Force Multipliers: How an anonymous band of fierce foot soldiers is revolutionizing health in America from the ground up.
Americans are approaching what’s being called our “coming age of permanent austerity.” Serious economies, some severe, are likely triggering long-term and significant changes in our daily lives. At the Robert Wood Johnson Foundation, the expectation and proactive design of change is the true currency of our philanthropy. In this President’s Message I take a look at forces presently affecting our work and some of the remarkable members of the RWJF family who are leading a quiet revolution in the health and health care of everyone in America. It’s all about the power of people and ideas.¹
The tale is told in Homer’s ancient epic poem, *The Odyssey*, about the legendary Greek king, Odysseus and his wise friend, Mentor who looks after the royal household while the wandering warrior is off dealing with the Trojan War. Today, 3,200 years later, the old king is long gone. “Mentor” survives, however, as the word for someone older and more experienced who nudges and nurtures the progress of a promising younger protégé. Aristotle, for example, mentored Alexander the Great. Lionel Logue mentored King George VI. Florence Nightingale mentored America’s first professionally trained nurse, Linda Richards.²

When asked about my own mentors, without hesitation I name...

**My mother, Blanche Lavizzo**, a pediatrician and one of Seattle’s first African American physicians. She took this little girl along as she delivered care for the poor and needy in the city’s Central District. “Quality care with dignity,” she would declare in the face of health care discrimination and neglect. Mother possessed an unforgettably fierce compassion for the least among us.

**John Eisenberg**, an MD, RWJF Clinical Scholar, Wharton MBA and dear friend. Early in my career, while I was teaching at Temple University, John sounded me out about joining RWJF’s *Clinical Scholars™* program across town at Penn. That’s where he infected me with his enthusiasm for leveraging the knowledge gained from health services research to improve the quality of patient care. And that’s where I met Sam Martin.

**Dr. Sam Martin**, director of Penn’s *RWJF Clinical Scholars* program, was one of the last century’s great leaders of American medicine. He single-handedly created a new breed of physician-MBA to meet the emerging policy and economic complexities of health care. Sam, early-on, challenged his protégés to reach beyond the confines of purely clinical training to make a difference in the lives of others.

Each of my mentors in their own way held up a mirror and challenged, “This is who you are. Now who are you going to be?”
In my own years as a Clinical Scholar at Penn I learned first-hand how the Robert Wood Johnson Foundation sharpens the minds and expands the capabilities of people like myself to engage the entangled perplexities of health and health care with the purposeful intent to find a better way. What I discovered about myself in the process irreversibly altered the arc of my own life’s narrative in ways still unfolding to this day.

Adam Smith, father of modern political economics, coined the imprecise phrase “human capital.” Invest in human capital, Smith advised, and productivity, quality and profits will multiply. That alone is not quite enough, however. When we marry human with intellectual capital–then we can fully capture the lightning of change in a bottle.

From the day the Foundation opened its doors we’ve worked hard to locate, nurture and propel forward women and men with the vision, intellect and courage to recalibrate the nation’s health policies and practices. Our aim is to populate the health and health care arenas with bold, disruptive and effective agents of change. Nothing we do is more important.

An Old French word, peonier, applies nicely. It means “the foot soldier who prepares the way for the army.” I like to think of RWJF’s cadre of change agents as health care’s most forward voyagers, always ahead, just over the horizon, taking the risks, carving a new way, then turning back to teach the rest of us to trust the future.

Jim Collins, student of the rise and fall of companies and organizations, calls it “boarding the bus.” Begin with the “who,” not the “where,” he advises. Get the right people on the bus sitting in the right seats and you have everything needed to create something great. We know what he’s talking about. Who gets on our bus is the predicate for all our aspirations. Change breaks out whenever and wherever they alight.
The Greyhound bus to Bayard, New Mexico, drops you at the McDonalds just off I-10 on the edge of Lordsburg, in the far southwestern boot heel of New Mexico. From there, the two-lane state road to Bayard threads northeast, skirting Apache Mountain, Gold Hill and Burro Peak.
The town is just over 2,000 miles from our home offices in Princeton, N.J. In almost every measurable mode—geography, climate, demographics, economy, history—our two locations seem worlds apart. Ask in Princeton about heroes of “the revolution” and you will hear about Washington crossing the Delaware. In Bayard they will tell you about the night Pancho Villa’s revolutionary army crossed the border and attacked nearby Columbus.

So far apart, yet the clinical needs of patients in either locale are much the same. The big difference comes in what it takes to meet those needs. What is easy and routine, and overserved, in New Jersey, is difficult, rare and underserved in New Mexico—which is how and why we got to know Bayard in the first place.

Bayard is in remote and rural Grant County, with 7.8 people per square mile. (Princeton, while not exactly urban, is exactly 1,000 times more dense). The government deems the county a “medically underserved area,” with high rates of poverty, infant mortality, chronic disease and few, if any, primary care providers within easy reach.

Our objective was basic: If we can help the right people with the right ideas resolve health care challenges in places like Bayard, perhaps, a model for other isolated and underserved rural and urban communities would emerge. And that’s exactly what happened!

A visit to Bayard is like stepping back in time. The town is a mile-high pocket of 2,400 people caught on the cusp between the Old West’s past and present. It started out as a dusty crossroads with a single ranch house and a one-room Sante Fe depot installed after the Civil War for the convenience of the cavalry. Streets still have names like Lariat, Canyon and Empire. Just to the west, at the convergence of ancient Apache trails, is Fort Bayard, an early posting of the army’s famous African American “Buffalo Soldiers.”

Just to the east is one of the world’s oldest and largest open pit copper mines, the El Chino, mainstay of the local economy for nearly 100 years. When falling copper prices forced the mine’s shutdown in 2008, hundreds of families lost their income and health insurance. Unemployment jumped 25 percent. One in every five people was in poverty, including 36 percent of the town’s children and nearly half of all single mothers. Housing costs gobbled up at least 30 percent of most households’ income.

That doesn’t leave much in the family budget for health care, even though chronic and complex medical conditions have spread through the local population. Compounding the problem, where to go for sophisticated care is a decades-long dilemma. The Army’s old TB hospital shut down more than 45 years ago. Since then, both population and resources have been too scarce to justify a new facility.
Dr. Naomi Clancy is the town’s one and only family doctor. She describes her practice as on “the frontier of medicine… I wanted to work where I could see the mountains from my back door and deal with a lot of the challenges that rural folks are dealing with.” (She and her husband also raise chickens, goats and two boys).¹⁰

“I take care of the mamas, and deliver the babies, and see the grandmas, and if we can pull Daddy or Grandpa into the clinic, we do so. And, it’s very nice. I have families here that I’m caring for three or four generations.”

There is a big “but” though. Birthing babies, treating the flu and patching up minor wounds is one thing. Meeting the major medical needs of patients chronically ill with serious, chronic medical conditions is something else altogether. Especially prevalent are life-changing diseases that require specialist care, such as diabetes, asthma, obesity, and the full spectrum of rheumatic disorders.

A major public health concern: the rising spread of hepatitis C infection, caused by a virus that can inflame and scar the liver. It is one of the most common instigators of serious liver diseases like cirrhosis or cancer.

Symptoms commonly kick in when the disease is advanced. Appropriate care demands a level of disease management and treatment beyond the training and education of rural-practice general internists like Dr. Clancy. To acquire the necessary new knowledge and skills she’d have to take a sabbatical and leave town, paradoxically abandoning the very patients who need her in the first place.

**Bottom line:** Realities of time and distance lock her into Bayard just as tightly as her patients; she decided to stay put. It was a classic Catch 22—the solution was denied by deep-seated circumstances inherent to the problem itself.

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A patient I’ll call Adelita was locked in as well.11 This 35-year-old single mother of four small children lived just outside Bayard, close enough to her job as a Walmart shelf stocker to drive her kids to school and still get to work on time. With an hourly wage under $9 and no health care coverage, the family struggled well below the poverty level.12 Theirs’ was always life on the edge.

Adelita was one of those whose chronic liver disease, triggered by an unremitting hepatitis C infection, routinely brought on abdominal pain, fatigue, fever and depression. The disease is treatable with a long-term regimen of weekly injections and pills. That’s great if you live near a metropolitan area with its big-time health care capacity. However, Dr. Clancy says, “access to specialist care is very difficult” on the frontier.

For Adelita, the nearest specialists were in Las Cruces (two hours to the east), Tucson (three-and-a-half hours west), or Albuquerque (more than four hours north). That translates into at least two tanks of gas and valuable time lost from work. Multiply that by a dozen or more doctor appointments a year and this health care becomes unreachable—literally and financially. The quandary is common and consequential.

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“A lot of things that people take for granted in the big city, we just don’t have available here,” Dr. Clancy explained. “If you’ve got an 8 a.m. appointment, you have to go spend the hotel money to stay overnight,” she said. “And sure, you can take it off of your taxes, but if you don’t have the gas money to get there, much less the hotel money, you’re out of luck. And a lot of people right now don’t even have the gas money.”

This explains why less than 5 percent of New Mexico’s 28,000 known hepatitis C patients receive treatment. The untreated 95 percent—Adelita included—are part of a stunning surge of new cases (up 132 percent)13 that swept across the state in recent years. As a result, New Mexico consistently registers the country’s highest death rate from chronic liver diseases, nearly 22 of every 100,000 deaths.14 The national rate is less than 10.15
“Unacceptable,” says Dr. Sanjeev Arora at the University of New Mexico, one of the Southwest’s few specialists in liver disease. This raw example of health care’s most brutal failings kept him awake nights, puzzling out “something I could do to make a difference.”

“I could only treat 70 to 90 hepatitis C patients per year in my clinic,” he said. For those lucky enough to live nearby, the waiting list was “only” six months. Away from Albuquerque, there were no viable alternatives.

“Most primary care physicians have received little or no education in treating these diseases,” he explained. Online physician referral services list no more than three hepatologists for the entire state—or about one for every 10,000 people with hepatitis C. For those who do make it to Dr. Arora’s clinic, too often it is too late. “I always had that nagging thought that if I’d been able to treat them earlier, I’d have been able to prevent this problem.”

Yet, he was confident he could solve the puzzle. After all, as a boy in India he watched as his physician father (whom he sharply resembles) lead the effort that eradicated small pox from that country. And he followed his mother, an OB/GYN, on her rounds among the poor and the sick. When he came to America, a physician in his own right, he carried with him that same dogged determination to make a difference for his patients.

The trick, he figured, would be to find a way to train local family physicians like Bayard’s Dr. Clancy right where they live and practice. How to open a “quick path for getting new information out to isolated communities” was the big open-ended question.

Then, one Christmas holiday he watched his two daughters chat up friends online using a forerunner of Skype™. Ah Ha! Dr. Arora suddenly had his answer. Before long, he convened the state’s first online video hepatitis clinic, linking primary care physicians and other health professionals from 14 sites across the state.

The project quickly and cleverly was christened “ECHO™”—a stroke of naming genius because it says exactly what it is—a disruptive innovation that gains strength as it repeats and rebounds. For the record, ECHO literally means Extension for Community Healthcare Outcomes.

Community and Outcomes are the key words. At least once a week primary care providers embedded in far-apart communities connect via real-time technology with a knowledge network of specialists in Albuquerque for a “one-to-many” sit down. They co-manage patients (who may be present), coordinate care and—this is the big ticket—educate and train the rural medical professionals as mini-specialists in the disease and conditions most common among their patients (e.g., pediatric obesity, substance abuse, HIV/AIDS, mental health issues, rheumatology, chronic pain, asthma and high-risk pregnancies).16

Just like boarding Jim Collins’ bus to something great, the trick is to get the right people in the right seats around the table at the right time. For instance, Dr. Arora’s hepatitis C teleclinics are joined by an RN and perhaps an advanced nurse practitioner, a pharmacologist, mental health expert, public health outreach professional, and others as needed.
ECHO is a force multiplier, in Dr. Arora's terms, permanently expanding “tenfold” the capacity for care by hard-pressed family providers who are cut off from customary professional and educational resources by the geography of the region's isolating desert and mountain vastness.

“We don’t know of anybody that has done it the way we do it,” he says. “Every doctor can provide best practice care without being an expert in all chronic diseases… it’s more efficient and less costly than sending the specialist out to every rural clinic without compromising the quality of care.” He likens it to teaching someone to fish rather than just giving him the day’s catch.

I think of it as instant and interactive virtual grand rounds. The transfer of knowledge is spontaneous, affordable and effective. “We work through 20 cases in two-and-half-hours,” Dr. Arora reports.17 RWJF supports the project with a $5 million Pioneer grant; the federal Agency for Healthcare Research and Quality adds $1.5 million more.

ECHO is an extraordinarily potent global model for the delivery of better, cheaper care to vulnerable and underserved rural and urban populations. This year Dr. Arora’s force-multiplying model is spreading to the universities of Washington and Chicago.18 Other underserved communities may be next.19 Meanwhile, Dr. Clancy and her far-flung medical colleagues routinely take part in the weekly ECHO conferences at any of nearly four dozen sites. Top travel time might be 15 minutes. She says “it’s a giant mind center of collaboration… like having a specialist in my back pocket.”

The best news is that Adelita and thousands of other chronically ill patients and their families now have the peace of mind that comes from knowing the level of care they require is available in their own hometown.

Not long ago we sent a video production crew to Albuquerque for an ECHO update.20 To set the visual scene, Dr. Arora graciously met our team early one morning just outside of town. It is an elegant shot. He stands amid the Chihuahuan desert hardscrabble as a breeze flutters his white doctor’s coat. He looks like a change-making time traveler from tomorrow, stepping out of an old-time pioneer yesterday into a today pre-loaded with promise and hope.

Back in his office, he tells us how well the patients of those outlying family doctors are doing. “The care that these doctors provide is as good as we provide at the university. It’s as safe and as effective. We’ve been able to demonstrate conclusively that the model works.” And he lights up like one of his own kids on Christmas morning.

We invest in gifted talent like Dr. Arora and disruptive innovations like ECHO because today’s populations and systems need help in the here and now.

Watch our video to learn more about Project ECHO
The nation needs brave new leaders and bold new ideas to chart the way. The United States is undergoing the most wrenching re-appraisal of the balance between private and public responsibility since the Great Depression. How well our society adjusts to the challenges—both known and, as yet, unknown—is among the hallmark tasks of our time.

The current debate over the best way forward is fiery, partisan and unavoidable. As the Financial Times observed, “much conflict lies ahead, with huge implications for politics, federal finance and the U.S. ability to play its historic role.” The outcome will determine the health of our people and the quality of our communities far beyond our own lifetimes.

Warning signs about how the United States finances and delivers health care have been in plain sight for a long time. A decade ago, the Institute of Medicine (IOM) issued its landmark call to action, the report called Crossing the Quality Chasm: A New Health System for the 21st Century. The first sentence said it all:

“The American health care delivery system is in need of fundamental change.”

The IOM’s vision was clear and correct, the case for change certain and convincing. But while we needed metamorphosis, our collective choices gave us just more of the same. In the meantime our national health expenditures doubled to $2.7 trillion, about $9,000 for each one of us. The more important number to track, though, is the bite that health care takes out of the overall economy. A generation ago, it was barely 9 percent of our Gross Domestic Product. This year, it is more than 17 percent; by 2020 it will hit 20 percent. This, more than anything else, is what drives the too-often shrill Washington debate over spending, debt and programs like Medicare and Medicaid.
The seeds for RWJF’s search for talent took root one autumn afternoon more than a generation ago at an old 19th century inn along the rocky northern shore of Nahant Bay, near Swampscott, one of those picture postcard Massachusetts villages by the sea.

The inn, with its red clapboard siding and bright white shutters, had been a landmark by land and sea since the 1800s. Inside, some of the best thinkers in education, medicine, economics and public health gathered for an off-the-record, no-holds-barred assessment of medical education’s legendary disconnect from the world of patients and hands-on care. Apparently, it didn’t go too well. “Lousy meeting,” someone said over lunch. Too much celebrating the problem and too little coming up with answers.

During a break a small group of disenchanted medical professors took a seaside stroll to talk out their frustrations. The discussion was animated and productive. By the time they returned to the inn, they were gripped by the germ of a powerful idea—let’s invent a creative new kind of medical and academic high-achiever who:

1. Grasps the impact of societal forces on health care;
2. Recognizes the necessity of social research to lay bare the problems;
3. Relies on evidence to define solutions;
4. Possesses the skills and the courage to effect change.

Within weeks, the professors signed off on a plan to launch what they called the “Clinical Scholars Program” at their separate medical schools. These were brave academics, going up against the orthodoxy of their own field’s hidebound status quo. They stuck to it, though, and for that the Foundation is permanently grateful.
RWJF appeared on the philanthropic scene nearly three years later. From Day One, the pressure was on our first president, David Rogers, to get money out the door. New IRS laws required that the Foundation spend 5 percent of its assets—some $60 million—in that first year. This, before we even had real offices with our name on the door.

Rogers, former dean of Johns Hopkins University School of Medicine, knew the field and the players. He shrewdly convinced leaders of the Swampscott Group to join his staff in Princeton. They brought Clinical Scholars with them. The program turned into RWJF’s first major grant initiative. It is our longest running national grant program and led to all our other human and intellectual capital investments.

Looking back, the Swampscott dissenters seem prophetic. Yes, it has been said that “prophecy, however honest, is generally a poor substitute for experience.” Unless, that is, experience validates the initial vision—which certainly holds true in our continuing hunt for talent. In fact, the checklist that guides our current search has not changed much at all. It proves its worth every step of the way.

RWJF’s Summer Medical and Dental Education Program is a six-week intense academic enrichment program that helps undergraduate students from disadvantaged backgrounds compete successfully for medical and dental school admission.
College volunteers for Health Leads are changing how patient care is delivered to low-income families. Its next-generation health leaders understand that our health is about more than just medical care.

**America’s return on our human capital investment is incalculable.** Our grantees work across every sector of the U.S. health and health care complex. Their objective is noble—to elevate the health trajectory of our entire population.

To get them ready, we prepare executives for leadership, hone the skills and focus the careers of front-line health workers, train scholars to conduct policy research with practical applications, and encourage young talent to pursue health and health care careers. Building on the success of *Clinical Scholars*, we’ve expanded our human capital ranks to include nursing, dentistry, faculty education, community health, minority health care and public policy.

Like Dr. Arora, they tend to be strategic, team builders, low on ego, high on courage and unreservedly devoted to the common good. They are as interested in wellness and prevention as in sickness and treatment. They attend to the health and health care needs of communities as well as individuals. They collaborate, reach across sectors and disciplines, tear down silos and are not afraid of transparency or accountability. Thousands have participated. Millions benefit.
We measure the success of our investments in human and intellectual potential by the eventual impact on people and communities, no matter how long it takes. It helps that our grantees share a daunting determination to stay the course until momentum is secured and meaningful change achieved. Whether widely heralded or not, most fight so remarkably long and well for the good health of our communities and better health care for our people that they become a public testament to why RWJF invests in them in the first place.

Consider, for example, how six typical recipients of Foundation backing are making a difference in their own terms and on their own turf, propelled forward by the instinctive conviction that, in the words of Britain’s Prince Phillip, “Change is a challenge and an opportunity, not a threat.”
Nirav Shah, at 38, is New York’s youngest-ever State Commissioner of Health. A Yale-trained general internist with a master’s degree in public health, he is a rare RWJF triple grantee (Health e-Technology investigator, Clinical Scholar and Physician Faculty Scholar), all within the past decade. In the process, he says, he learned from legendary mentors to turn cutting-edge research into more sensible, efficient, patient-centered care with better patient outcomes achieved at lower costs.

Evidence-based prevention is his top priority, he told legislative budget-makers in Albany, singling out tobacco use, HIV/AIDS, diabetes and obesity. “I’ve watched my patients struggle to stay healthy while facing unemployment, poor nutrition and poverty,” he says. “I’ve been preparing to solve problems like these for a very long time.” RWJF “helped to give me a deep understanding of the problems society faces: access to care, the need to increase coverage, meeting the needs of patients with chronic diseases.”

Also critical to his new job: experience as a general internist at the famous Bellevue, oldest public hospital in the United States, and his investigations for the Geisinger Center for Health Research into the very different needs of thousands of rural, older patients in Pennsylvania. As a result, he is considered a trailblazer in the use of electronic health records and so-called patient portals that turn patients into virtual partners in the behind-the-counter planning and management of their own care, especially chronic conditions.

Social media is part of the e-mix. A new program is the commissioner’s “I Choose 600” campaign, urging New Yorkers to cap each meal at 600 calories. A campaign Facebook page is one measure of successful engagement with the public. Dr. Shah hopes the program will help reduce the prevalence of obesity among children and adults and the nearly $8 billion a year the state spends on obesity-related health care spending.

RWJF’s Human Capital Portfolio, he said, “is one of the best investments they’ve ever made because there’s no other model for training the next generation of health leaders in every area—nurses, physicians and patient care workers.”
Amanda Gaynor Ashley, fresh from dental school in Pennsylvania, wanted to combine rural practice with travel and adventure. So she didn’t flinch when the U.S. Indian Health Service told her they had an internship open in Barrow, Alaska, a tiny town of Native Alaskans on the icy edge of the Arctic Ocean some 330 miles north of the Arctic Circle.

Oh, yes, they said, you need to know that Barrow is the toughest spot in the United States to recruit and retain dentists. Something, they explained, about the 10-week-long winter night with average lows of minus-22; milk that costs $8 a gallon; polar bears who disrupt high school football practice. The only way in and out of town is by air or summer cargo barge, and the big cultural event of the year occurs when town whaling teams capture and butcher a 60-foot-long, 120,000 pound bowhead whale that may still be impaled with harpoon heads from the 1800s.

Much to Barrow's surprise, Dr. Ashley liked it all so much that, more than a decade later, she was still there, running an Inupiat-owned tribal clinic, delivering dramatic improvements in the oral health of North Slope Alaska Native children and families, and gaining a national reputation as one of the few dentists ever selected an RWJF Community Health Leader.

When she arrived in Barrow, young children’s toothless grins were evidence of years of inadequate dental care and sugar-rich diets. Locals called the dental office the “extraction” clinic—“the place you would go when you couldn’t stand the pain anymore.” She changed that by introducing a “force-multiplier” model common in underdeveloped countries but seldom seen in the United States. Rather than wait for willing volunteers from the lower 48, she trained local Inupiat moms as dental assistants and preventive care specialists.

It all worked because Dr. Ashley stayed the course long enough to morph from an outsider to an inside, established and valued member of the community. She installed ancillary services in smaller, more remote North Slope villages, even cross-country skiing 70 miles to one community. Barrow drew kids to the clinic by loading up a surprise box with gift toys. She even put on a tooth costume and marched with the whalers and football team in the July 4th parade.

“That is how we transformed the clinic,” Dr. Ashley told RWJF. “It is no longer a group of outsiders. We have empowered the local residents to take charge of their own teeth… Local people can provide the best care to local people.”
Thermosphere

ROBERT L. "BOBBY" SATCHER JR.
ASTRONAUT
Robert L. “Bobby” Satcher Jr.—educator, scientist, orthopedic surgeon and mentor—remembers exactly where he was when he answered two of the most important calls in his life. The first call, in January 2004, brought news that he was awarded a Harold Amos Medical Faculty Development grant from RWJF to support his postdoctoral studies at Northwestern University into how cancer cells in men spread from the prostate to the skeleton. He said the grant, tailored to support minority faculty in academic medicine, provided “the longitudinal stability” to pursue teaching and research without economic headaches.

Five years later, far from home on an unfathomably cold Saturday morning in November 2009, another memorable call jolted him awake. It was his wife and kids blasting the Isley Brothers soulful recording, “Voyage to Atlantis.” They picked the right tune, because by now “Mission Specialist” Satcher was into Day 6 of the NASA Space Shuttle Atlantis’ Thanksgiving voyage to resupply the International Space Station. The temperature on the dark side of the spacecraft was minus 200.

During Atlantis’ 12-day flight he served as mission medical officer; investigated how astronauts’ skeletal connections stretch apart in zero gravity, returning them home taller than they were at launch; set up experiments on how space affects the human immune system and the bones of mice. During two spacewalks he installed a new antenna, external storage platforms, and manipulated the shuttle’s giant robotic arms.

It was like being back in the operating room! “The surgical training carries over,” he said. “The work we are doing on the spacecraft… is a lot of intricate stuff. And it’s important to pace yourself and keep your focus the same way you do in an operating room… It’s something we’re already trained to do.”

The media dubbed him “The Twitter Astronaut,” messaging @Astro_Bones and @ZeroG_MD from 220 miles up. “Launch was amazing,” he wrote. “7.7 million pounds of thrust, mach 25, microgravity in less than 9 minutes. Awesome!” After one of his spacewalks he posted a self-portrait reflected on his helmet faceshield.

There is added significance to Dr. Satcher’s out-of-this-world career. The nephew of former U.S. Surgeon General David Satcher, he is no stranger to the difficulties people of color confront in our society. As a boy, he watched grainy TV images of NASA’s early moonwalkers and fantasized about doing the same thing someday. “But when you looked at a picture of who was in the astronaut corps,” he said, “you didn’t see anyone who looked like you.

“It had a profound effect on me, when they first allowed African Americans and women to become astronauts. After having had the good fortune to meet astronauts who were medical doctors, I decided to apply for the astronaut program, and I was lucky enough to get selected.”

He was among NASA’s final group of astronauts selected for human spaceflight and is one of only 19 African Americans out of the approximately 400 ever chosen. We were doubly pleased Dr. Satcher had his Harold Amos tee shirt along with him on the Atlantis flight.
Boston, MA

TOM DELBANCO & JAN WALKER
PRIMARY CARE DOCTOR & REGISTERED NURSE
Tom Delbanco was a pioneer before he was an RWJF Pioneer grantee. In the 1970s, a young internist and primary care doctor at Beth Israel Hospital in Boston, he was one of RWJF’s first Health Policy Fellows. He spent a year in the policy trenches on Capitol Hill, working with legends of oversight and health legislation, Rep. John E. Moss (D-CA) and Sen. Bob Dole (R-KS). A hot issue at the time was whether patients had a legal right to read their doctors’ clinical notes and charts. “No way,” Congress said, defeating legislation that would have given that right to every hospital patient in the country. Meanwhile, back in Boston, a prickly patient confronted Dr. Delbanco himself for hiding his notes. “I’m a printer,” said the patient, “I can read your writing upside down.”

Delbanco later told a reporter, “For me, that was the moment of truth.” Before long he was inviting chronically ill patients—high blood pressure, diabetes, congestive heart failure—not only to read their own medical records, but also to help write them. It was a highly innovative project at the time, and articles began to appear suggesting that patients taking part in record-sharing projects were “pleasantly surprised to be treated as adults.”

Physicians, unfortunately, were not as positive. They fretted that their raw notes would confuse, even frighten inexpert patients. As a result, Dr. Delbanco’s innovation never got traction, leaving the issue unresolved. Though the 1996 passage of HIPAA opened up patient records for the first time to everyone in the United States, little changed. Today’s patients seldom see, much less know what is written in their own records.

More than a generation later, Dr. Delbanco is still at Beth Israel, still urging doctors “to see through the eyes of the patient and understand patients’ expectations, perceptions, and experiences.” And he is still pushing physicians to let the sun shine on their notes.

This time he and his colleague, Jan Walker, RN, MBA, may well succeed, as lead investigators on Open Notes®, a $1.4 million RWJF project to analyze what happens when more than 100 primary care physicians in Boston, Pennsylvania and Seattle open their notes and charts to some 25,000 patients through the same type of interactive online “portals” activated by New York’s Commissioner Shah.

“We have one simple research question,” Delbanco explains. “After a year, will the patients and doctors still want to continue sharing notes?” After persisting for more than 30 years, this will be a long-anticipated answer.
Linda Thompson Adams is the archetype crossover nurse leader. RWJF’s Executive Nurse Fellows program, she says, gave her the confidence to follow a nursing road so high-risk and less traveled that the National Black Nurses Association granted her their most recent Trailblazer Award. About the Executive Nurse Fellows program, she said, “We were encouraged to look at how nursing could make a difference outside of nursing and in the broader community. I found out how to make policy work for the good.”

Adams’ career tracks from bedside nursing in hometown Detroit to a PhD in public health from Johns Hopkins to health policy-making for the mayor of Baltimore and governor of Maryland to the highest levels of nursing education and administration. Last year she became provost and vice chancellor of academic affairs at North Carolina A&T State University.

It was at Johns Hopkins, studying the health of rural 8th graders, that she says she realized her true calling: to advocate for vulnerable populations and for the health of women and children.

Later, as dean of the school of nursing at Oakland University just outside Detroit, she raised $60 million to train nurses and nursing administrators and to fast-track bachelor’s and advanced second-degree programs for nurses—key to solving the nation’s current nursing shortage while widening nursing’s scope of clinical practice.

Now, in her new and expanded role at North Carolina A&T she is preparing a wider spectrum of scholars, researchers and professionals to deal with social and economic determinants of life in America as varied as inequality, food security, health care, energy, technology and agriculture.

As a leader, Adams relies on the same tools that are so critical to our own work at RWJF—scholarship, research, collaboration, and connection with the community. She explained it this way some time ago to nursing students in Salt Lake City:

“Outside those beautiful buildings, people just like us are struggling to survive. Too many of these people—a disproportionate number—are people of color. They are dying within earshot of your university or school. Let the history of our time say that it was nurses who opened up the windows of America so that everyone could hear the cries for help. Let the history of our time say that it was nurses who were among the first to hear the call and respond.”

RWJF’s Initiative on the Future of Nursing, launched late 2010, is putting in place the educational, clinical and leadership platforms Adams and her nurse colleagues will need as they turn that call into action.
Camden, NJ

JEFFREY BRENNER
PHYSICIAN
Jeffrey Brenner, a family physician in Camden, N.J., was too mild-mannered to be a street fighter. Until, that is, he ran out of tolerance for the city’s notoriously dysfunctional, even dangerous health care system. “I’ve seen mothers with cancer that get diagnosed too late,” he says. “Fathers with uncontrolled blood pressure who have a stroke…depression relapse and patients descend into deeper despair…children dumped off insurance plans and lose access to their asthma medicine…families torn apart from the financial stress of no insurance.”

Serving a medical residency providing free care to poor immigrants is when Brenner became radicalized. Why, he wanted to know, was local health care always so broke? Granted, Camden was in terrible financial shape, with half the police and a third of all firefighters laid off. Still, where did all the money for health care go?

To find out, he adapted the New York City police department’s computerized “hot spot” crime-busting program to uncover the Camden neighborhoods with the highest concentrations, not of crime, but of hospital utilization. What Dr. Brenner discovered was that barely 1 percent of the city’s hospital patients accounted for 30 percent of all the city’s health care costs.

The data was convincing: Over six years, 947 patients from one housing project and one nursing home just a “hot spot” block apart, made more than 4,000 hospital visits and generated about $200 million in health care bills. One “super-user” patient had 324 hospital admissions in five years; another patient cost insurers $3.5 million.

To most policy and budget analysts, the long-established answer would be to cut costs by slashing the supply of care. Dr. Brenner, however, went the opposite direction and reduced the demand for care in the first place. Help sick people become healthier and stay out of the hospital and spending will fall.

With the help of RWJF and others, Dr. Brenner and a tiny staff sought out patients in ER waiting rooms, apartments, shelters, even street corners. Three hundred patients later, the early results are impressive. Monthly hospital and ER visits among 36 targeted super-utilizers dropped 41 percent—from 62 visits to 37. Monthly hospital bills similarly went down 56 percent—from $1.2 million to just over half a million. That’s a savings of nearly $8.5 million in the annual cost of care for just three dozen patients.

“In the next few years we’re going to have absolutely irrefutable evidence that there are ways to reduce health care costs (that) are ‘high touch’ and (those solutions) are at the level of (patient) care,” Brenner told The New Yorker’s surgeon-author Atul Gawande.
MANAGING CHANGE ON THE FRONTLINES…

“I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything new that might improve the past.”

Clara Barton
Civil War battlefield nurse
Clara Barton would have joined Jeffrey Brenner in an instant, because out of that Camden struggle comes a dramatic lesson in how the pragmatic deployment of advance practice nurses is helping fill the gap in community care caused by a disturbing scarcity of primary care physicians. The shortage goes far beyond Camden. It is national and long-term. The American Association of Medical Colleges estimates that by the end of this decade, the country will be short 45,000 family doctors (along with another 46,000 surgeons and specialists).47

Parallel shortfalls—a million or more—of nurses and nursing faculty further deepen health care’s deficit of human and intellectual capital. Left unchecked, this insufficiency of care threatens to undermine the health status of entire segments of our population, especially vulnerable minorities, the poor, the historically underserved, and the rapidly increasing numbers of the aged.

We believe that a stronger, better educated, empowered nursing profession is essential to preserving the nation’s overall good health and health care. Since our founding, we have steadily invested in nursing leadership and improvements in nursing care at the bedside.

Progress, though, comes slowly; strengthening nursing is the toughest of all our human capital challenges, perhaps because it is the system’s longest neglected component. Among the barriers: remnants of an archaic health sector culture that wrongly pigeonholes nurses as second-tier players and not as full partners in care.

An oncology nurse and op-ed contributor to The New York Times had it partly right when she wrote: “Today nurses are highly trained professionals, and in the best situations we form a team with the hospital’s doctors. If doctors are generals, nurses are a combination of infantry and aides-de-camp.”48 But they are much more than that—optimally partners collaborating in providing quality care.

The American public agrees. Speaking from personal and family experience, they say they trust nurses more than any other group involved in their health care, including their doctors and pharmacists.49

Opinion leaders in health care, business, government, and academia back them up, saying that nurses are needed more than ever at both the patient bedside and around the table where the big health care decisions are made.50

Ironically, each cyclical attempt at national health system reform has shuffled nursing farther to the margins as sideline spectators rather than on-the-field participants. We have watched with increasing dismay as the profession, lacking champions on the outside and a voice of its own on the inside, has weakened in stature and effectiveness.
Three years ago we proposed that the Institute of Medicine undertake a sweeping examination of nursing and what the nation will need from the profession in the years ahead. Anticipating the range of the IOM’s vision, we stepped in to prime the pump—committing $10 million to the investigation and related research and on readying the field for implementing its recommendations.

The IOM reported in the fall of 2010. *The Future of Nursing: Leading Change, Advancing Health* is a landmark imperative for change that comes loaded with the same urgent authority as previous IOM reports on the quality of care and on patient safety. We’re talking human and intellectual capital improvements on a massive, cross-sector scale.

The IOM’s conclusions are courageous and consequential. They found that nurses possess “a unique ability to act as partners with other health professionals and to lead in the improvement and redesign of the health system and its many practice environments.” The profession, they affirmed, has “potential capacity to implement wide-reaching changes in the health care system” and “the power to deliver better care.”

This at last provides nursing with an evidence-based justification for change to transform nursing and a blueprint for making it happen. Just now getting underway, this will be the most thorough overhaul of the profession in the history of American nursing. Key action steps include:

- **Empower nurses** to take a seat at public policy and corporate leadership tables, with a full and fair say in how patient care is designed and delivered.

- **Align nurse education upward** to provide the human capital necessary to shape the future of the profession and its impact on all of health care. A full revamping of nurse education is required to ensure that 80 percent of nurses hold bachelor degrees by 2020.

- **Enable nurses to practice to the full extent of their education and training** to offset the health professional shortages that will only be exacerbated as millions of newly insured Americans seek care and our population continues to age.

- **Promote a culture of collaboration** across professions, disciplines and sectors and acceptance of nurses as necessary and full partners with physicians and other health care professionals in improving the quality and delivery of care.

At Broward General Medical Center, in Ft. Lauderdale, Florida, an interprofessional collaborative team of doctors, nurses, social workers, school board and early intervention representatives meet to discuss patients and their needs.
As a next step, in partnership with AARP, we set up Future of Nursing™ Campaign for Action, to build on the report’s recommendations. At the national level we seek to engage all professions, policymakers, payers, business executives, licensing bodies, educational institutions, foundations, consumer advocacy groups and others. At the same time, Action Coalitions are forming in states—15 now but quickly expanding—to spur action for change on the state level. Our nation is under pressure to transform its health care system, which will require full utilization of all providers—especially nurses. Working together we can become a nation where all Americans have access to high-quality, patient-centered care.

It has long been our conscious intention to help Americans realize the best health and health care of any people on Earth. To get us there, we recruit and champion an eclectic band of remarkable individuals gifted with the intangibles of true grit, sharp intellect, collaborative spirit, and an unshakeable confidence in the power of our own conscious intentions to get this job done—and done right—a day at a time, within the span of our lifetime. This African proverb puts it perfectly:

“Tomorrow belongs to the people who prepare for it today.”

Now, after all these days spent preparing for tomorrow, I see that when the mentors of our youth turn us to that mirror, they are in fact setting our sights on the tomorrow they know is already coming into view. We strive for our philanthropy to prepare for tomorrow with an elegance no less precise.

Respectfully submitted,

Risa Lavizzo-Mourey, MD, MBA
President and Chief Executive Officer

“Running through these snapshots from RWJF’s family album are common threads of the character, condition and consequences of history unfolding in real time. These stories present us with anecdotal evidence that, as columnist George Will suggests, “Americans, more than most people, believe that history is the result of individual decisions to implement conscious intentions.”

At the University of Miami nursing school, nurses teach students in classrooms that look and feel like hospitals.
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9 Gila Regional Medical Center in Silver City, 15 miles west, has an ER, outpatient surgery, mental health services, and non-critical inpatient care.
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10 See a terrific video of her from the NM Primary Care Association at http://vimeo.com/14246913
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11 http://en.wikipedia.org/wiki/La_Adelita
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13 “Stalk Interviews.”
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16 Profile of Dr. Arora.
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18 Project Echo at www.rwjf.org/pr/product.jsp?id=71905
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20 www.rwjf.org/pr/product.jsp?id=71905
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38 Health Insurance Portability and Accountability Act. See www.hhs.gov/ocr/privacy/
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49 See, for example, “Patients Trust Nurses More Than Doctors,” Readers Digest, April 2009. www.nursingtimes.net/whats-new-in-nursing/management/patients-trust-nurses-more-than-doctors/5000550.article
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