people living with diabetes have equal access to care or the necessary

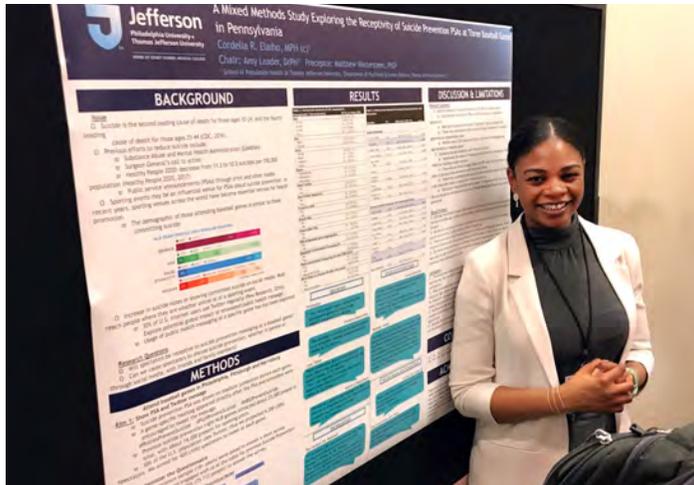
resources to successfully self-manage their disease. As a result, hospitals across the nation have seen an influx of diabetic cases flow through their emergency departments. The costs associated with diabetic hospitalizations can easily be reduced and/or avoided with the implementation of comprehensive case

management for those with complex health and social needs.

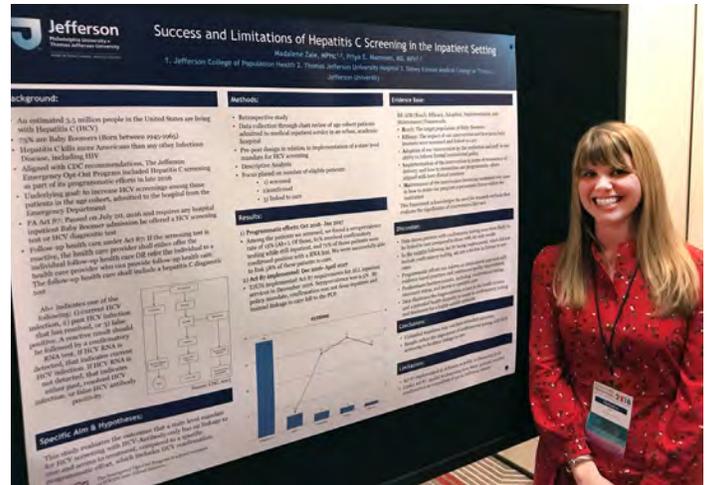
Beginning in 2011, Jefferson Health New Jersey embarked on the Delivery System Reform Incentive Payment Program

Continued on page 15

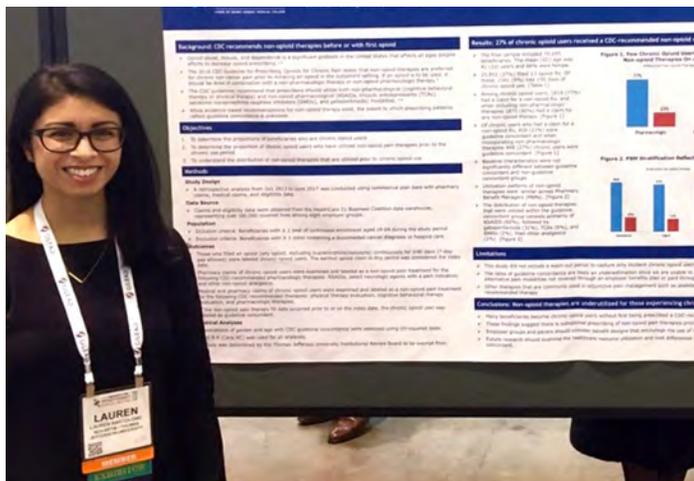
IN THE NEWS



Alumna Cordelia Elaiho presented at the Association for Prevention Teaching and Research (APTR) Annual Meeting.



MPH student and Jefferson employee Madalene Zale with her poster at the APTR Annual Meeting.



HEOR Fellow Lauren Bartolome, PharmD was recognized for her poster with a silver ribbon award at the Academy of Managed Care and Specialty Pharmacy Annual Meeting.



Nine MPH students were honored at the Leadership LIVE ceremony. Leadership LIVE is a student leadership development program which consists of a series of workshops, special events, and community service opportunities. Photo left to right: Saheedat Suliamon; Rashida Smith; and Nicole La Ratta.



Charles Baron at the Spring MPH Student Capstone Symposium.



Jane Jacob at the Spring MPH Student Capstone Symposium.

IN THE NEWS



The MPH Student Capstone Symposium with (left to right): Preethi Selvan, Ndid Enwerji, and Samantha Soprano.



MPH Student Spring Capstone Symposium .



Former Secretary of U.S. Department of Veteran Affairs, David Shulkin, MD gave a key note presentation at the 18th Population Health Colloquium.



Darryl Strawberry shared his moving story about his journey through addiction at the 18th Population Health Colloquium .



Niki Buchanan, Population Health General Manager of Philips presented on value-based care at the Population Health Colloquium.



Left to right: Jennifer Voelker, PharmD; Vittorio Maio, PharmD, MS, MSPH; Lauren Bartolome, PharmD, and Alberto Batista, PharmD.

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JCPH at the International Society for Pharmaeconomics and Outcomes Research (ISPOR)

Annual Meeting 2018
May 19 - May 23
Baltimore, MD

Podium Presentations

Batista A, Bartolome L, Nelson F, **Maio V**, Mammen P. Cost-effectiveness analysis of universal vs. targeted Human Immunodeficiency Virus (HIV) screening approaches to identify new HIV diagnosis in the emergency department (ED).

Voelker J, Crawford A, Sabonjian M, **Maio V**, Mammen P. Annual change in controlled substance opioid prescribing and concomitant medications from an urban academic emergency department from 2011 – 2016.

Jennifer Voelker received the Best New Investigator Podium Research Presentation.

Poster Presentations

Bartolome L, Choi M. The impact of online patient communities on patient outcomes: A systematic review.

Bartolome L, Payton C, Maio V, Altshuler M. Prevalence of pneumococcal vaccination in a recently resettled refugee population.

Lee S, Romney M, Goldfarb N. Return on Investment (ROI) of Value-Based Insurance Design (VBID) for diabetic patients.

Lee S, Savant K, Hsiao C. National Health and Nutrition Examination Survey (NHANES) Analysis of the USA's obese population and related comorbidities.

Decker-Palmer M, Thompson T, George M, **Frasso R**. Identifying community reported health priorities using free listing interviews in a mixed methods approach.

Decker-Palmer M, Delgado D, Maloney TD. Emphasizing quality of life in treatment recommendations for node-positive stage II non-small cell lung cancer.

(DSRIP) with the New Jersey Department of Health and Centers for Medicare & Medicaid Services. Our DSRIP program focuses on the care and treatment of patients 18 years and older, who are residents of New Jersey, living with diabetes and/or hypertension, insured by Medicaid, Managed Medicaid and Charity Care.

The goals of Jefferson Health New Jersey DSRIP program are: to increase patient access to primary and specialty care; improve care coordination between hospital and outpatient settings; improve patient self-care management; reduce hospital admissions relating to complications of diabetes and hypertension; reduce unnecessary Emergency Department (ED) visits; increase preventive diabetes and hypertension health screenings; promote overall wellness; and leverage technology to facilitate patient tracking and communication of clinical data. The overarching goal of our project is to address the critical gap between clinical care and community services in the current health care delivery system.

Currently, the project has enrolled more than 4,000 patients, who are provided medical services from over 800 physicians. Jefferson Health New Jersey has implemented relationship-building as the primary method to engage patients in their health care, with such techniques as motivational interviewing and therapeutic communication, as well as addressing health-related social needs through enhanced clinical-community linkages.

Many of our patients have complicated social needs that must be addressed in conjunction with their medical needs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may reduce an individual's ability to manage their medical conditions, increase health care costs, and lead to avoidable health care utilization.

Evidence-based health coaching approaches were designed and are utilized to support effectiveness in patient engagement and care. This is an innovative approach that our DSRIP team has embraced to engage patients. It puts the focus solely on the patient, which is different from the traditional medical model in which health care professionals who "know best" define the agenda, terms, and the goals of care. Through this practice, the team has developed and refined their Motivational Intervention (MI) techniques that help patients work through ambivalence with change-talk and goal setting.

In addition to linking patients to appropriate social services, our master's level social workers employ cognitive behavioral therapy as a technique to address issues with treatment adherence and psychosocial barriers to overall health.

Our nurse navigators work with patients to provide clinical education in order to better understand their chronic medical conditions, symptoms, medications and actions they can take to support their health.

As a result of the team's continuous efforts in patient engagement, care coordination/navigation, and education, the team has had many successes within the last year.

The DSRIP team has seen a 17% overall reduction in ED utilization and hospitalization of patients and a 15% reduction in hospital admissions for uncontrolled diabetes. In addition there has been an 11% reduction in hospital admissions for short-term complications due to diabetes and a 23% reduction in hospital admissions for uncontrolled hypertension. Jefferson Health New Jersey's DSRIP project has resulted in a significant reduction in health care spending, through reduced hospital costs and reduced governmental payments, aggregating approximately \$3.3M.

Unlike other population health case management initiatives, DSRIP provides a comprehensive, collaborative, patient centered approach that educates and empowers patient to enact the changes they need to improve their overall health. This initiative provides a strong return on investment that can be reinvested into health promotion and improving quality outcomes across the Jefferson Health NJ community. Chronic care management programs will become essential revenue sources to hospital systems as financial incentives for better quality outcomes become standard with the adoption of MACRA. Our DSRIP model has shown great success in managing care for those underserved patients with diabetes and hypertension. We believe our model will easily translate to additional disease states and can be used for future Jefferson Health chronic Case Management applications such as COPD, Congestive Heart Failure, and Asthma.

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Optimizing Older Adult Sexual Expression

Sex is Alive and Well

Most people are uncomfortable when confronted with issues relating to older adult sexuality. In my experience as a trainer and sexuality educator for close to 25 years, I have talked about sex with people of all ages: young girls and their parents (mostly their moms) about what to expect in puberty, high school and college students navigating their way through mating and dating, adults who were incarcerated and/or in recovery, and older adults and their service providers. Human sexuality is a compelling topic, and the curiosity and enthusiasm it arouses is perfectly normal regardless of the age group.

However, for many, fascination with the subject of human sexuality is also charged with negative emotions and concerns. Sometimes curiosity is tinged with feelings of guilt, shame, fear, and foreboding; and often for good reason. Sexuality issues include topics that are very difficult to discuss and this can be especially true when we talk about older adults.

Sex and sexuality are human needs that evolve and change over the lifecycle and the need for intimacy is ageless. It is simply not true that people lose interest in sex as they age, regardless of their sexual orientation and gender identity or the health challenges they may face.

The following anecdotes exemplify some of the ways sexuality evolves and changes as we age, but is still very much a part of who we are.

Consider the following question asked by a member during a recent workshop on “SEXcessful Aging” that I conducted at a local senior center: “Will I have a chance to talk about Eddy today?” My response: “Sure, tell me more about Eddy.” Older adult: “Eddy is my vibrator.”

A man in his 80s talked about how making love to his wife (now deceased) was “the best sex he ever had, and I still think about those years.” Another person asked whether or not oral sex was still “sex” and if it was “safe”. A woman shared, “It’s been so good to talk about sex and relationships. I haven’t talked about it to anyone in years, these conversations bring

back such pleasant memories.” A 70+ year old transwoman talked about her gender transition process that started in her mid 50’s and how much happier she is. Grandparents asked questions about their grandchildren’s “gay identity” and if the word “queer” was okay to use. Older LGBT adults voiced concerns and fear about “coming out” when seeking aging services.

So many people, even those who work in the field of public health, may not think of seniors experiencing intimacy and sexuality concerns. The above anecdotes reflect some of the needs seniors have in relation to their sexuality and sexual activities; concerns about relationships, feelings, memories, morality, and the lack of knowledge.

Sex and Sexuality: Is there a difference?

There are many facets of senior sex and sexuality, but too often, the words sex and sexuality are used interchangeably, and that may lead to diminishing the value of sexuality as we age.

One can think of sex in terms of intimate behaviors people engage in, or what box to check when identifying one’s gender. Sexuality is a central aspect of being human and encompasses sex, gender identity and roles, sexual orientation, pleasure, intimacy and sexual health; and it is influenced by social, economic, political, cultural and religious factors. We express our sexuality in our thoughts, fantasies, desires, attitudes, values, and behaviors, and these change throughout our lives.

Implications for Practice

Sexual expression and intimacy among older adults is a reality that providers who work with them must be prepared to face. How can we help them to meet this challenge and support healthy older adults’ sexual expression across the decades of aging? Here are some tips:

- Remember that sexuality is physical, mental, emotional, and spiritual and spans an individual’s entire life. The need to enjoy and express one’s sexuality does not diminish with age. Older adulthood can be a time of new discoveries and powerful sexual

experiences. Being “sexually active” involves more than just intercourse.

- Understand your beliefs and attitudes toward sexuality in later life, and examine any barriers there might be to working supportively with older adults. The Aging Sexual Knowledge and Attitudes Scale (ASKAS) is a tool designed to measure two realms of sexuality as they relate to older adults: knowledge about changes in sexual response and general attitudes about sexual activity.¹
- Get to know the important sexuality and intimacy issues that are specific to those served—older adults living with HIV, residents in long-term care setting, lesbian, gay, bisexual and/or transgender older adults, clients with dementia. Increasing understanding will help providers become more aware of and identify intimacy needs and opportunities for discussion, as well as offer tools to begin addressing intimacy needs.
- Advocate that sexuality and intimacy be integrated into the services provided. For example, education for staff, addressing sexual consent policies, activities that allow seniors to build intimacy/relationships (dances, date nights, social functions), incorporate physical intimacy goals into physical therapy, or provide a confidential space for older adults to discuss sexual health issues.
- Learn about the PLISSIT model. PLISSIT is an acronym for Permission, Limited Information, Specific Suggestions, and Intensive Therapy, a model developed by psychologist Jack Annon to address sexuality issues with patients.¹ The PLISSIT model provides a framework for conversations about sexuality, including sexual health. The model includes several suggestions for initiating and maintaining the discussion of sexuality.

To summarize, sexuality is an important contributing factor to quality of life and wellbeing. Sexuality, intimacy, and sex are central pleasures to the human experience and all adults have the right to express their sexuality, regardless of their age, sexual orientation, gender identity or HIV status. We all need to join in conversations with older adults

to empower them with comprehensive information about sex and sexuality, thereby increasing knowledge and developing positive attitudes and behaviors towards sexuality, intimacy and relationships, which are key to successful aging and quality of life.

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Terri is a certified trainer with the SAGE (Services and Advocacy for GLBT Elders)

serves on the American Society on Aging's Leadership Council of their LGBT Aging Issues Network (LAIN) constituent group and is currently the Coordinator of Prevention Services at Action Wellness in Philadelphia, PA. To learn more about Terri and Action Wellness visit: <https://www.actionwellness.org/>

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1. White CB. A scale for the assessment of attitudes and knowledge regarding sexuality in the aged. *Archives of Sexual Behavior*. 1982 December; 11(6):491-502.
2. Annon, JS. *Behavioral Treatment of Sexual Problems: Brief Therapy*. Oxford, England: Harper & Row; 1976.

Reducing Cancer Disparities by Engaging Stakeholders (RCaDES) Initiative - 2nd Annual Conference

Beginning in 2015, the Sidney Kimmel Cancer Center (SKCC), a National Cancer Institute (NCI)-funded cancer center, initiated a 2-year collaborative project with Jefferson Health (JH) and Lehigh Valley Health Network (LVHN) to form a learning community dedicated to reducing colorectal (CRC) and lung cancer (LcA) progress screening disparities in primary care practice patient populations. This project, known as the Reducing Cancer Disparities by Engaging Stakeholders (RCaDES) Initiative, was supported by the Patient Centered Outcomes Research Institute (EAIN 2471) and Thomas Jefferson University. The RCaDES Initiative sponsored its first annual conference in December, 2016. The 2nd Annual Conference, which is described below, took place on December 1, 2017 at Thomas Jefferson University campus.

Ronald E. Myers, DSW, PhD, Professor of Medical Oncology and Director of the Center for Health Decisions at Jefferson, opened the 2nd Annual Conference. He described the learning community infrastructure (a coordinating team [CT]; a steering committee [SC] and a patient and stakeholder advisory committee [PASAC] in each health system), and provided an overview of the meeting agenda. Next, Sharon Sowers, Director of the Comprehensive Cancer Control

Program for the Pennsylvania Department of Health described progress made by the Commonwealth of Pennsylvania to address cancer screening disparities. She applauded the work of the RCaDES Initiative and reinforced the importance of collaborative efforts to engage stakeholders in the public and private sectors to increase cancer screening rates and reduce screening disparities.

Following these introductory remarks, members of the RCaDES Initiative CT (Table 1) presented a summary of accomplishments from each year of the 2-year project. These included: 1) Establishing a communication strategy to foster a collaboration and develop trust, 2) Developing shared statements of purpose and common agendas for each learning community component (CT, SC and PASACs), 3) Measuring CRC screening rates among whites, African Americans, Hispanic Americans, and Asian Americans served by JH and LVHN primary care practices, 4) Conducting a literature review to identify effective evidence-based intervention(s) to increase CRC cancer screening adherence and reduce related disparities, and, 5) Completing an environmental scan of CRC and LcA screening programs in the health systems.

These efforts yielded the following observations: 1) CRC and LcA screening

Table 1: RCaDES Coordinating Team Presenters

Marty Romney, RN, MS, JD, MPH
RCaDES Coordinating Team Assistant Professor
Jefferson College of Population Health

Beth Careya, MD
RCaDES Steering Committee Associate Director
Lehigh Valley Practice-Based Research Network
Lehigh Valley Health Network

Jenné Johns, MPH
RCaDES Steering Committee Director of Health Disparities
Corporate Medical Management
AmeriHealth Caritas

Melissa DiCarlo, MPH, MS
RCaDES Project Manager
Clinical Research Coordinator
Division of Population Science
Thomas Jefferson University

Randa Sifri, MD
RCaDES Coordinating Team Director of Research
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Continued on page 18

rates are low in the general and minority patient populations; 2) decision support and navigation intervention(s) can increase CRC screening rates and reduce CRC screening disparities; 3) the implementation of LCa screening programs lags behind CRC screening programs; and 4) there is little coordination between payers and health systems in efforts to encourage patients to have CRC and LCa screenings.

A panel on LCa screening, “Adapting Evidence-Based Strategies for Implementation,” was moderated by Linda Fleisher, PhD, MPH, Senior Researcher, Digital Health, Health Communications and Disparities, Children’s Hospital of Philadelphia, in which PASAC patients and providers shared what they learned about the process of adapting a feasible LCa screening program for the respective patient populations and health systems. Panel members reported the following: 1) Literacy-appropriate and culturally-sensitive patient education materials are needed, 2) Clinician support for LCa screening is necessary to encourage patient uptake, 3) Community members are not sufficiently aware of LCa screening opportunities and screening eligibility criteria, and 4) Efforts to encourage patient uptake of LCa screening must address patient knowledge, attitudes, beliefs, and need for social support.

The morning concluded with an announcement by Bruce Meyer, MD, MBA, Senior Executive Vice-President of Thomas Jefferson University and the Chief Physician Executive for Jefferson Health. Dr. Meyer announced that Jefferson was to receive a \$2.8 million grant from the Bristol-Myers Squibb Foundation that would build on the RCaDES Initiative learning community model, and launch a multi-year initiative to increase LCa screening in vulnerable populations in Philadelphia. Patricia M Doykos, PhD, Director of the Bristol-Myers Squibb Foundation, followed Dr. Meyer, and expressed her excitement about working with Jefferson to increase LCa screening and improve related outcomes in vulnerable populations, and about the potential for developing a model approach to engaging health systems in LCa screening. Both Drs. Meyer and Doykos highlighted Philadelphia as an

important setting for the project, due to a high LCa risk in the population, and socioeconomic and cultural barriers that deter those who are at risk from screening and from seeking smoking cessation services (Table 2).

Table 2: Bristol-Myers Squibb Foundation Announcement

The Bristol-Myers Squibb Foundation’s \$2.8 million grant to launch a multi-year initiative to increase LCa screening in vulnerable populations in the Philadelphia region was made possible through the efforts of the Jefferson Office of Institutional Advancement and:

- Gregory Kane, MD, Jane and Leonard Korman Professor of Pulmonary Medicine and Chair of the Department of Medicine
- Ronald E. Myers, PhD, Professor and Director of Population Science at Sidney Kimmel Cancer Center
- Rickie Brawer, PhD, MPH, Assistant Professor and Co-Director of the Center for Urban Health
- Nate Evans, MD, Associate Professor and Chief of Thoracic Surgery

Their collaboration leverages the full breadth of Jefferson enterprise’s expertise in pulmonary and lung cancer care, public health and community and engagement, and population science and shared decision making research.

Following lunch, a panel conversation titled, “Learning Community Formation as a Strategy for Reducing Disparities: Strengths, Weaknesses, Opportunities & Threats” took place between Electra Paskett, PhD, Marion N. Rowley Professor of Cancer Research, Director, Division of Cancer Prevention, of Ohio State University; Jamie L. Studts, PhD, Professor at University of Kentucky Louisville College School of Medicine, and Director of Behavioral Oncology Program at the James Graham Brown Cancer Center and Community-Based Research SRF; and Robert A. Winn, MD, Associate Vice Chancellor for Community-Based

Practice, and Director of the University of Illinois Cancer Center.

All panel speakers spoke to the *strengths* of the RCaDES Initiative: the use of diverse partners, assessing organizational readiness as one of the first steps of the project, and the creation of a learning community structure that could be used with other cancers. Dr. Studts noted the use of a systematic approach to identifying and adapting an evidence-based intervention strategy; and the use of a model-based approach to engage diverse populations in cancer screening. In terms of *weaknesses*, all keynote speakers agreed that greater outreach by the health systems was needed to engage those most in need of preventive health care. For example,

Table 3: The RCaDES Initiative 2nd Annual Conference Roundtable Discussion Questions and Answers

- 1) What do learning communities need to achieve their goals?
 - Motivated/engaged patients and other stakeholders
 - Commitment of health system leadership
 - Consensus on shared statement of purpose and common agenda
 - Continuous communication among learning community members
- 2) How can the success of a learning community be measured?
 - Community member participation
 - Adoption by health systems
 - Identification, adaptation, implementation of intervention strategies
 - Intervention strategy reach, fidelity, and effectiveness
- 3) Who should provide resources needed to support and sustain a learning community?
 - Public health grants
 - Private foundations
 - Health systems
 - Private payers
 - Communities

Dr. Winn suggested that in the future, RCaDES Initiative staff could arrange to have meetings in the community, in addition to those that take place in health system locations. Dr. Studts noted that in terms of LCa screening, it would be important to focus more attention on understanding the at-risk populations' views of screening, including stigma, perceived bias against smokers and former smokers, and fatalism. They speakers agreed the RCaDES Initiative *opportunities* are substantial. As explained by Dr. Studts, "Persons at risk for lung cancer represent a unique community of individuals that has not been targeted for LCa education and screening in the past. This initiative is a unique effort that can be transformative." Potential *threats* to the success of the RCaDES Initiative included the need to obtain continued support for the learning community, the challenge of encourage health system leadership

to embrace the PASACs as a resource to guide the adaptation and implementation of screening activities, and the problem of catalyzing cooperative efforts involving health systems and payers.

The afternoon session of the conference consisted of roundtable discussions on supporting and sustaining a health-based learning community. Attendees were assigned to 4 groups (including a virtual group of NCI-designated cancer centers) to discuss three questions (see sidebar) designed to facilitate discussion and collaborative thinking about learning communities, their goals, the ways to measure their success and the resources needed to support and sustain them. Each group reported out key points from their discussions at the close of the session (Table 3).

The RCaDES Initiative 2nd Annual Conference provided a unique opportunity

for members of the learning community to share both with each other and all conference attendees the opportunities and challenges that lie ahead to increasing both CRC and LCa screening in health systems and how working together can move this needle forward more efficiently.

If you are interested in learning more about the RCaDES Initiative, and if you would like to become a member of the learning community, please email rcades@jefferson.edu.

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The 2nd Annual Philadelphia Trauma Training Conference Preventing Childhood Trauma and Its Impact Across the Lifespan: An Interprofessional Agenda for Providers, Advocates, Policy Makers and Community Members July 23-25, 2018

Nearly one in eight children (12 percent) have had three or more negative life experiences associated with levels of stress that can harm their health and development, according to Child Trends, a national research organization based in Washington, DC. Unfortunately, many health and human service providers do not have adequate skills and training to identify, mitigate, and address the complex health and psychological needs of trauma-affected clients and patients.

To address this significant unmet need, the Community and Trauma Counseling

Program of Jefferson (Philadelphia University + Thomas Jefferson University) has organized and will host the Second Annual Greater Philadelphia Trauma Training Conference, to be held on Jefferson's East Falls Campus on July 23-25, 2018, with special post-conference workshops available on July 26.

The program will offer intensive, discipline-specific trauma training; exposure to innovative practice models; and opportunities for cross-sector, interprofessional case conceptualization and planning.

The program is for professionals and paraprofessionals working in the following fields: medical, healthcare, mental health, justice, child welfare, early childhood and K-12 education, and philanthropy, as well as lay people invested in the health of their communities. Continuing education credits will be available in a variety of disciplines.

For more information or to register, visit: EastFalls.Jefferson.edu/PTC.

POPULATION HEALTH FORUMS

Community-Based Population Health Research: A Report from the Field

Sharon L. Larson, PhD
Executive Director

Norma Padron, PhD, MPH
Associate Director
Main Line Health System
Center for Population Health Research
Lankenau Institute for Medical Research

Trina Thompson, DrPH, MPH, BSN
Executive Director

Marquita Decker-Palmer, MD, PhD
Associate Director
1889 Jefferson Center for Population Health

April 11, 2018

This Forum highlighted the work of the 1889 Jefferson Center for Population Health and Center for Population Health Research (CPHR) at Lankenau Institute for Medical Research (LIMR).

Leaders from both research centers provided an overview of the history and purpose of the centers and described accomplishments and current initiatives. These centers exemplify health partnerships between academia (College of Population Health), research, and community.

Sharon Larson, PhD, Executive Director of CPHR, kicked off the session by offering a foundation for the work of both centers. She described the Learning Health Approach, which is focused on **knowing** – characterizing the groups of people served; **learning** – identifying the needs of the populations and best practices for addressing health, wellness, and prevention; **doing** – developing relevant strategies and interventions to improve the quality of care and outcomes for populations in partnerships with consumers, communities, providers, healthcare organizations, payers, and others. She went on to point out the importance of **learning some more** – assessing what is working and what isn't working.

Trina Thompson, DrPH, MPH, BSN, Executive Director of the 1889 Jefferson Center for Population Health gave an overview of the young Center, which was the result of a philanthropic donation from the 1889 Foundation, Inc to Jefferson College of Population Health. The mission



Left to right: Norma Padron, PhD, MPH; Sharon Larson, PhD; David Nash, MD, MBA, Marquita Decker-Palmer, MD, PhD; and Trina Thompson, DrPH, MPH, BSN

of the Center is to improve health and wellness by building resilient communities through collaboration, research, and education. Located in Johnston, PA, the Center is primarily focused on improving health in Cambria and Somerset counties in southwestern PA. Based on an analysis of local data and community interviews, it was decided that priority health areas would be: diabetes, obesity and inactivity; tobacco, drugs, and alcohol, and mental health.

Thompson explained that the Center is not an "implementer" but rather a "facilitator." There are many organizations in the region working to improve health, but they are working independently from one another, often with the same goals. The Center hopes to bring those organizations and communities together to work collaboratively and increase their impact. The Center is also seeking to partner with organizations that have had demonstrated success in implementing evidence-based programs to serve as a consultant or mentor. The Center also aims to build a

health related infrastructure by bringing in initiatives that will help the community.

Marquita Decker-Palmer, MD, PhD, Associate Director of the 1889 Jefferson Center for Population Health, described the details of various tools and research methods used to assess community -reported health priorities that will inform the Center's strategic plan. She found the "free list" qualitative research technique to be very helpful. This method is based on the assumption that the first item a respondent places on a list may carry the most importance. In interviews participants were asked to: list the things that improve your health; list the health problems that affect you; and list the things that make it hard for you to stay healthy. Dr. Decker-Palmer explained that one of the surprising findings was that both populations of adults 65+ and 18-64 identified work and occupational concerns as being very important. Younger adults stated that motivation was a barrier to health while older adults identified aging

as a barrier. She emphasized that this type of assessment is important in focusing future health interventions and developing community buy-in.

Dr. Larson described the environment of CPHR as being very different from the 1889 Jefferson Center. Because CPHR is embedded in a clinical system, it is very important to forge partnerships that engage clinicians in telling important population health stories. Lankenau serves two very different populations – one that is urban with striking health disparities, and the other that is suburban with mostly high socioeconomic status – which creates some distinct differences and needs. For example, it is no surprise that the lower socioeconomic area had greater challenges accessing affordable medications than their higher socioeconomic counterparts.

CPHR is involved with many initiatives; one that has generated a great deal of discussion has been a CPHR's scientific review of safe injection facilities conducted in conjunction with the Philadelphia Department of Health and the Mayor's Opioid Task Force. The [report](#) was published in December 2017 and showed that these facilities can in fact save lives but that tailored, evidence-based strategies must be considered when implementing harm reduction program. Other research topics that CPHR has

been tackling include: human trafficking, emergency department utilization, women's heart health, and cancer and care coordination. Challenges they have faced include: identifying silos and potential partners; data access and development; staffing, and funding.

Norma Padron, PhD, MPH, Associate Director of CPHR, talked specifically about ED utilization and what is referred to as "unscheduled" care. Padron created a population health dashboard prototype to convey what the center could do. She started by aggregating and pulling information from various sources, looking at designs and tools used in other settings. Padron then used the data to outline geographic variations in ED utilization in the five southeastern Pennsylvania counties. She pointed out that for this type of research center in this setting, it is not only important to outline the problem, but to use evidence based strategies to connect the dots. Padron concluded by explaining that the model of the CPHR could be very valuable to other health systems with huge opportunities for multi-sectoral collaborations.

The Forum was followed by the Grandon Society Workshop, which afforded members the opportunity to engage with the speakers in more detail with an interactive discussion. Dr. Nash initiated the session by asking the

panel, "what would you like to see happen in two years, what will you tell us about your work?" Dr. Larson responded with the idea of helping the health system figure out where the vulnerabilities are by providing them with the data. "We are the detectives that help figure out where's the data, how do we tell the story, and does it reflect what we thought it would reflect." She described the idea of a farm that would grow fresh fruit and vegetables, but the challenge is knowing how it would produce change.

Dr. Thompson described the challenges of collecting data in rural areas and believes that the Center could be the collector of new rural health data in the region. She also described the need for a cultural shift and education moving toward health. Thompson would like to see new ways of transporting people in her region, with more opportunities to access areas for walking and activity.

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

To learn more about the Grandon Society visit: Jefferson.edu/GrandonSociety

JCPH PRESENTATIONS

Bartolome L. Utilization of non-opioid pain therapies prior to initiating an opioid among chronic opioid users across multiple employer plans. Poster presented at: Academy of Managed Care Pharmacy, April 23-26, 2018, Boston, MA. *Poster received a silver ribbon recognition.*

Decker-Palmer M. Bayesian network meta-analysis of breast cancer utilities – an innovative approach to evidence synthesis. Presented at: Society for Medical Decision Making 39th Annual Meeting, October 24, 2017, Pittsburgh PA.

Ekije N, **Frasso R**, Andy U, Flick L, Markland A, Arya L. Diet modifications in older women with fecal incontinence: a qualitative study. Presented at APHA, Nov. 4-9, 2017.

Frasso R, Buckshire K, Garg P, Ivins R, Thompson M, Hexem K. Oral health: understanding the LGBTQ experience. Presented at APHA Annual Meeting, Nov. 4-9, 2017.

Frasso R, Godissart C, Martinez A, Siddiqui H. Public health: an overview and new view. Presented at: Penn State, April 4, 2018.

Frasso R. Public health: the lens, the mission, the tools. Presented at: Rutgers University, March 20, 2018, Camden, NJ.

Frasso R. Public health professionals: what do we know? Presented at Rider University, April 6, 2018, Lawrenceville, NJ.

Frasso R. Public health: the lens, the mission the tools. Presented at Philadelphia College of Osteopathic Medicine, March 19, 2018.

Frasso R. Social determinants of health: addressing the needs of every patient. Presented at: 45th Annual LSMA Northeast Regional conference, February 17, 2018.

Haltzman B, **Leader A, McIntire RK.** A qualitative investigation of the relationship of social capital and health amongst older adults in the Kensington neighborhood of Philadelphia, PA. Presented at: APHA Annual Meeting, November 4-9, Atlanta, GA.

Harris D. Best in class collaboration models with Pharma for improving population health in chronic conditions. Panel presentation at: 18th Population Health Colloquium, March 20, 2018, Philadelphia PA.

Harris D. Keynote address at PopHealth 18 Summit, University Hospital, March 26, 2018, Newark NJ.

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Continued from page 21

Harris D. Keynote address at Healthcare Business Academy Fellowship Program, March 23, 2018, Rochester, NY.

Juon H, **McIntire RK**, Lake M, Barta J. Racial differences of Lung-RADS among patients enrolled in a lung cancer screening program. Presented at: American Society for Preventive Oncology, March 2018, Chicago, IL.

Padron N. Collaborative design of tools to assess and prevent algorithm bias: the context of health care. Presented at: 2018 Health Datapalooza, April 26-27, Washington, DC.

Paniagua-Avila MA, **Frasso R**, Calderon TA, Bream K, Barg F. Social, emotional, economic and physical factors that influence type 2 diabetes mellitus self-management in a Guatemalan indigenous Tz' utujil community. Presented at: APHA Annual Meeting, November 4-9, 2017.

Rutkowski-Urban T, **LaNoue M, McIntire RK.** Associations between social capital and health in Kensington, Philadelphia. Presented at: Association for Prevention Teaching and Research, April 2018, Philadelphia, PA.

Saeks C, Karamanian V, Curry A, **Frasso R.** A qualitative study of food pantry patron experiences in Philadelphia. Presented at: APHA Annual Meeting, Nov. 4-9, 2017.

Scalzo L, **McIntire RK**, Juon, H. Borders and blood pressure: understanding the role of acculturation in a hypertension diagnosis among Hispanic Americans: 2014 California Health Interview Survey. Presented at: APHA Annual Meeting, Nov. 4-9, Atlanta, GA

Segal A, **Frasso R**, Sisti D. Is it jail or a hospital? Ethical conflicts in correctional mental health care. Presented at: APHA Annual Meeting, November 4-9, 2017, Atlanta, GA.

Skoufalos A. Developing your team to meet local needs. Presented at: Population Health Webinar Series, UCB Pharma, May 4, 2018.

Stockbower G, D'Alonzo B, Solomon S, Dupuis R, Lawman H, Mendelson A, Cannuscio CC, **Frasso R.** Urban gardening: keeping it safe, healthy and fun through the development of an urban gardeners' handbook in Philadelphia, PA. Presented at: APHA Annual Meeting, November 4-9, Atlanta, GA.

Thompson T. Meeting the needs of rural and urban communities at the 18th Population Health Colloquium, March 20, 2018, Philadelphia, PA.

Walsh K. ACMQ's Population Health Intelligence: What does big data tell us about quality and safety. Presented at: ACMQ webinar, March 27, 2018.

Weigelt D, **Frasso R**, Facund R, True J. Reintegration: using photovoice to explore veterans experiences after war. Presented at: APHA Annual Meeting, Nov 4-9, Atlanta, GA.

When Online Faculty Meet in Person: The CATS program

The Jefferson College of Population Health develops online faculty through a systematic program of course authoring and teaching support known as 'CATS'. Comprised of both online and face to face meetings with College administrators and faculty, CATS program activities culminate each fall and spring term with a working dinner held on campus—the CATS dinner. At these events program-level meetings held with Program Directors in the late afternoon lead in to a meeting of the whole conducted over dinner to address a selected general theme.

In recent years, the dinner's themes have included the role of virtual office hours in online environments, options for enhancing online lectures, and the use of grading rubrics online. Importantly, these CATS dinners also provide an opportunity for online instructors to share experiences and learn what is working for other instructors while coming together in person with administrators to discuss College news.

At the latest February gathering, the faculty were joined by Dr. Juan Leon, Director of Online Learning, Dr. Billy Oglesby, Associate



Photo by Lisa Chosed

Dean for Academic and Student Affairs, and Dr. David Nash, the Dean of the College of Population Health. After updates from Dean Nash on strategic planning and opportunities afforded by the merger with Philadelphia University, Dr. Leon highlighted successes program graduates have had with their Capstone Projects, and he explored with the group the various ways online instructors can provide the 'rich feedback' to students that supports that success.

The faculty in the room, as well as those participating via web conference, broke

off into separate groups to discuss individual approaches to providing feedback to students and implementing workable methods for any challenges they come across in their classes. Dr. Oglesby concluded the evening explaining plans for redevelopment of certain courses to accommodate students wishing to move more quickly through the online curriculum.

All in all, these sessions end up being professionally enriching for the faculty and administration due to the exchange of ideas,

and the opportunity to have some social engagement with each other outside of the semester-to-semester responsibilities.

In addition, the future of CATS will be an attempt to bring together all on-site faculty with the instructors who teach primarily online. The goal will be to encourage all instructors to more

effectively utilize online educational technology across the College.

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Investiture of Dr. Trina Thompson as the first Victor Heiser, MD Professor of Population Health

Excerpt from Executive Vice President and Chief Development Officer, Elizabeth Dale's speech.

We are truly honored to welcome a great American, a narrator, and historian Mr. David Mc Cullough. Mr. McCullough has been called America's greatest storyteller, which is really just a way of saying he's a national treasure. I'm a huge fan! My favorite quote – a timeless bit of McCullough wisdom – "history is a guide to navigation in perilous times."



Mr. David Mc Cullough

The Johnstown Flood, which was Mr. McCullough's first book, is among my favorites. What's fascinating is, the disaster of the Johnstown Flood of 1889 that was recounted in his great book is now bound, in perpetuity to Jefferson.

Perhaps the most famous survivor of the flood was Dr. Victor Heiser, Jefferson



Left to right. Stephen Klasko, MD, MBA; David Nash, MD, MBA, Mark Tykosinski, MD, Trina Thompson, DrMPH, BSN; Susan Mann; and Elizabeth Dale

class of 1897. Dr. Heiser went on to circle the earth 17 times between 1903 and 1934 on public-health missions to combat malaria in the Philippines, hookworm in India, and disease in Egypt and China.

Dr. Heiser's name is now associated with Dr. Trina Thompson who is now invested as the first Heiser Professor, a professorship endowed by the 1889 Foundation. Congratulations to Dr. Thompson and

behalf of Jefferson, I extend our deepest appreciation to the 1889 Foundation for their gift of \$7.5M to improve lives in Johnstown.

That gift, like every gift to Jefferson, was born out of a bold vision to improve lives. That vision owes a great deal to Dr. David Nash who founded the first College of Population Health here at Jefferson 10 years ago.

Population Health Matters

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