

The
Robert
Wood
Johnson
Foundation
Quarterly
Newsletter

Minority Faculty Program Expanded, Renamed



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Looking for Breakthrough Ideas



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One Step At a Time



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Is America Prepared for Bioterrorism And Other Public Health Threats?

More than \$2 billion in federal funding has been committed for revitalizing the nation's aging public health system since the September

11th terrorist attacks, leading to a perception that America's long-neglected public health system is undergoing rapid and substantial improvements. But recent research shows most states still have a long way to go in preparing to respond to all kinds of health emergencies.

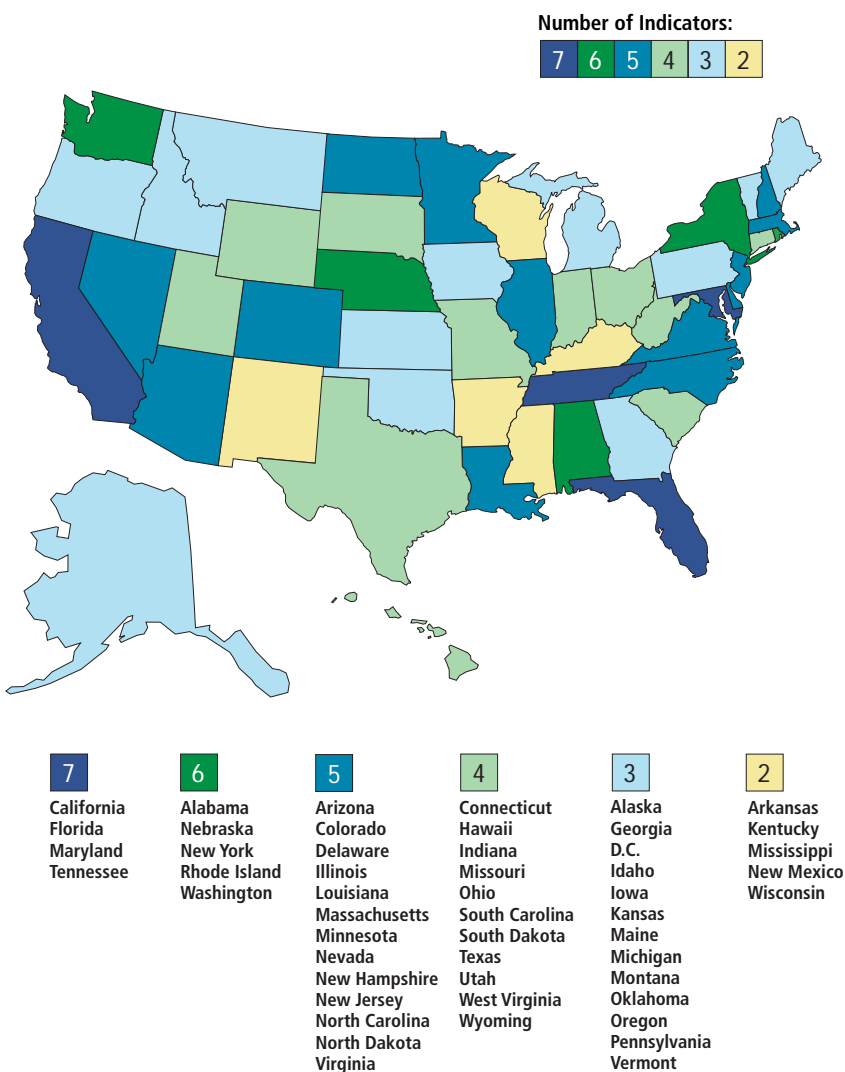
With support from The Robert Wood Johnson Foundation, Trust for America's Health (TFAH) examined 10 key indicators in each state and the District of Columbia to assess areas of improvement and areas of ongoing vulnerability in the nation's effort to prepare against bioterrorism and other large-scale health emergencies. The resulting report, "Ready or Not? Protecting the Public's Health in the Age of Bioterrorism," found that nearly 75 percent of states earned positive marks for only half of the 10 measures.

"Are we ready or not? The answer is not," says Shelley A. Hearne, Dr.P.H., executive director of TFAH, a Washington-based nonprofit, nonpartisan organization focused on community health and disease prevention. "Now is the time to get serious about developing an all-hazards approach to public health to ensure that we are ready for the

range of possible threats we face. The federal bioterrorism funds were an important first step. However, two years of increased funding cannot make up for two decades of underinvestment."

See **Bioterrorism**—page 2

Level of Public Health Preparedness
Based on how many of 10 indicators of preparedness each state met



Source: *Ready or Not? Protecting the Public's Health in the Age of Bioterrorism*, Washington: Trust for America's Health, 2003.

See the full report including an interactive state map at www.rwjf.org/news/preparedness.

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Major Findings

TFAH found a complicated and, at times, unsettling picture. The report discovered that, while states have achieved piecemeal progress, a full-scale effort to fix the nation's public health system is falling short.

According to the report, significant progress has been made in most states to expand their health emergency communications networks, upgrade public health laboratories and develop initial bioterrorism response plans. Among the accomplishments:

- Significant improvements have been made in emergency communications, with 89 percent of the U.S. population now covered by the Centers for Disease Control and Prevention (CDC) emergency communications network.
- Initial bioterrorism plans are now in place in all 50 states and the District of Columbia. However, these plans often consist only of an initial framework rather than specific action steps for emergency implementation.
- Preliminary laboratory equipment, facilities and staffing upgrades are occurring, but much more needs to be done. Only six states report having sufficient facilities.

The report also noted the following concerns:

- State budget cuts in nearly two-thirds of states threaten to undermine bioterrorism and other health-crisis readiness.
- Only half of states have spent 90 percent of fiscal year 2002 funds. Procurement problems, hiring freezes and shortages of trained workers contribute to the delays.
- Only one-third of states have passed along half of their federal funds to local health departments. State, local and city health departments often disagree on how resources should be distributed.

- Only two states are at the highest preparedness level required to receive and distribute pharmaceuticals and other medical supplies needed to provide emergency vaccinations and antidotes.
- Readiness for threats from infectious diseases and other health crises is in jeopardy, with only one-quarter of states having a plan to respond to a pandemic flu outbreak.

State-by-State Preparedness: Indicator Scores

TFAH's report examined every state's preparedness level in three general categories: funding, including state budgets for public health programs; public health infrastructure, including an examination of workforce, laboratories and communications preparedness; and "double duty" indicators that reflect how recent public health bioterrorism funding has affected traditional public health functions.

Collectively, the indicators provide a snapshot of improvements that have been made since September 11th and areas where the public health system is still vulnerable.

California, Florida, Maryland and Tennessee received the highest scores, achieving seven out of the possible 10 indicators. With two of 10 indicators met, Arkansas, Kentucky, Mississippi, New Mexico and Wisconsin had the lowest scores. More than 70 percent of states received scores of three, four or five.

National Approach to Public Health Protection

To ensure the nation does not squander this unprecedented opportunity to transform its outdated public health infrastructure into an efficient, accountable, responsive system that is prepared to respond not only to bioterrorism, but also to many forms of illness and injury, TFAH recommends the following actions:

- **Public health agencies must be battle-ready for all hazards, not just bioterrorism.** TFAH findings indicate progress in rebuilding the

public health system, and the nearly \$2 billion in congressional appropriations has had a noteworthy impact on initial efforts to modernize the nation's public health infrastructure. However, because the system has been underfunded for decades, achieving a battle-ready public health defense at the federal, state and local levels will take many years of sustained commitment, funding and oversight.

- **Establish health security requirements: Mandates and accountability to ensure all citizens are adequately protected.** To date, oversight of how the federal preparedness funding is being used has been insufficient. In fact, the CDC does not routinely track annual state and local appropriations for public health programs.
- **Convene a summit on the future of public health to develop a cohesive, national approach to public health protection.** The president, in consultation with Congress, should convene a summit that will develop a concrete vision for the future of the American public health system and the resources needed to make it a reality. The goal of the summit should be to produce a blueprint for the future, to redesign our public health system to meet this century's current and emerging health threats. At the same time, there should be a national dialogue on the resources required to implement the requisite changes and the need for accountability at every level of the public health system.

"The investments that we make in our public health system today need to be strategic, so that we cover the full spectrum of risk," says TFAH's Hearne. "Our hope is that bioterrorism preparedness is not just another specialized program; it's a commitment to modernizing today's health defenses."

Mentoring Medical Faculty from Historically Disadvantaged Backgrounds

For many medical students with an ethnic, financial or educational disadvantage, getting into medical school is only the beginning of a difficult struggle.

The Robert Wood Johnson Foundation began examining the issue of underrepresented minorities in health care professions around 1980. At that time, only 6.5 percent of entering medical students were from nonwhite backgrounds. These numbers dwindled even further as students progressed through their medical training periods, and evidence exists that such large drop-off rates are caused by a lack of adequate role models. In other words, minority medical students felt unable to turn to faculty or other senior physicians for advice and assistance.

“Once minority students got into medical school, their likelihood of staying in was compromised by inappropriate and grossly inadequate mentoring and guidance,” recalls James R. Gavin III, M.D., Ph.D., director of the *Harold Amos Medical Faculty Development Program* (AMFDP).

Although some nonminority medical faculty can and still do a conscientious job of shepherding minority as well as nonminority students, “you simply can’t speak to experiences that you never had,” says Gavin, who is president of the Morehouse School of Medicine and an RWJF Trustee. “That’s not an indictment, just a reflection of how we are partitioned as a society. We can either bemoan the fact that we have to take special steps to close gaps, or we can get on with it and try to change things.”

In 1983, the Foundation launched the *Minority Medical Faculty Development Program*, a program to help promising young minority physicians develop the research and publishing skills needed to gain medical faculty

positions. The program was recently expanded and renamed in honor of Harold Amos, Ph.D., director of the program from 1989 to 1993 and the first African American to chair a department at Harvard Medical School. AMFDP now offers postdoctoral research fellowships to 12 outstanding young physicians each year from historically disadvantaged backgrounds.

For four years, AMFDP fellows receive an annual stipend up to \$65,000, plus a \$26,350 annual research grant, to enable them to devote 70 percent of their time to research. The program also requires each fellow to establish a formal mentoring relationship with a senior academic, to make sure the young researchers get the institutional backing they need.

“The program helps at a critical point in your career, when you need support as a junior faculty member,” explains



Glenn Flores, M.D.

Glenn Flores, M.D., a fellow from 1997 to 2001, who is now an associate professor of pediatrics, epidemiology

and health policy at the Medical College of Wisconsin and a member of the program’s National Advisory Committee. “It gives you four years to develop as a researcher—to write your papers, write your grants and do all the important activities you couldn’t do otherwise.”

Arleen Brown, M.D., Ph.D., a fellow from 1999 to 2003, who is now an assistant professor of medicine at UCLA, agrees. “I love clinical



Arleen Brown, M.D., Ph.D.

work, but it’s hard to make big advances in your research if you’re seeing patients the majority of your week,” she says.

While all junior medical school faculty members are pressed for research time, “that need is higher for minority faculty,” Flores insists. “We’re presented with incredible time demands. Because there are so few minorities in academia, we’re often asked to be on committees—internal review boards, diversity committees. We have a perspective that still, unfortunately, is fairly unique. But every committee that you serve on means less time for research.”

The Foundation’s investment has clearly paid off in terms of medical research in a wide variety of disciplines. Flores, for example, recently studied a group of Spanish-speaking patients treated by English-speaking doctors and found that their language interpreters made frequent mistakes that could result in harm to the patients’ health. Brown is a co-principal investigator in a major multicenter study of how managed care systems influence outcomes for patients with diabetes.

AMFDP does more than provide needed research funding. It helps its fellows build relationships with senior scientists and minority faculty around the country. As part of the program, AMFDP holds an annual meeting, a required event for all fellows. Fellows present their research, attend career-development workshops, and network with other fellows and mentors.

“The meeting is just incredible,” says Giselle Corbie-Smith, M.D., M.S., assistant professor of social medicine at the University of North Carolina–Chapel Hill, who is a third-year fellow in the program. “The work that people are doing is cutting-edge in health services or biomedical or pure basic science. I feel very fortunate to be

able to hear this amazing work just as it is being published.”

More than a scientific conference, the meeting gives the fellows an opportunity to connect with other young physicians from similar backgrounds. “There are so few minorities in academics, and fewer still doing research,” Corbie-



Giselle Corbie-Smith, M.D., M.S.

Smith says. “Our nonminority colleagues don’t know the experience of being the only racial minority in a department or division. It’s

so rare to have the support of peers who have had that shared experience.”

In the 20 years since it began, AMFDP has helped to launch the careers of dozens of young faculty members—80 percent of whom have remained in academia.

“From the beginning, we were trying to fill a huge gap in the numbers of under-represented minorities in medical school faculties, a need that is no less urgent now,” Gavin says. “We’ve seen a large number of our people go on to penetrate the infrastructure of American medicine, assuming major national positions as health advisers, directors of major national institutes. People who were drawn to this program understood that they were expected not only to close these gaps, but to act as conduits for the recruitment of others like them.”

Currently, the Association of American Medical Colleges reports that only 4.9 percent of the nation’s 67,041 full-time medical faculty members are minorities. “One day we’d like it to be phased out, but given the statistics, it’s still a crucial program,” Flores says.

—ELIZABETH AUSTIN



A year ago, The Robert Wood Johnson Foundation conceptually organized its grantmaking into four measurable portfolios—targeted,

human capital, vulnerable populations and pioneer. While the Foundation has always funded pioneering efforts, it never before specifically set aside funding to directly pursue such efforts. Stephen Downs, RWJF senior program officer, leads the pioneer portfolio team. Downs recently discussed plans with *ADVANCES* for this new initiative.

Can you define pioneering?

Downs—The concept we use is to think about ideas and activities that could lead to breakthroughs in health and health care. Instead of ideas that represent the best we can do in the current environment, pioneering work is about ideas that can *change* the environment. We are looking for ideas that can be infectious, that don't require a lot of high-level agreement and policy change up front. Ideas that can be tested fairly independently and then spread quickly and easily because of their usefulness. We're looking for new thinking—like the story of the Gordian knot, where many had failed to untie the knot until Alexander came along and cut through it with his sword.

History is full of influential thinkers or artists whose ideas may not have been popular in their time but who greatly influenced their field for years to come. We are looking for people with that kind of vision, people who can imagine a better future and ways to bring that about.

The Pioneer Portfolio: A New Initiative

How do you engineer these kinds of breakthroughs?

Downs—You can't really engineer breakthroughs, and that is one of the challenges. It is about creating the environment for ideas, bringing fresh minds to the problems—even looking outside health and health care—and being able to recognize potential. These kinds of changes will involve a lot of trial and error, and we are comfortable with that. But it is a change of mind set for us to be able to look at work that has a reasonably high chance of failure and say "Let's go for it."

I think we will be surprised by the ideas that people bring us.

What role will the pioneer portfolio team play in fostering ideas?

Downs—We have talked about experimenting with a number of approaches. One is to provoke the field through solicitations—not for grant proposals, necessarily, but for problems to tackle or ideas to explore. Another is to convene unlikely collaborators—examining how advances in other disciplines could be brought to bear on challenges in health and health care. We also expect in some cases to engage directly with people and challenge them to think more expansively or aggressively.

What kinds of ideas are you seeking?

Downs—We are staying within the Foundation's mission of improving the health and health care of all Americans. Several Foundation policies apply to this portfolio as well: We do not support medical research per se, and, in general, we do not do international grants. Other than that, it's fairly open.

We don't recommend that people should send us fully developed proposals, but contact us with ideas in a developmental stage. We would like to hear from people who say "I have an idea about how to bring about this change," rather than come in with a 10-point plan, a budget and a timeline. That gives us an opportunity to interact more with the applicants and helps us learn how to foster pioneering work most effectively. We also will develop networks of people who bring expertise from a wide range of disciplines to help us evaluate ideas.

So you are encouraging people or organizations to approach the Foundation early in the formation of their ideas?

Downs—Yes, particularly in terms of proposal development. That is our thinking now. We are a work in progress. But I expect that we will be—and should be—a work in progress all the time. I expect as the year goes on, we will develop more specific mechanisms for bringing ideas to us, but we always want to keep the door open.

From whom are you expecting to receive ideas?

Downs—We want a broader-than-usual base of applicants. We want to make sure that we are getting a wide range of perspectives, so we are not closing our eyes to any potentially valuable ideas.

How would you like people to think of the pioneer portfolio?

Downs—As a chance to imagine the ideal health and health care systems of the future and to take a shot at creating them. People probably have preconceived notions about what the

Foundation would or would not fund. Rather than saying "Oh, I don't think RWJF would fund that," we would encourage them to think about it differently, to think that maybe the Foundation would support it through the pioneer portfolio.

There is a distinction to be made, though. The pioneer portfolio is not the place to support work that does not fit elsewhere at the Foundation. The ideas have to have "breakthrough" potential.

How large will the grants be?

Downs—We anticipate grants of all sizes, somewhat weighted to the smaller end (\$50,000 to \$100,000). We also see staging funding in such a way that initially we make a relatively small grant to develop the concept. If the first work is promising, then we would have the opportunity to support further development. Overall, the pioneer portfolio is a small percentage of Foundation assets, so at this time we do not expect to do many large grants.

If someone would like to propose an idea to the pioneer portfolio team, what steps should they take?

Downs—Send a short e-mail—just a page or two—to pioneerideas@rwjf.org.

—INTERVIEW BY
LAURIE JONES

To see summaries of more research funded by The Robert Wood Johnson Foundation, including links to the full text, visit the new RWJF Research Center at www.rwjf.org/research

Avoidable Pediatric Hospital Stays: Parents' and Physicians' Views

If you ask parents and physicians involved, most children's hospital stays classified as "potentially avoidable" could not have been prevented, according to a recent study. Yet researchers found that a substantial minority of visits might have been avoided had parents and children been better educated about the child's condition, medications, the need for follow-up care and how to avoid disease triggers.

Avoidable hospitalization conditions (AHCs) is a term used to describe hospital visits that probably could have been prevented with timely outpatient care. To determine how these hospitalizations might be avoided, researchers surveyed the parents, primary care physicians and inpatient attending physicians of more than 500 children admitted to an inner-city Boston hospital. Six conditions—asthma, dehydration/ gastroenteritis, pneumonia, seizure disorder, skin infections and urinary tract infections—accounted for 90 percent of all AHCs.

The proportion of AHCs varied between 12 percent and 46 percent, depending on who was asked. Only 25 percent of parents said their child's admission was avoidable, compared with 29 percent of primary care physicians and 32 percent of inpatient attending physicians. According to the researchers, if AHCs were defined by unanimous agreement, only 13 percent of cases would qualify,

whereas 46 percent of cases were categorized as AHCs by any one of the three sources asked.

While parents and physicians were more apt to blame each other for AHCs, they identified common measures for preventing them. Parents cited failure to follow medication directions as the single most common reason for AHCs; doctors largely agreed. But both parents

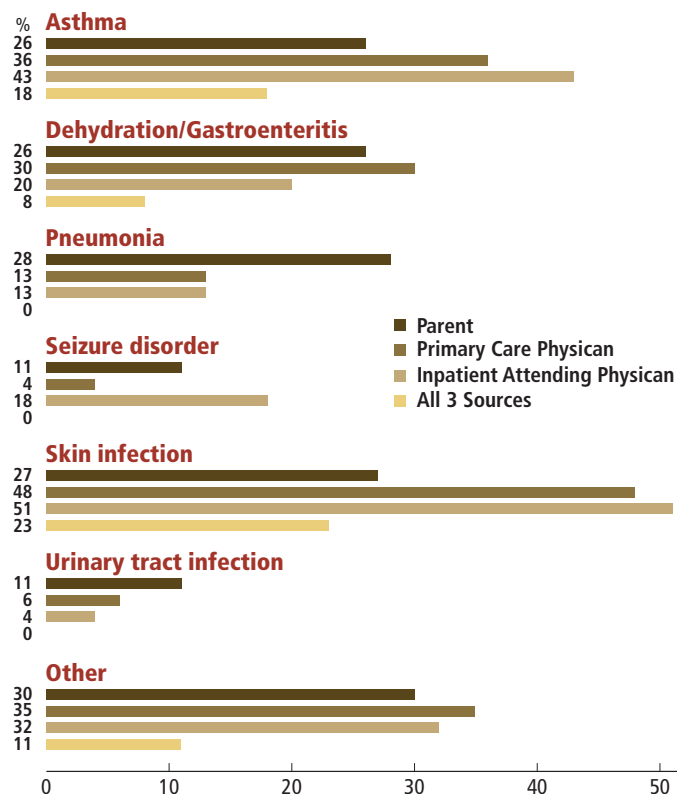
and physicians frequently noted that doctors dropped the ball in educating children and parents about the child's condition and how best to prevent medical crises.

The findings also suggest that many hospitalizations might be prevented by targeting at-risk populations. For example, adolescents, children with asthma, children from low-income working families and uninsured children were two to three times more likely to be hospitalized for an avoidable hospitalization.

Flores G et al. "Keeping Children out of Hospitals: Parents' and Physicians' Perspectives on How Pediatric Hospitalizations for Ambulatory Care-Sensitive Conditions Can Be Avoided." *Pediatrics*, 112(5): 1021–1030, 2003.

Glenn Flores, M.D., was a fellow in the Harold Amos Medical Faculty Development Program (formerly The Robert Wood Johnson Foundation Minority Medical Faculty Development Program) at the time of this research. He currently is a Robert Wood Johnson Generalist Physician Faculty Scholar.

Proportion of Hospitalizations Assessed as Avoidable



One Size Does Not Fit All in Getting Women from Diverse Backgrounds to Exercise

Physical activity is an important part of heart disease prevention and overall good health. Yet more than one-quarter of Americans are completely inactive, and trends are showing little improvement, especially among low-income and minority groups. Researchers in this study analyzed the results of a large survey of women from a variety of ethnic groups, looking for which factors either encouraged or discouraged them from exercising.

The survey went to thousands of white, African-American, Latina and Native-American women (ages 20 to 50) living in rural, urban and suburban areas. Women were asked which personal, social and environmental factors influenced their exercise patterns.

The study found that "only a few concrete similarities existed among the groups." Younger age, good health and confidence about exercising were the most frequently reported personal factors associated with women who exercise. Two social factors influenced exercise behavior both positively and negatively. Knowing people who exercise had a positive connection to physical activity among Native Americans, Latinas and rural

blacks. However, it had an opposite correlation for one group of urban Latinas and one group of urban black women. Similarly, rural whites, Native Americans and rural black women who attended religious services were all more likely to exercise than those who did not, whereas the association was the opposite for one group of urban Latinas.

When it came to physical environmental factors, while two urban black groups reported that street safety was an exercise deterrent, few other factors were mentioned, either positively or negatively, among all groups. When asked what environmental changes would encourage exercise, the most common answer offered across all groups was having access to facilities. The researchers suggest that access includes affordability.

Study authors recommend that the best way to get women from various backgrounds to exercise is to tailor interventions to the unique aspects of each cultural group.

Eyler AA et al. "Quantitative Study of Correlates of Physical Activity in Women from Diverse Racial/Ethnic Groups." *American Journal of Preventive Medicine*, 25(3Si): 93–103, 2003.

Unraveling Racial Disparities In HIV Mortality

If we are to eradicate lingering racial disparities in clinical outcomes, clinicians, policymakers and others must understand what lies behind them. This study looked at differences in survival rates among white and minority HIV-positive U.S. veterans.

Using national administrative data on survival for more than 5,600 white, black and Hispanic patients and in-depth clinical data from a longitudinal study of more than 800 HIV-positive veterans at three Department of Veterans Affairs (VA) Healthcare System medical centers, the researchers examined the role of four factors in racial disparities in survival: health status at study entry, use of clinical services, clinical management and adherence to HIV-related medications.

They found that black and Hispanic HIV-positive veterans have mortality rates that are approximately 40 percent higher than whites. These appeared to be explained by a greater severity of illness at presentation among the minority patients compared to their white counterparts. Based on physician prognoses from the longitudinal study (covering 1999 and 2000) almost 30 percent of white veterans were expected to still be alive in five years, compared to 22 percent of blacks and 14 percent of Hispanics. More black and Hispanic patients than white patients had four or more comorbid medical conditions (in addition to their HIV) and three or more HIV-related conditions. The investigators saw no significant differences in the number of outpatient visits, clinical management of the HIV or patient adherence to HIV medication by race. When these differences in severity of HIV and comorbid illness were included in an adjusted model of survival, the difference in survival between minority and nonminority patients disappeared.

Since there was evidence that minority patients might be coming into care later in their course of disease (as witnessed by their greater HIV and comorbid disease burden), the investigators also asked whether more minority patients were likely to be diagnosed during the course of an acute hospital stay rather than in the outpatient setting. Minority patients were substantially more likely to be first diagnosed with HIV as inpatients. Thus the authors conclude that delayed treatment for HIV among minority patients “may partially explain poorer survival.” To catch HIV earlier among minority patients and increase their survival rates, the researchers recommend HIV screening for minority patients who are already in care for other medical conditions.

McGinnis KA, Fine MJ, Sharma RK, Skanderson M, Wagner JH, Rodriguez-Barradas MC, Rabeneck L and Justice AC. “Understanding Racial Disparities in HIV Using Data from the Veterans Aging Cohort 3-Site Study and VA Administrative Data.” *American Journal of Public Health*, 93(10): 1728–1733, 2003.

Amy Justice, M.D., Ph.D., was a Robert Wood Johnson Generalist Physician Faculty Scholar at the time of this research.

Walking and Older Women: The Role of the Environment

As a group, women over age 65 are among the least physically active in the nation. More than half are sedentary, although modest increases in physical activity levels could help prevent osteoporosis, arthritis, heart disease and other common ailments.

Finding ways to increase physical activity has become a public health priority in the United States. An environmental approach holds promise. Some environmental factors—such as easy access to parks and walking trails—appear to be associated with higher levels of physical activity.

A recent study examined the effect of environmental factors on physical activity levels among older women: living within walking distance of common destinations and the overall suitability of their neighborhoods for walking. The investigators used data on 149 women with a median age of 74 from a 15-year follow-up evaluation of a 1982–85 walking intervention among 229 white women living in Pittsburgh. The follow-up included a comprehensive clinical evaluation of participants; measures of their health, functional status and physical activity levels; and a telephone survey about their neighborhood environment. Physical activity was gauged by questionnaire and a pedometer worn by participants for at least six days. Women were asked about the safety, aesthetics and overall quality of their neighborhoods, and their ability to walk to grocery stores, parks, churches, doctors’ offices, restaurants and other locations.

Walking was the most popular activity reported, and the most common destination was the convenience, deli or grocery store, followed by the park. Half of the participants lived within walking distance of at least four common destinations. Median walking and physical activity levels increased significantly when participants reported being able to walk to at least two destinations and then remained constant with each additional convenient destination. Based on pedometer readings, women who lived within walking distance

Accessibility and Popularity of Walking Destinations

Destination	Women within walking distance (20-minute walk) of destination % (N)	Women who walk to destination at least once/month % (N)	Walking trips to destination/month* Median (25th, 75th percentile)
Biking or walking trail	25.5 (38)	11.4 (17)	8 (1, 16)
Bus stop	77.9 (116)	11.4 (17)	3 (1, 8)
Café or coffee shop	55.0 (82)	8.7 (13)	1 (1, 4)
Church or other religious institution	45.6 (68)	14.1 (21)	4 (1, 8)
Community center	30.9 (46)	9.4 (14)	6 (1, 8)
Convenience, deli or grocery store	59.7 (89)	25.5 (38)	4 (1, 4)
Department, discount, or hardware store	20.1 (30)	8.7 (13)	4 (2, 4)
Library	30.2 (45)	12.1 (18)	3 (1, 4)
Park	46.3 (69)	20.1 (30)	4 (1, 16)
Post office	33.6 (50)	14.1 (21)	2 (1, 4)
Restaurant, pub or bar	52.4 (78)	17.5 (26)	4 (1, 8)
Any above destination	85.6 (128)	59.1 (88)	12 (4, 28)

*Number of walking trips/month to the designated destination for women who report walking to the designated destination at least once a month.

of a biking or walking trail; department, discount or hardware store; or park walked significantly more than women who did not.

A majority of women gave their neighborhood a favorable walkability rating. Women who gave their neighborhood a higher walkability rating engaged in more physical activity—and convenience of destinations factored into their walkability ratings.

The results suggest that “creating environments in which older women can make utilitarian walking trips from home” may increase their physical activity levels.

King WC et al. “The Relationship Between Convenience of Destinations and Walking Levels in Older Women.” *American Journal of Health Promotion*, 18(1): 74–82, 2003.

School-Based Program Helps Children with Posttraumatic Stress Disorder

Given the high rates of violence in many neighborhoods, school officials are becoming more familiar with the phenomenon of posttraumatic stress disorder (PTSD) and its crippling effect on children. The majority of children who either witness or experience violence display symptoms of PTSD and depression, which include nightmares, emotional numbness, acute fear and anxiety, depression (not PTSD), avoidance, and, in some cases, thoughts of suicide (not PTSD). One 10-week, school-based intervention has been shown to significantly lessen many of these effects.

Researchers working with the Los Angeles public schools designed a group therapy program for use by school-based mental health clinicians to treat students with clinical levels of PTSD. The program served 126 sixth-graders in two schools in low-income neighborhoods.

Psychiatric social workers used cognitive behavioral techniques to get students to remember their

trauma, understand their symptoms, and develop relaxation techniques and other strategies to prevent relapse. Students met in small groups (five to eight students each) once a week for 10 sessions.

Students were measured according to their own reports of PTSD symptoms and depression, parents’ reports of problems, and teachers’ reports of classroom behavior and learning problems. Sixty-one students were given the program immediately. The remaining 65 students waited three months to begin the program.

After three months, students who had gone through the program scored significantly lower on symptoms of PTSD and depression than those who had not yet started. Researchers describe the program’s impact on PTSD symptoms as very large, and as moderate for symptoms of depression. Parents’ reports of dysfunction were also lower for the students who participated, but teachers’ reports were no different between

Better-Educated Nurses Increase Patients' Odds of Surviving Surgery

Surgical patients have a better chance of survival in hospitals with more highly educated nurses, according to a recent study.

Researchers linked data for more than 230,000 surgical patients discharged from 168 Pennsylvania hospitals to data on nurses' education, staffing ratios and other factors. They examined the association between nurses' levels of education and deaths within 30 days of hospital admission, both among patients with and without complications.

They found that the higher the rate of nurses with bachelor's degrees, the lower the risk of post-surgical death. Each 10 percent increase in the proportion of nurses with higher degrees decreased the risk of mortality and "failure to rescue" (when a patient with complications dies) by 5 percent.

The results imply that increasing the percentage of hospital nurses with bachelor's degrees would substantially lower mortality rates. For example, if the proportion of nurses with bachelor's degrees in all hospitals increased from 20 percent to 60 percent, the study projects 3.6 fewer deaths per 1,000 patients and 14.2 fewer deaths per 1,000 patients with complications.

Previous research suggests that nurse executives in teaching hospitals prefer that 70 percent of their nurses have bachelor's degrees, a rate that is currently at about 50 percent. While community hospital nurse executives prefer to have 55 percent of their registered nurses with bachelor's degrees, only 11 percent of the Pennsylvania hospitals studied met this standard. Among the hospitals studied, the proportion of nurses with at least a bachelor's degree ranged from 0 to 77 percent.

The study has implications for dealing with the current nursing shortage. Public policy discussions have focused on how to increase the supply of nurses. While lower nurse-to-patient ratios correlate with improvements in patient safety, little attention has been paid to the benefits of investing in nurse education.

Aiken LA et al. "Educational Levels of Hospital Nurses and Surgical Patient Mortality." *Journal of the American Medical Association*, 290(12): 1617-1623, 2003.

students who completed the program and those who had not yet started. (Researchers suggest there may be a lag time between students' emotional improvement and progress in classroom behavior.)

At six months, the students who initially received the program were doing as well as they had been when the program ended, and the students who had waited three months to begin the program had improvement comparable to the students who had first gone through the program.

Stein BD, Jaycox LH, Kataoka SH et al. "A Mental Health Intervention for Schoolchildren Exposed to Violence," *Journal of the American Medical Association*, 290(5): 603-611, 2003.

Bradley Stein, M.D., Ph.D., and Sheryl Kataoka, M.D., M.S.H.S., were Robert Wood Johnson Clinical Scholars at the time of this research.

Does Diabetes Care Differ by Race?

Increases in the prevalence and burden of diabetes among young and old in the United States have put the disease in the spotlight. Black Americans in particular suffer more complications and die more often from diabetes than white Americans. What lies behind this racial disparity? To answer this question, these investigators looked at care processes and treatment intensity for 801 white patients and 115 black patients with diabetes in 21 facilities in the Department of Veterans Affairs (VA) Healthcare System. Because VA patients have equal health benefits, the researchers were able to rule out access to care as a contributing factor.

In their analysis, the investigators used survey data on patients' health, medical care, diabetes self-management and demographics. In addition, during 1999 and 2000, trained abstractors collected information on the type and intensity of diabetes care patients received inside and outside the VA Healthcare System. They looked at five care processes and three outcome measures commonly used in most quality measurement systems in the United States, including receipt of an eye or foot exam, blood pressure readings and LDL cholesterol level. The investigators also examined national VA data on the racial composition of each facility's patient population to understand whether "facilities with a higher ratio of black patients have lower quality and/or whether blacks receive poorer quality [care] regardless of the racial composition of their facility."

Their analysis showed no significant differences between black and white patients in the overall use of health care services or the average number of outpatient visits. However, the quality of diabetes care for black patients was significantly lower than for white patients for two of the five care process measures: receipt of an LDL test and a dilated eye exam. In fact, within the same facility, black patients were more than 50 percent less likely to receive an LDL test. The racial disparity in eye exams was ultimately attributable to black patients more often receiving care at facilities with overall lower rates of eye screening. Across all facilities, black patients with diabetes had higher blood pressure readings than white patients, although they were more likely to take at least three blood pressure medications.

The authors conclude that "deficiencies in medical care could indeed contribute to worse outcomes for black patients with diabetes." They suggest that "measures to improve the overall quality of diabetes care could also reduce disparities in receipt of services within facilities."

Heisler M et al. "Racial Disparities in Diabetes Care Processes, Outcomes, and Treatment Intensity." *Medical Care*, 41(11): 1221-1232, 2003.

Michele Heisler, M.D., M.P.A., was a Robert Wood Johnson Clinical Scholar at the time of this research.

Quality Improvement in Community-Based Care

Although quality improvement efforts have made significant headway in institutional settings such as hospitals and nursing homes, community-based long-term care has not fared as well. These programs offer a variety of services—including home health care, adult day care, transportation and home-delivered meals—to impaired elderly and disabled clients to help them remain in their homes. What is the biggest obstacle to implementing quality improvement strategies in this setting? Primarily, demonstrating improved outcomes and health status for such a significantly impaired population. However, improvements in client satisfaction and meeting clients' needs are possible, and desirable.

In 1995, the Indiana Bureau of In-Home Services installed a computerized management information system in all of its Area Agencies on Aging, which manage the public and Medicaid community-based long-term care programs in the state. Simultaneously, researchers implemented and evaluated two computer-assisted quality improvement strategies: one that assessed client needs and how well those needs are met (the needs-focused strategy) and a second that provided systematic feedback on client satisfaction to vendors providing the in-home services (the satisfaction-focused strategy). Investigators conducted a randomized controlled trial of more than 1,000 clients to test the effects of the two strategies—alone, in combination and in comparison to care as usual.

Through a series of telephone interviews conducted in late 1995 through early 1997, the investigators evaluated how well clients' needs were met and how satisfied they were with services. Across the board, there were only small gains in satisfaction and meeting needs. The only clients reporting an improvement in needs being met were those in the needs-focused strategy group. However, client satisfaction was higher among clients in both the needs-focused and satisfaction-focused quality improvement groups, compared to care as usual. Interestingly, the combination group—which used both quality improvement strategies—showed no significant change in satisfaction or needs being met. The investigators suggest that the "burden on case managers of using both strategies might have inhibited the complete implementation of either strategy."

The authors conclude that it is possible to implement quality improvement strategies in a community-based care setting with demonstrable results, and suggest that these efforts should be "supported and promoted."

Kinney ED et al. "A Randomized Trial of Two Quality Improvement Strategies Implemented in a Statewide Public Community-Based Long-Term Care Program." *Medical Care*, 41(9): 1048-1057, 2003.

Taking Steps to Restore Tribal Fitness

One step at a time. That is all it takes to walk into health.

That is the message Nancy Campbell brings to the residents of the Coeur d'Alene Reservation near Plummer, Idaho. Campbell should know. As the walking instructor for the Coeur d'Alene Tribal Wellness Center, she spends her days counting people's steps, about 1.6 million a day, adding them up and posting them on a large billboard on the reservation for all to see.

Campbell is playing a key role in the wellness center's "Enhancing a Community Through Physical Activity" project, supported by The Robert Wood Johnson Foundation. The program is designed to increase the physical activity of residents on the reservation and surrounding Benewah County, where 26 percent of residents smoke, 15 percent engage in binge drinking and 64 percent are overweight, all statistics higher than the national average.

The county's health problems are exacerbated by its economic ills. Fourteen percent of its residents live in poverty, and the county has one of the highest unemployment rates in the state, more than double the national rate. While Campbell can't resolve all those issues, she can help residents improve their physical activity levels—and thus their health—one step at a time.

For Nancy Campbell, the wake-up call came when she turned 40 in 1999. She knew she needed to lose the extra weight she'd put on after having three children and living a fairly sedentary life. So she decided to check out the 43,000-square-foot, \$5-million Coeur d'Alene Tribal Wellness Center that had recently opened six miles from her house. There she found a five-lane lap pool, basketball and racquetball courts, an indoor walking track, and programs in physical and cardiac therapy.

She started walking on the treadmill and around the track, gradually working her way up to running, and today notes that not only has she lost 25 pounds, but in August 2003 she participated in her

first triathlon. "I feel better than I did 15 years ago," she says.

Today, the center, which opened in 1998, boasts 1,464 members, a little over one-third of them from the Coeur d'Alene and other tribes, according to Cheryl Weixel, the wellness center's director.

That's still a small percentage of the 1,500 tribal members and 10,000 residents who live in the surrounding area, many of whom get little or no physical activity. So the idea of the walking program was born.



Nancy Campbell records, then resets pedometers for youths participating in the Coeur d'Alene Tribal Wellness Center walking program.

The walking program began in October 2002 with a very simple logo: "1+1=1." The message: "One step at a time, plus one foot in front of the other, equals one community moving together." The center purchased 1,500 digital pedometers (one for each tribal resident), rented a billboard in nearby Worley and hired Nancy Campbell, who had been working in an administrative position for the tribal council.

The idea behind using pedometers for physical activity comes from research showing that the small gadgets, which are worn on the waistband, make physical activity fun, tapping into people's competitive streak by enabling them to compete against others or themselves. For instance, one study

found that when a group of sedentary people were given a daily goal of 10,000 steps of brisk activity as measured by a pedometer, their fitness level, blood pressure and body fat improved just as much as a group that followed a traditional gym-based aerobic program.

Every week, Campbell visits the Coeur d'Alene schools, collecting steps from all the children and resetting their pedometers to zero. Most kids, she says, walk between 100,000 and 200,000 steps a month.

She also spends one day a week sitting in a conference room at the tribe's largest employer, the Coeur d'Alene Casino/Hotel, waiting for employees to visit her and "turn in" their steps. Most adults log between 300,000 and 400,000 steps a month.

Since she began collecting step counts in November 2002, Campbell has entered more than 500 million steps on the enormous spreadsheet on her computer. By late summer 2003, the tribe was halfway towards its billion-step goal, with about half the original 1,500 people who received pedometers still participating. Beyond the number of steps, the program's goal is to have at least half of tribal residents engaging in routine, moderate physical activity.

"It's a really fun job," says

Campbell, who tracks about 100,000 steps a week herself. The best part is working with the community, she says. "I wanted to work with them in a positive way, in a healthy way, and maybe in some tiny way do something to help my community members."

Tribal participants in the walking program get their steps in unique ways, says Campbell. For example, instead of just one person going into a store, the whole carload goes just to get the extra steps. At the casino, employees walk the entire length and breadth of the complex, a distance of about six football fields. They're usually surprised at how the steps add up, just from changing some of their regular, day-to-day activities without adding formal exercise.

Although the program deliberately doesn't track participants' weight or health, Campbell says she can see the changes. One woman, who was significantly overweight and had a heart condition, told Campbell she had lost 40 pounds. The lost weight means she not only feels better physically, but can now do her housework.

One of the program's most active participants is 72-year-old Lucille Bassah. Even though she is the tribe's mail courier, Bassah gets little exercise from her job since she rarely has to leave her truck to deliver the mail. Today Bassah walks at least 100,000 steps a week, about 47 miles. She does it by walking every chance she gets. Even before the new golf course at the tribal casino officially opened, Bassah was out walking its trails—a seven-mile, or 14,000-step, jaunt. Like many on the reservation, Bassah has gotten competitive about the steps, trying to beat a younger employee with whom she works.

When Campbell asked Bassah what the walking had done for her, the answer came easily and immediately: "It's changed my life."

—DEBRA GORDON

For more on the Foundation's Active Living, Obesity and Nutrition program work, see www.rwjf.org/programs/physicalactivity.jsp.

Obesity Epidemic: What to Do?

Obesity is—literally—the biggest health problem in America today. According to the Centers for Disease Control and Prevention, 64 percent of Americans are overweight, resulting in 300,000 preventable deaths each year. And those numbers are likely to increase as today's obese children grow into adults.

“When we talked to experts across the nation, particularly pediatricians, they tell us that children are getting obese at younger and younger ages,” says Jeane Ann Grisso, M.D., Sc.D., senior program officer for The Robert Wood Johnson Foundation. “It’s really dramatic.”

The trouble is, there’s no single “obesogenic” factor causing America’s epidemic of overweight, Grisso says. Instead, patients, doctors, parents, teachers and health advocates are all struggling to find ways to identify—and vanquish—the

most important causes of the nation’s rapidly expanding waistline.

To get a better-informed look at the causes and possible cures of childhood obesity, RWJF commissioned a study of children’s in-school eating and exercise habits, *Healthy Schools for Healthy Kids*. Two national polls—one of 600 parents of school-age children and one of 500 public school teachers—found that parents and teachers overwhelmingly agree that schools could do much more to help kids make healthier choices. For example, 86 percent of teachers and 83 percent of parents oppose allowing soda and candy machines in elementary schools. Parents and teachers also believe strongly that kids who get plenty of exercise learn more and behave better in school.

The polls were buttressed by research on state laws and school district policies on nutrition and physical education. Overall, the results weren’t encouraging; one federal report found that 93.6 percent of senior high schools are equipped with vending machines and snack bars that sell soft drinks and other sugary beverages. In 2000, half the nation’s school districts had granted contracts giving soft drink companies the right to sell their products on school grounds, and almost all districts make money from vending machine sales.

But researchers did find some promising local and state programs that may work as models for schools nationwide. In California, the Strategic Alliance—a consortium of organizations working to improve children’s nutrition and physical fitness—won a ban on soft drinks in the Los Angeles Unified School District. The Opelika City School System in Alabama stopped offering fried foods in its cafeterias a decade ago, and a closed-campus policy keeps high school students from going on junk food runs at lunchtime.

“Schools are part of our focus,” says Grisso, “but we want to think about the environments that families face, especially low-income families. We need to ask, ‘What options do they have?’”

A different set of questions faces researchers working to reduce adult obesity. While grown-ups have more control over their schedules and their diets, they also may be more resistant to advice on diet and exercise.

To aid doctors in finding better ways to help their obese patients, the American Medical Association, in partnership with the U.S. Department of Health and Human Services, has published *Assessment and Management of Adult Obesity: A Primer for Physicians*. The 10-booklet primer, funded by a grant from RWJF, offers a wide range of advice on obesity management, including tips on how to make a doctor’s office feel more comfortable and inviting to overweight patients; questionnaires and checklists for physicians to use to assess their obese patients’ lifestyles and emotional issues; and practical advice on how to create targeted, effective strategies for individuals to reach a healthier weight.

“This primer is an important tool in helping physicians halt the epidemic of obesity in this country,” says Michael McGinnis, M.D., M.P.P., an RWJF senior vice president. “When you consider that nearly two out of three adults are overweight, and that parental obesity is a strong predictor of childhood obesity, it is critical that doctors are skilled in obesity prevention, screening and treatment.”

—ELIZABETH AUSTIN

For more information and a copy of the report *Healthy Schools for Healthy Kids*, visit www.rwjf.org/special/healthyschools.

For a copy of *Assessment and Management of Adult Obesity: A Primer for Physicians*, visit www.ama-assn.org/ama/pub/category/10931.html.

What’s New on the RWJF Web Site

RWJF has launched an e-mail service that delivers funding and content alerts in various Foundation program areas of interest. The publication of e-mail alerts marks the beginning of a new effort to inform readers about important new information on the site. Register for free e-mails in 11 program areas at subscribe.rwjf.org.

RWJF continues to launch new content in the growing online Research Center, including:

- “Can Doctors Improve Patient Health by Preaching Prevention?” at www.rwjf.org/news/prevention.
- “Survey: Gaps in State Medicaid Coverage for Programs to Help Clients Stop Smoking” at www.rwjf.org/news/medicaidtobacco.

To see additional new features in the Research Center, which offers access to research funded by the Foundation, visit www.rwjf.org/research.

Several new installments in the RWJF Television Health Series are now available for review, including Healthy Steps for Young Children at www.rwjf.org/news/healthysteps. To see more TV Health Series segments, go to www.rwjf.org/news/videos.jsp.

The Web team also continues to add to its store of webcasts, including the Last Acts Partnership Launch Event, and press briefings detailing research findings by the Alliance for Health Reform and the Center for Studying Health System Change. To view webcasts, go to www.rwjf.org/news/eventcastsUpcoming.jsp.

—JEFFREY MEADE

Program Offers Financial Rewards for Quality Improvements

Primary care doctors who follow the latest practice guidelines to treat patients with certain chronic conditions can find themselves in a financial quandary.

Providing high-quality care to a diabetes patient, for example, requires not only regular physician office visits, but extensive, ongoing follow-up. This can include making phone calls, writing e-mails and sending reminders to the patient, tracking regular lab tests and monitoring medications. These tasks, performed by the physician's office staff, take considerable time, but few are reimbursable under most health care plans. As a result, the cost of providing the recommended level of care can make it difficult for a physician to stay in business.

"The reality is, we can't expect most providers to make major investments in learning how to improve quality and in hiring staff and making systemic changes if they are going to lose money doing it," says Michael Rothman, M.P.P., a senior program officer at The Robert Wood Johnson Foundation.

Through its national program *Rewarding Results: Aligning Incentives with High-Quality Health Care*, RWJF is funding a number of projects aimed at developing practical, "real-world" approaches for improving the quality of health care. Bridges to Excellence: Creating Rewards to Improve Processes and Outcomes of Care is one such project. The Foundation has awarded a three-year, \$332,802 grant to General Electric Corp. in Fairfield, Conn., to implement and evaluate the project.

General Electric launched Bridges to Excellence in early 2003, following two years of

planning and consulting with physicians, health plans, large employers, policy-makers and patients. The initiative aims to improve the quality of care by recognizing and rewarding health care providers who provide "safe, timely, effective, efficient, equitable and patient-centered care," says Francois de Brantes, M.B.A., coordinator of Bridges to Excellence and program leader for health care initiatives for General Electric.

In addition to General Electric, employers participating in Bridges to Excellence include Ford Motor Co., United Parcel Service, Procter & Gamble and Verizon, all of which offer bonus payments to doctors who deliver high-quality care to their employees. The National Committee for Quality Assurance selects which doctors qualify for awards by evaluating and verifying their performance data.

In all, the Bridges to Excellence project will involve about 250,000 patients in four geographic markets, including Albany, N.Y.; Boston; Cincinnati; and Louisville, Ky. In each market, between 2,000 and 3,000 physicians are participating.

"The power behind this particular program is the level and scope of the demonstration," says de Brantes. "We knew we had to include large numbers of patients and physicians, involve several large employers and offer significant incentives in order to determine if this approach could improve quality."

Through Bridges to Excellence, top-performing physicians could see income increases as high as 10 percent from the bonuses paid by participating employers, according to de

Brantes. "The bonus payments are too compelling to pass over," he says.

The program also offers non-financial incentives, according to Rothman. Top-performing doctors are highlighted in provider directories and participating physicians receive regular feedback on how their performance compares to that of other physicians. Patients also are provided with information, tips on how to better manage their own disease and can become eligible for prizes for meeting certain goals.

"For physicians, professional pride can be a great motivator. They know their peers and patients will see who the top performers are," says Rothman. "And the patients are motivated to become active participants in their own care."

C. Russell Hoffman Jr., M.D., a Louisville physician participating in Bridges to Excellence, praised the program for involving both patients and doctors and for offering a variety of incentives to physicians.

"With this type of approach, the physician's role moves from that of prescriber of drugs and fixer into being coach, teacher and motivator," says Hoffman, an internist specializing in diabetes care. "The program encourages doctors to reach certain benchmarks in their practice, and those benchmarks are based on nationally accepted, scientifically based standards.

"If this pilot program proves successful, it could have broad applicability to other communities and other chronic diseases," Hoffman says.

As for the employers, they are participating in the program "because it makes good business sense," says de Brantes.

"There has been a deepening understanding in recent years that there are significant gaps in the quality of health care being delivered," he says. "At the same time, the amount of money businesses spend on health care on a yearly basis continues to grow. We have to make sure we are getting good value for the amount we spend. We have an obligation to our employees, to our shareholders and to society to make sure there is accountability in how health care dollars are spent."

It is hoped that Bridges to Excellence can serve as a model for many large employers and large health plans. Project leaders deliberately chose to include different markets to test the approach in a broad spectrum of health care systems. Boston, for example, is an "organized" market, with several large health care systems that dominate the market. Louisville, on the other hand, is much more fragmented, with many small practices of two or three physicians.

Says de Brantes: "If we can demonstrate success in improving quality with this program, other large purchasers and health plans will pay attention."

—LAURIE JONES

For more information on this project, visit www.bridgestoexcellence.org.

Active Living, Obesity and Nutrition

- > For accelerating nutrition/food policy to improve public health, \$102,000 to Public Health Institute, Oakland, Calif.
- > For the National Coalition for Promoting Physical Activity, a renewal award of \$250,038 to NCPPA Foundation, Washington.
- > *Active Living by Design*. Awards to 25 sites, totaling \$5 million.
- > *Active Living Research*. Awards to seven sites, totaling \$2.5 million.
- > *Active Living Leadership*.
 - For educating local government leaders about active living, \$175,486 to the National Association of Counties Research Foundation, Washington.
 - For supporting state leaders on active living issues, one renewal award of \$199,952 to the National Governors Association Center for Best Practices, Washington.
 - For the Active Living Leadership and Active Living Coordination Center, one renewal award of \$290,245 to San Diego State University Foundation.

Alcohol and Drug Addiction Prevention and Treatment

- > For analysis of the implications of *Crossing the Quality Chasm* for the treatment of mental and addictive disorders, \$189,000 to the National Academy of Sciences–Institute of Medicine, Washington.
- > *Reclaiming Futures®: Communities Helping Teens Overcome Drugs, Alcohol & Crime*. Awards to five sites, totaling \$2 million.
- > *Resources for Recovery: State Practices that Expand Treatment Opportunities*. Awards to five sites, totaling \$999,418.
- > *Substance Abuse Policy Research Program*. Awards to nine sites, totaling \$2.1 million.

Building Human Capital

- > For the Gold Humanism Honor Society, a renewal award of \$317,426 to the Arnold Gold Foundation, Englewood, N.J.
- > *Better Jobs, Better Care: Building a Strong Long-Term Care Workforce*. A renewal award of \$330,465 for evaluation of the program to the Pennsylvania State University Department of Health Policy and Administration, University Park, Pa.
- > *Innovators Combating Substance Abuse*. Awards to two sites, totaling \$600,000.
- > *Partnerships for Training: Regional Education Systems for Nurse Practitioners, Certified Nurse-Midwives and Physician Assistants*. For institutionalizing a Web-based curriculum repository for Partnerships for Training, \$250,000 to the Association of Academic Health Centers, Washington.

- > *Summer Medical Education Program* (formerly *Minority Medical Education Program*). Renewal awards to four sites, totaling \$2.4 million:
 - Baylor College of Medicine
 - Case Western Reserve University School of Medicine
 - University of Virginia School of Medicine
 - University of Washington School of Medicine
- > *Summer Medical Education Program*. Award of two grants for the Dental Pipeline Program, totaling \$240,000:
 - Columbia University College of Physicians & Surgeons
 - University of Washington School of Medicine

End-of-Life Care

- > For best practices for end-of-life care in nursing homes, \$199,220 to Brown University School of Medicine, Boston.
- > For making pain relief a reality for cancer patients, \$183,680 to the University of Wisconsin–Madison Medical School.
- > *Targeted End-of-Life Projects Initiative*. Awards to two sites, totaling \$156,294.

Health Insurance Coverage

- > For targeted research on covering the uninsured, \$155,000 to the Urban Institute, Washington.
- > For a provider and government summit meeting on health care and the public interest, a renewal award of \$149,000 to the University of North Carolina at Chapel Hill School of Public Health.

Nursing: Transforming Care at the Bedside

- > For research on the impact of nurse staffing ratios on patient outcomes, \$157,916 to the University of Illinois at Chicago Institute of Government and Public Affairs.

Public Health Leadership and Capacity

- > For mental health and primary care in a time of terrorism, a renewal award of \$102,947 to America's Health Together, Washington.

Quality Health Care

- > For achieving national consensus of quality measures for physician-level ambulatory care, \$300,000 to National Quality Forum, Washington.
- > For studying the value of health care information technology in chronic disease management, \$350,005 to Partners HealthCare System, Center for Information Technology Leadership, Wellesley, Mass.
- > For the Health Insurance Reform Project: Medicare, Access and Quality, a renewal award of \$218,279 to George Washington University, Washington.
- > For assessing the relationship of clinical practice systems to care outcomes, a renewal award of \$398,229 to the National Committee for Quality Assurance, Washington.

Reducing Racial and Ethnic Disparities in Chronic Care

- > For research into changes in racial disparities when using surgical procedures among Medicare enrollees. \$133,149 to Harvard University School of Public Health, Boston.
- > *Building Community Supports for Diabetes*. Five renewal awards, totaling \$125,000.
- > *Hablamos Juntos: Improving Patient–Provider Communication for Latinos*. Awards to nine sites, totaling \$7.7 million.
- > *Southern Rural Access Program*. Awards to two sites, totaling \$1 million.

Vulnerable Populations

- > Completion funding for statewide family support services networks, a renewal award of \$750,000 to Family Support America, Chicago.
- > *Faith in Action II*. Awards to 25 sites, totaling \$875,000.
- > *Injury Free Coalition for Kids: Dissemination of a Model Injury Prevention Program for Children and Adolescents*. Awards to 13 sites, totaling \$2.1 million.
- > *Local Initiative Funding Partners Program*. Award of two grants from the special opportunities fund, totaling \$228,621.
- > *New Jersey Health Initiatives*. Awards to 15 sites, totaling \$5.3 million.
- > *Nurse–Family Partnership*. One award of \$3 million to the University of Colorado Health Sciences Center, Denver.
- > *Urban Health Initiative: Working to Ensure the Health and Safety of Children*. Award of two special opportunity grants, totaling \$400,000.

Other

- > For issue briefings on health policy for policy-makers, journalists and national organizations, \$1.1 million to Alliance for Health Reform, Washington.
- > For strengthening collaboration and information-sharing among health philanthropies, \$700,000 to Grantmakers in Health, Washington.
- > *Changes in Health Care Financing and Organization*.
 - Awards to three sites, totaling \$739,569.
 - For a study of the impact of Medicare's local medical review policies and national coverage policies on utilization of services, one renewal award of \$414,745 to the University of Minnesota School of Public Health, Minneapolis.
- > For a substance abuse prevention touring play for adolescents, \$168,835 to George Street Playhouse, New Brunswick, N.J.
- > For the Middlesex County Adult Substance Abuse Program, \$140,000 to Friends of the Middlesex County ASAP (Adult Substance Abuse Program), New Brunswick, N.J.

GRANT RESULTS REPORTS

Since November 2003, seven new National Program Reports and 64 new Grants Results Reports were posted to the RWJF Web site, www.rwjf.org. These reports, organized by topic area, detail the results of RWJF grants that are now closed. Among those posted are reports on projects with specific products that may be of interest to others. Recent reports on such projects include the following:

- **Research on the Leadership and Culture of Exemplary Health Care Organizations.** The Project on Technology, Work and Character, directed by Michael Maccoby, Ph.D., examined the leadership visions and strategies of 11 of the country's leading nonprofit health care organizations and academic health centers. The purpose of the project was not only to describe best practices but also to propose ways of improving and sustaining them. A report, *Leadership for Healthcare in the Age of Learning* can be downloaded at www.maccoby.com/PTWC. See the Grant Results Brief at www.rwjf.org/reports/grr/038157.htm.
- **Study of Injuries in the United States and the Response of Public and Private Agencies.** A panel of 17 researchers and practitioners from the Institute of Medicine was created to study the problem of injury in America. The panel assessed the

problem, determined the science base for injury control, identified opportunities and barriers for injury control, detailed progress made and isolated what remains to be done in injury prevention and control. The committee also made detailed recommendations, which can be found in a 336-page report, *Reducing the Burden of Injury: Advancing Prevention and Treatment*, available online at <http://books.nap.edu/catalog/6321.html> for \$35.96. See the Grant Results Brief at www.rwjf.org/reports/grr/030188.htm.

- **Panel on the Future of the Health Care Labor Force in an Aging Society.** To address the future of the health care labor force, particularly nursing care, the University of Illinois at Chicago Nursing Institute assembled a blue-ribbon panel for a series of meetings on "The Future of the Health Care Labor Force in a Graying Society." The panel examined the issue of the aging of the U.S. population and the consequences it could have for the health care labor force. Panel members were drawn from public institutions, academia, private businesses, think tanks, organized labor and professional groups. The 35-page report, *Who Will Care for Each of Us? America's Coming Health Care Labor Crisis*, can be downloaded at www.uic.edu/nursing/nursinginstitute/healthpolicy/labor.

htm. See the Grant Results Brief at www.rwjf.org/reports/grr/040375.htm.

- **Encouraging Best Practices in Chronic Disease Management and Intensive Care Unit Care.** The National Coalition on Health Care, a Washington-based nonprofit coalition of 95 organizations working to improve health care, and the Boston-based Institute for Healthcare Improvement, a nonprofit education and research organization, launched the initiative "Accelerating Change Today — For America's Health." Two teams of experts reviewed the practices of hundreds of health organizations and selected some 20 models of best practices in chronic illness management and intensive care unit (ICU) care, which were profiled in two reports: *Curing the System: Stories of Change in Chronic Illness Care* and *Care in the ICU: Teaming Up to Improve Quality*. The reports, which aim to encourage health care providers and purchasers to adopt best practices, can be

downloaded at www.nchc.org/materials/studies/index.shtml. See the Grant Results Brief at www.rwjf.org/reports/grr/043117.htm.

- **Developing System Strategies for Tobacco Use Treatment.** Project staff at Brandeis University developed a system for treating tobacco use and dependence as a chronic disease and a planning guide for implementing the treatment system in a clinical setting. The 29-page planning guide includes a tool for clinical practice sites to assess their system of care, and suggestions for organizing both internal and external care systems to sustain continuing treatment of tobacco use and dependence. *Treating Tobacco Use and Dependence as a Chronic Disease: A Planning Guide for Practice Sites in Developing an Office-Based System of Care* can be downloaded at www.sihp.brandeis.edu/tobacco.htm. See the Grant Results Brief at www.rwjf.org/reports/grr/040412.htm.

— HEDDA COLOSSI

PEOPLE

FRANK WIECHNIK joined the RWJF Central Files Unit in November 2003 as a records assistant. Previously, Wiechnik was a commercial interior designer working in New York City and Princeton, N.J.

HOLLIE CHAMBERS joined RWJF in November 2003 as a program administrative assistant for the Health Care Group. Prior to joining the Foundation, Chambers was an assistant to the board secretary for the Willingboro Board of Education in Willingboro, N.J.

GEORGINA MEDINA began working with the Foundation in February 2004 as an accounting clerk in the accounting department. Formerly, she was an administrative assistant with the Ramco Manufacturing Co. in Kenilworth, N.J.

BRIAN MULLEN joined RWJF in March as an investment analyst in the Investment Unit. Previously, he was a financial analyst for Merrill Lynch assisting in the strategic planning, design and development of new value-added products for the private client group.

AWARDS

MICHELLE LARKIN received the Beacon Award in December 2003 at the National Conference on Tobacco or Health in Boston. The award acknowledges outstanding leadership to advance diversity and equity in the tobacco-control movement.

J. Warren Wood III, J.D., vice president, general counsel and secretary,

retired from the Foundation in December 2003. Since 1975, Wood had served as the chief legal officer, responsible for the management and supervision of the Foundation's legal affairs, as well as a member of the Foundation's senior management team. He is a member of the bars of the states of New Jersey, New York and Virginia.

Before joining the Foundation, Wood was in private law practice in Richmond, Va., with the firm McGuire, Woods & Battle. He also was a commercial banker with Bankers Trust Co. in New York, and was on active duty with the U.S. Army Artillery with the rank of captain.

Wood continues to be active in various professional organizations, including as an arbitrator and mediator with the American Arbitration Association, as well as a member of its board of directors and executive committee. Effective January 1, 2004, he was elected president of the Global Center for Dispute Resolution Research, New York. The organization is dedicated to research that provides insight, information and guidance on the growth and practice of alternative dispute resolution methods throughout the world.