Robert Wood Johnson Foundation

Year in Review

For more than 30 years the Robert Wood Johnson Foundation has brought experience, commitment and a rigorous, balanced approach to the problems that affect the health of those we serve.

As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, we help people lead healthier lives and get the care they need.

Working with diverse partners, we address many of the most difficult health and health care issues facing the United States, attacking problems at their deepest roots. We advance our mission by supporting training, education and research and through groundbreaking demonstrations that promote effective services, particularly for the most vulnerable among us. This Year in Review provides a comprehensive analysis of our work in 2006.

Statistical Highlights

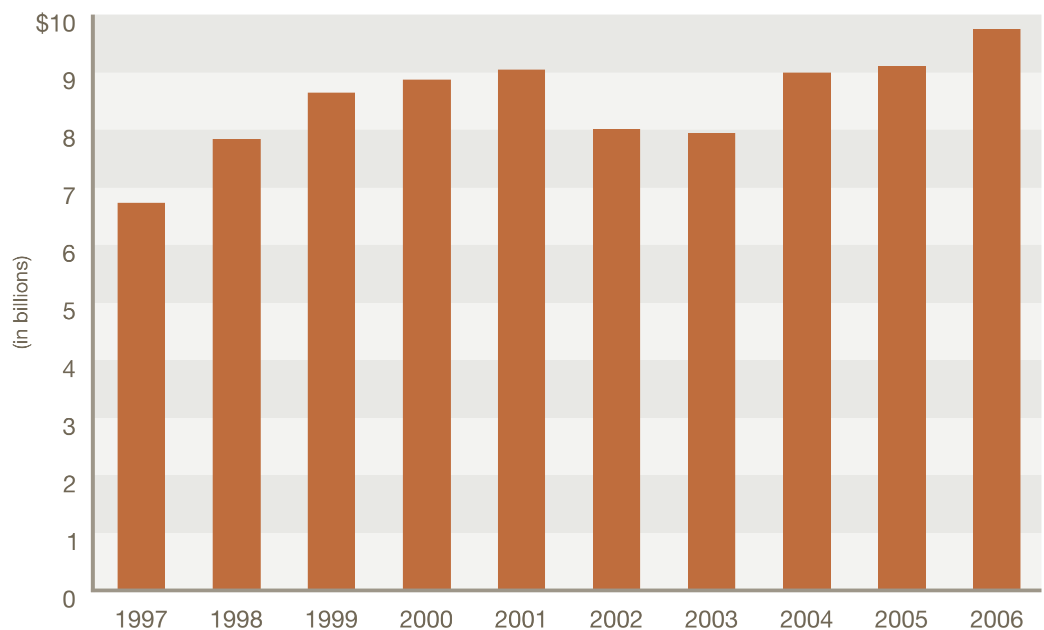
In 2006 we awarded 928 grants and contracts providing $403 million in support of programs and projects to improve health and health care in the United States. The awards were distributed as follows:

The Year in Review

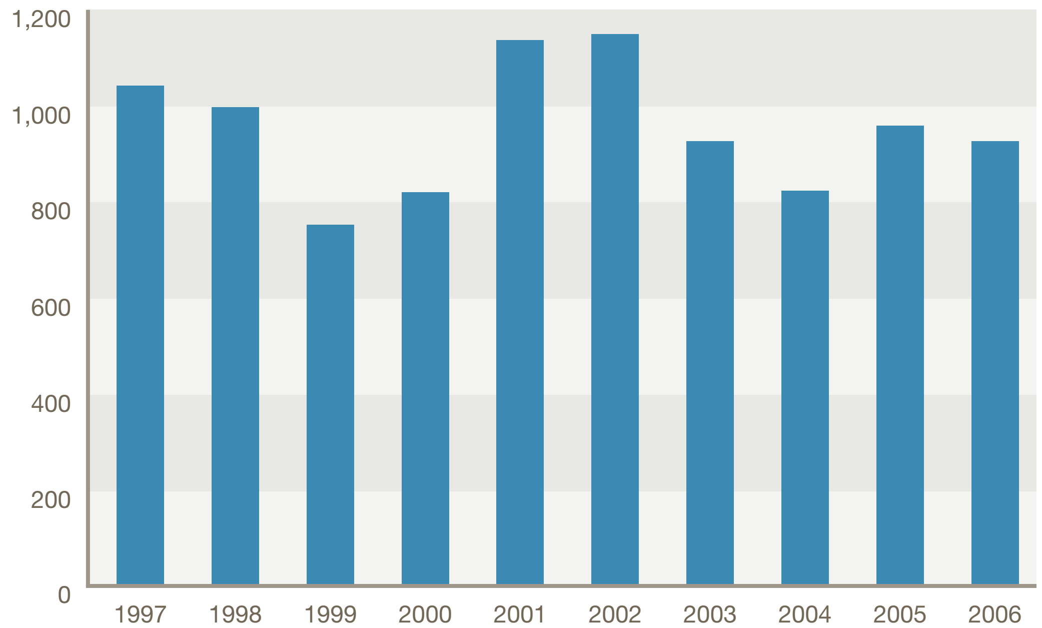
January 1–December 31, 2006

Total Assets	$9.74 billion
Total Dollar Amount of Grants and Contracts Awarded*	$403 million
Total Dollar Amount of Grants and Contracts Paid**	$367.57 million
Total Number of Proposals Received	6,588
Total Number of Grants and Contracts Awarded	928
Average Grant Amount	$434,533

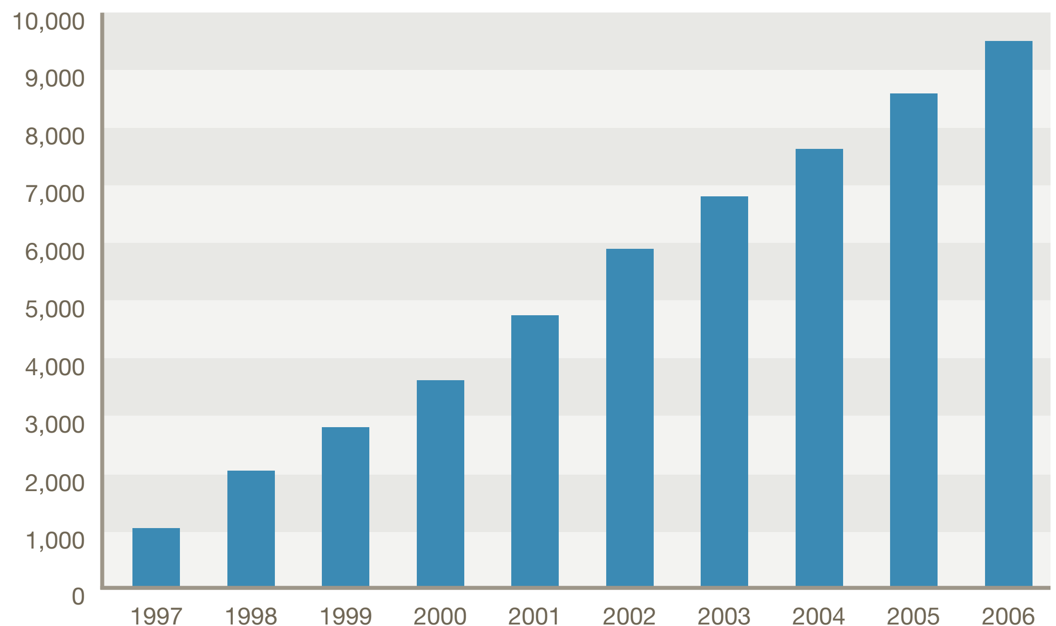
Assets of the Foundation 1997–2006



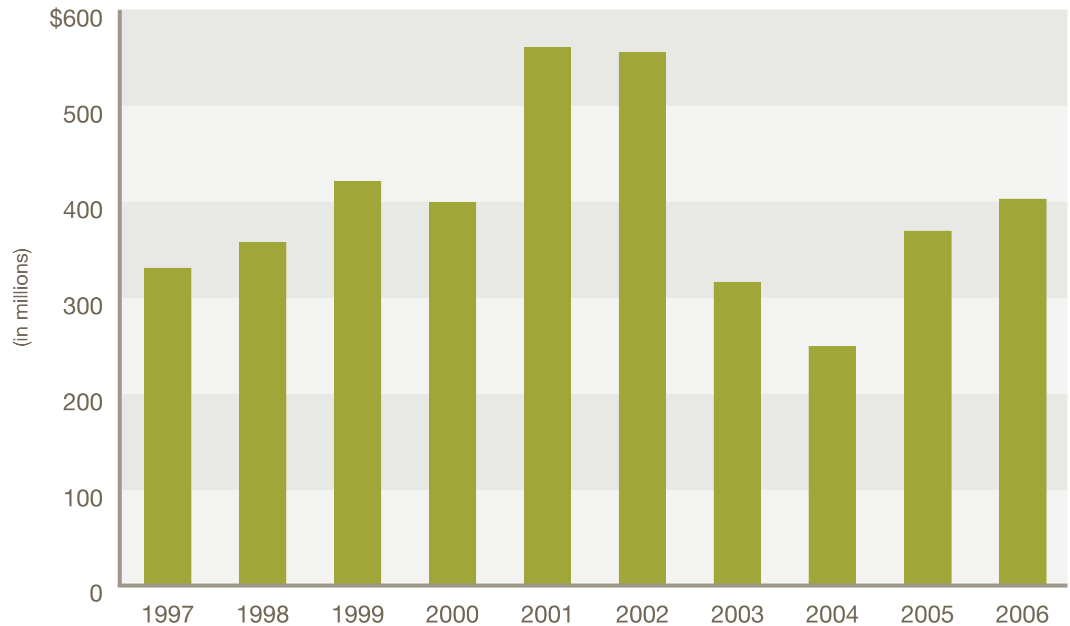
Number of Grants and Contracts Awarded by Individual Years



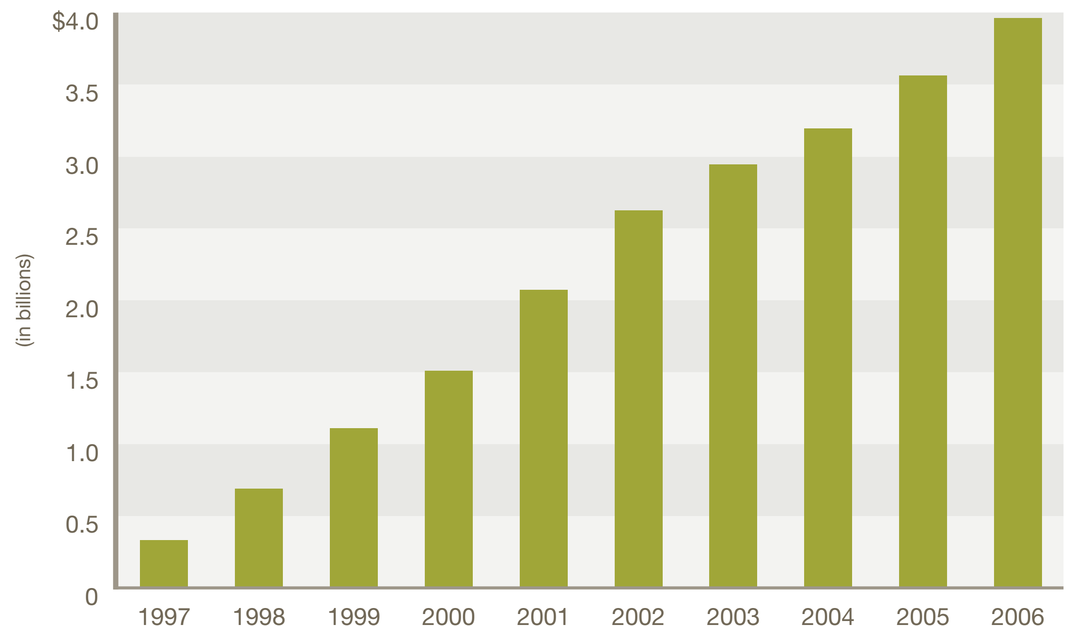
Cumulative Number of Grants and Contracts Awarded



Dollar amount of Grants and Contracts Awarded* by Individual Years

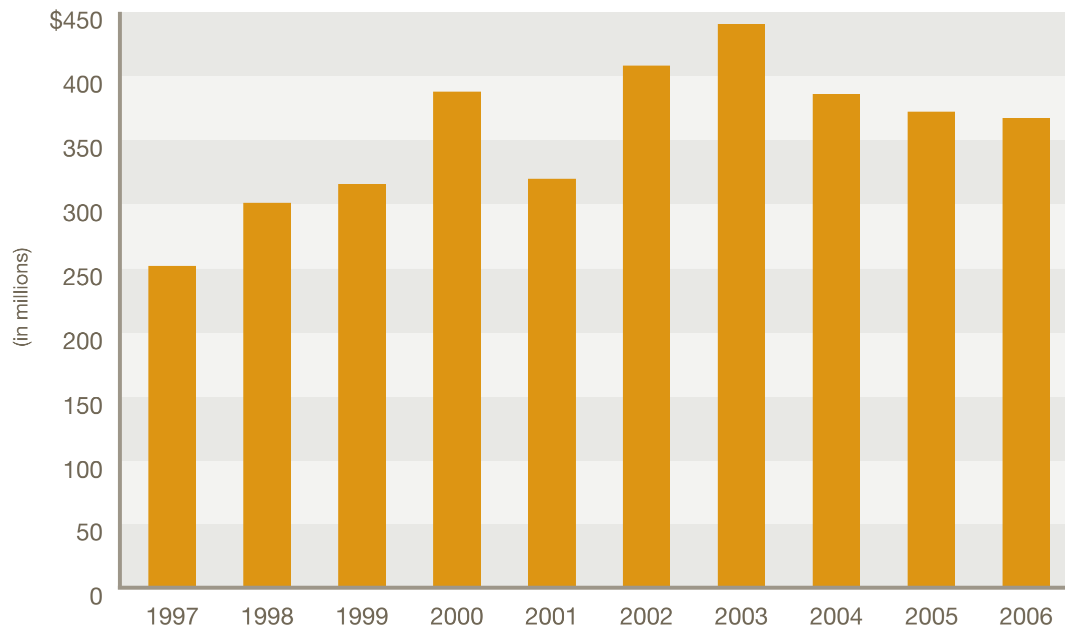


Cumulative Dollar Amount of Grants and Contracts Awarded*

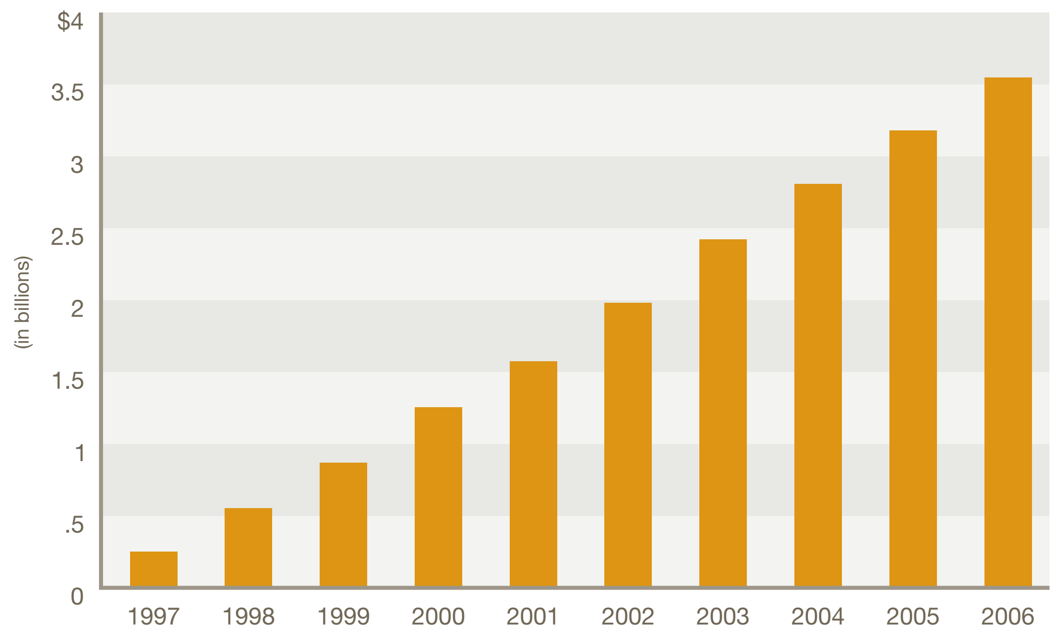


*Grants and Contracts Awarded reflects commitments made in the current year (2006) for program activities, for which payments may be made in 2006 or in subsequent years.

Dollar Amount of Grants and Contracts Paid** by Individual Years



Cumulative Dollar Amount of Grants and Contracts Paid**

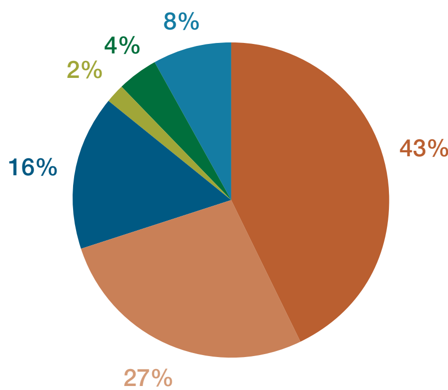


**Grants and Contracts Paid reflects program authorizations and awards made in the current year (2006) or in prior years for which payments were made in 2006.

Distribution of Funds

In 2006 we awarded 928 grants and contracts providing $403 million in support of programs and projects to improve health and health care in the United States. The awards were distributed as follows:

Distribution of Awards by Portfolios ($403 Million)



43% Targeted
$173.84 million for programs that address specific improvements in eight targeted health and health care challenges within a defined time period.

27% Human Capital
$106.97 million for programs that attract, develop and retain high-quality leadership and a workforce to improve health and health care.

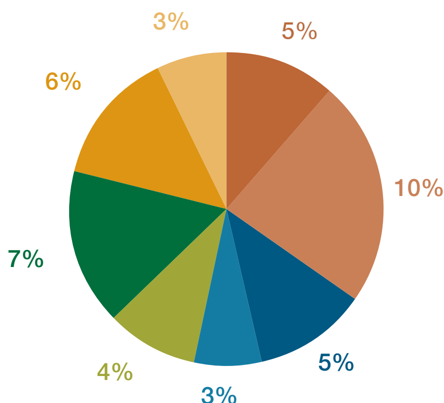
16% Vulnerable Populations
$64.80 million for programs that promote community-based projects that improve health and health care outcomes for society's most vulnerable people.

2% Pioneer
$8.06 million for programs that promote breakthroughs in health and health care through innovative projects.

4% Other
$17.14 million for programs that are consistent with the Foundation's overall mission but are not aligned with a portfolio or targeted objective.

8% New Jersey
$32.19 million for programs mainly in New Brunswick and the surrounding Middlesex County communities as well as health initiatives throughout the state.

Distribution of Awards in Targeted Portfolio, by Program Area ($173.84 Million)



5%	Addiction Prevention and Treatment ($19.18 million)
10%	Childhood Obesity ($41.61 million)
5%	Coverage ($19.40 million)
3%	Disparities ($10.71 million)
4%	Nursing ($17.87 million)
7%	Public Health ($29.41 million)
6%	Quality Health Care ($23.12 million)
3%	Tobacco Use and Exposure ($12.54 million)

Distribution by Geographical Region ($403 Million)

Region	Percentage of RWJF Funds
West-North-Central	2.31%
East-North-Central	10.08%
New England	11.47%
Middle Atlantic	30.00%
South Atlantic	20.71%
East-South-Central	1.47%
West-South-Central	5.16%
Mountain	3.94%
Pacific	14.86%

Addiction Prevention and Treatment

Substance-use disorders and addictions afflict more than 20 million Americans, often with devastating effects on their health and on the well-being of their families.

We know from definitive studies that only a small fraction of those who might benefit from addiction care get the treatment they need. Access to treatment is limited and few treatment programs are based on practices known to produce the best results.

In 2006 the Foundation continued to support efforts to improve community systems of care by helping youth deal with substance-use issues through national programs such as *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime®*. RWJF also continues to improve the effectiveness and efficiency of treatment through *Paths to Recovery: Changing the Process of Care for Substance Abuse Programs™*, designed to get more people into treatment and keep them there.

Over the past decade there has been significant progress in developing and testing effective evidence-based interventions for addiction. But these practices are not yet readily available in most communities nor routinely used among the 13,000 publicly funded treatment programs. Studies show that people suffering from alcohol dependence, for example, receive recommended care about 10 percent of the time in primary care settings; as few as 17 percent of addiction treatment programs use recommended pharmaceutical interventions for the treatment of alcohol or opioid dependence. Less than 50 percent of addiction treatment programs use proven psychosocial interventions such as cognitive behavioral therapy, contingency management and motivational enhancement therapy.

In 2006 we made a major commitment to stimulating the spread of evidence-based practices with the launch of *Advancing Recovery: State/Provider Partnerships for Quality Addiction Care*, an $11-million program designed to encourage treatment providers to use evidence-based practices through innovative partnerships with single state agencies.

To promote effective implementation of evidence-based practices, Advancing Recovery will support partnerships between provider organizations that deliver care and state agencies that purchase and regulate treatment services.

These partnerships focus specifically on increasing the rate of use of treatment practices in five categories identified by the National Quality Forum:

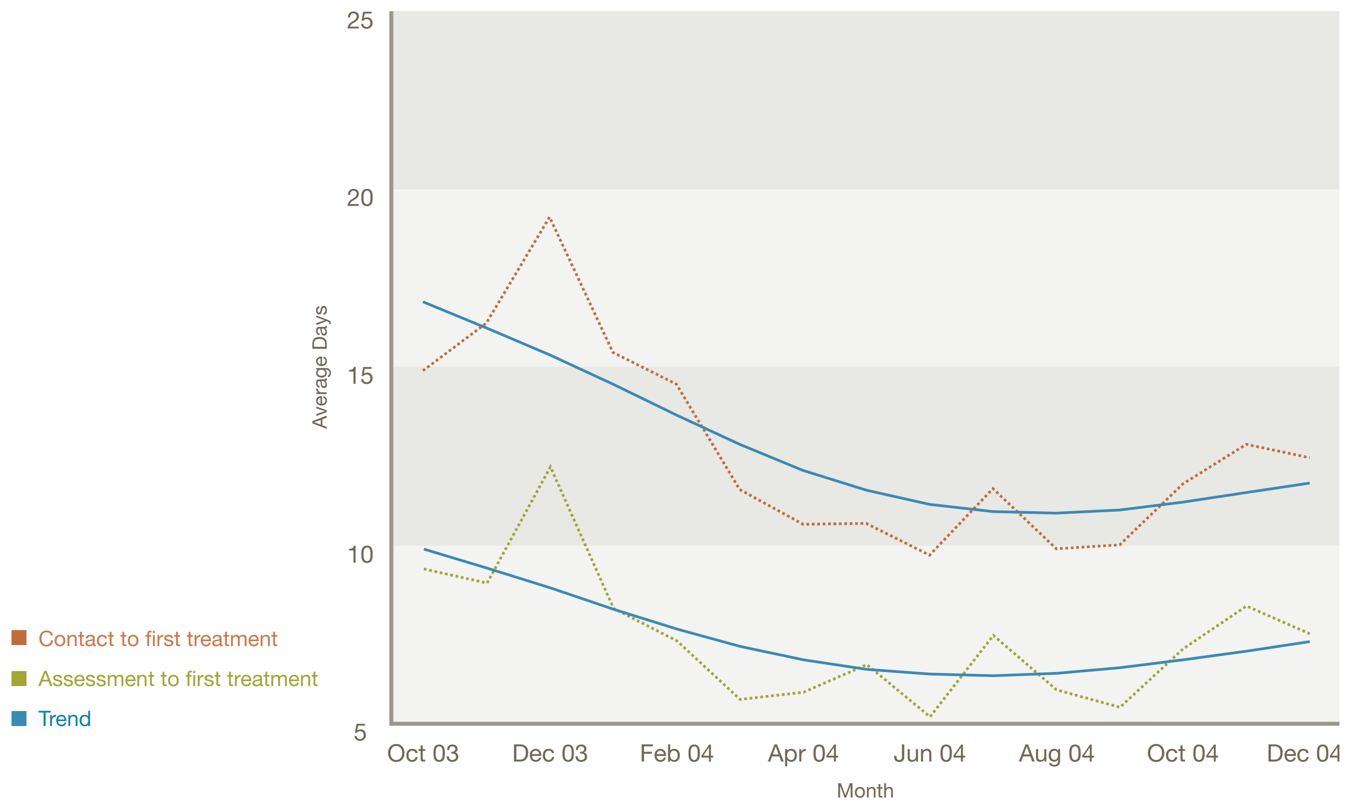
• Use of medications for specific diagnoses;
• Screening and brief interventions in primary care settings;
• Use of specific psychosocial clinical interventions;
• Use of post-treatment care;
• Provision of case management, wraparound and supportive services.

Advancing Recovery takes an innovative approach by bringing state agencies and treatment programs together to develop and improve *administrative* practices that encourage and sustain greater use of evidence-based *clinical* practices at the program level. The first round of funding for the initiative began in November 2006. Six state-provider partnerships in Missouri, Maine, Delaware, Florida, Kentucky and Rhode Island were selected to participate in a learning network. In addition to partnership grants, the initiative provides educational and communications support to help grantees overcome barriers to using proven methods.

In the coming year we will continue to support our current treatment programs for alcohol and drug addiction, and will make supplemental investments to measure the quality of care, overcome barriers to achieving quality care in local treatment settings, and help states develop reimbursement, licensing and accreditation policies that encourage greater use of evidence-based treatment practices.

For additional information about our initiatives and objectives, visit *www.rwjf.org/addiction*.

Mean Days Between Contact and First Treatment Session and Between Assessment and First Treatment Session by Month of Admission



SOURCE: The Network for the Improvement of Addiction Treatment: Enhancing Access and Retention. *Drug and Alcohol Dependence,* 2006.

Childhood Obesity

The focus of this year's President's Message, Childhood Obesity is one of the most pressing public health threats facing our nation. Rates of childhood obesity in the United States have quadrupled over the past three decades, and the epidemic is widely recognized as a public health crisis.

If current trends continue, today's young people could be the first generation in American history to live sicker and die younger than their parents' generation. The Robert Wood Johnson Foundation (RWJF) is dedicated to reversing the childhood obesity epidemic by improving the environments in which children live, learn and play, and by supporting policy changes that promote healthier eating and increased physical activity. We place special emphasis on reaching African-American, Hispanic, Native American and Asian/Pacific Islander children living in low-income communities, who are at greatest risk for obesity and its related health threats.

Two years ago, Congress passed the Child Nutrition and WIC Reauthorization Act, which required nearly all schools to develop wellness policies by the start of the 2006–2007 academic year. Because schools hold enormous potential to improve children's eating and activity patterns, the Foundation has focused on encouraging schools to include the most promising obesity-prevention practices in their wellness policies.

To provide guidance to schools, RWJF helped initiate and fund the Alliance for a Healthier Generation's Healthy Schools Program, which developed and promoted policy recommendations for nutrition, physical activity and staff wellness. Two hundred thirty-one schools serving diverse populations in 13 states have been recruited as pilot sites for the Healthy Schools Program. Those schools are receiving hands-on support to implement their wellness policies, and they are helping us learn what it will take to expand the program nationwide. The Alliance has created the Healthy Schools Builder, an online tool that is available to schools throughout the country to help them learn about wellness policies and customize their own programs. All schools that implement the Healthy Schools recommendations will receive national recognition and help in making their schools even healthier.

Because evaluation is a fundamental building block of our policy efforts, RWJF is supporting two phases of evaluation for the Healthy Schools Program. The first will explore what changes were made in schools; the second will examine what effect those changes had on kids' nutrition, physical activity and—ultimately—body mass index (BMI). The Healthy Schools

Program will continually refine its recommendations based on these findings and will work to spread the most effective policies and practices to schools nationwide.

We have invested in other major initiatives to help us learn how to prevent childhood obesity and to identify the key policy levers for doing so. RWJF's *Bridging the Gap: Research Informing Practice and Policy for Healthy Youth Behavior* initiative is combining information about policies with school survey data to generate a complete understanding of how policies related to physical activity, nutrition and BMI screening are being implemented on the ground, as well as the impact of those policies on student behavior. The study will examine state and school district policies, school practices and community characteristics, to identify and drive effective obesity-prevention practices. We also are working with the National Cancer Institute to measure the adequacy of school-based food, physical activity and BMI policies based on their likelihood of affecting student behavior and BMI.

Through RWJF's *Healthy Eating Research: Building Evidence to Prevent Childhood Obesity* program, we support evaluations of statewide nutrition-related wellness policy initiatives in California, Connecticut, Maine, North Carolina, Pennsylvania and Washington. These projects place special emphasis on assessing which policies are most effective in improving nutrition for children at greatest risk for obesity.

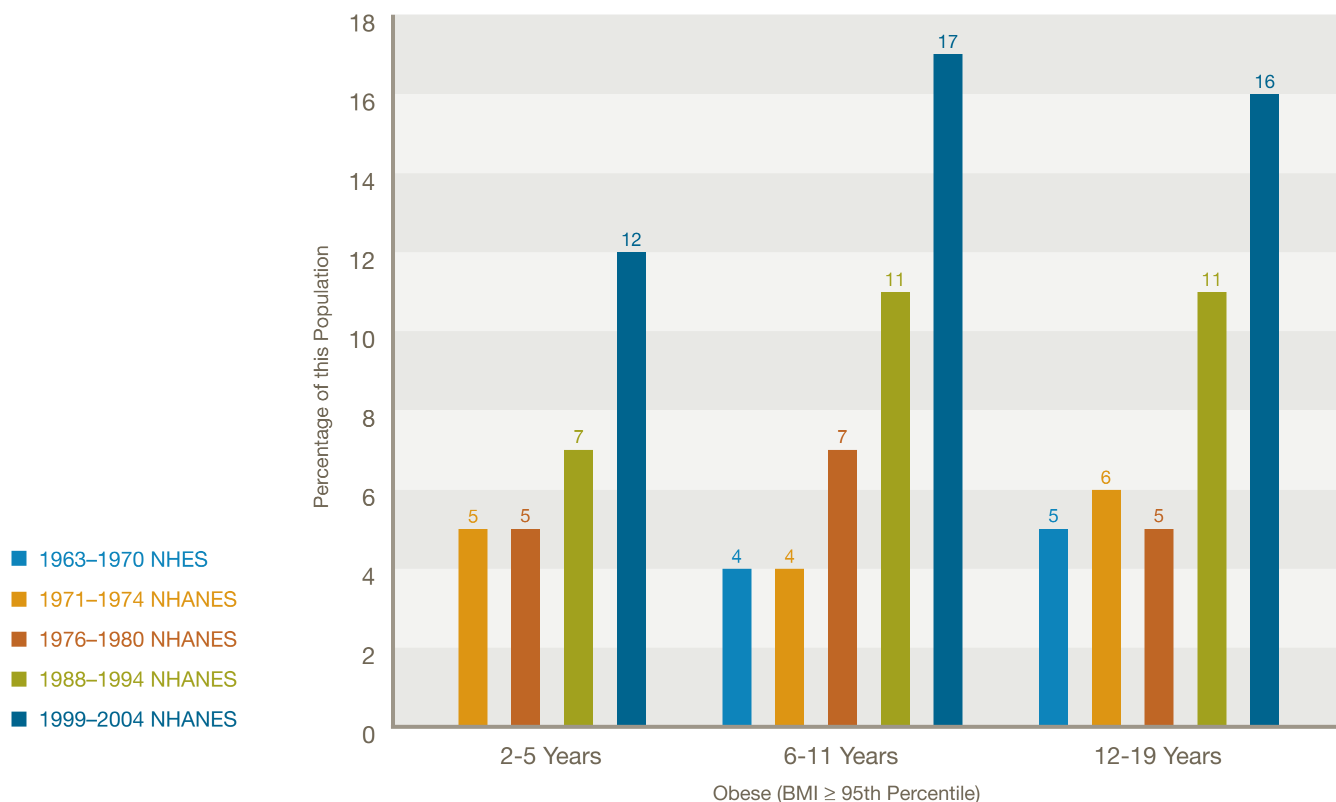
In Arkansas we are funding an independent evaluation of efforts to implement a state law passed in 2003 that mandated a comprehensive approach to addressing childhood obesity in all public schools. This evaluation project and a separate RWJF-funded initiative to analyze BMI data for all Arkansas public school students should point the way to which approaches being tried in Arkansas schools are most successful. The BMI initiative already has demonstrated that, in just three years, Arkansas has halted the progression of the epidemic in the state.

Core to RWJF's mission is a focus on translating research into effective policy and practice to improve health. To that end, RWJF funded an innovative effort by California's Project LEAN and the California School Board Association to develop ways to quickly distribute information about promising wellness policies and to help other states replicate California's highly regarded programs. Partners in the Foundation's *Active Living Leadership* program are supporting the efforts of state and local policy-makers to implement school wellness policies that promote good nutrition and increased physical activity. Among the many efforts of these important partners, the National Conference of State Legislatures produced a legislative brief on school wellness policies for its members, and the American Association of School Administrators and the National League of Cities are teaming up to offer a leadership academy on the topic.

RWJF is poised to communicate the results of these school-based efforts to policy-makers, educators, parents and public health leaders throughout the nation. In 2007 the Foundation will continue its focus on school-based childhood obesity prevention programs and will monitor the implementation and impact of new school wellness policies. Beyond the school grounds, we will work to promote policy and environmental changes at the state and local level that encourage healthy eating and physical activity for all children and families, but especially those at greatest risk for obesity and related harms.

For additional information about our initiatives and objectives, visit *www.rwjf.org/obesity,* and the 2006 President's Message.

Obesity Prevalence Among U.S. Children and Adolescents by Age and Time Frame, 1963–2004



SOURCE: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey for 2003 and 2004.

NOTE: NHES=National Health Examination Survey. NHANES=National Health and Nutrition Examination Survey. Data for 1963 to 1965 are for children ages 6 to 11 years; data for 1966 to 1970 are for adolescents 12 to 17 years instead of 12 to 19 years.

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Coverage

Providing access to health care coverage remains an acute and difficult challenge.

Today more than 46 million Americans, including more than 8 million children, go without health insurance. This lack of coverage is the single greatest barrier to obtaining timely, appropriate health care services. Therefore, focusing on insuring children has been an important strategic choice for the Foundation—an essential step toward ensuring that *all* Americans have access to quality health care.

We have been working to enroll uninsured, eligible children in public health care coverage programs and are tracking progress toward that goal. Even though the total number of Americans without health insurance is on the rise, a recent study by the State Health Access Data Assistance Center shows that the proportion of kids who are uninsured in America has decreased by 20 percent since the creation of the State Children's Health Insurance Program (SCHIP). States with the biggest decline in the percentage of uninsured kids are Arkansas (–60 percent), Maine (–50 percent), Alabama (–47 percent), South Carolina (–46 percent) and North Dakota (–44 percent).

Despite this progress, the latest census data (2005) show that nearly 8.3 million children remain uninsured nationwide. Experts say that more than 70 percent of these children are likely eligible for low-cost or free health care coverage through SCHIP or Medicaid, but have not yet been enrolled.

Therefore, we will continue to promote enrollment of uninsured children in SCHIP and Medicaid as one way to help achieve the goal of ensuring that all Americans have access to quality care. We will also work with the National Academy for State Health Policy to explore opportunities to expand coverage within Medicaid and SCHIP.

In addition to supporting children's coverage, we will conduct research and evaluate state reforms, while continuing to explore how burgeoning efforts on the part of states to improve coverage might influence a national approach to ensuring access to care.

For additional information about our initiatives and objectives, visit *www.rwjf.org/coverage*.

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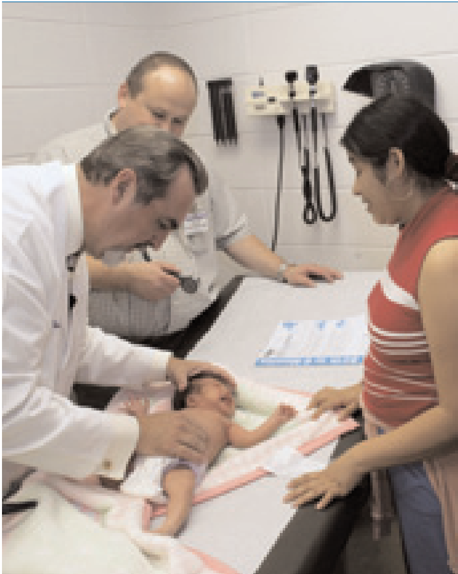
Public Insurance Coverage Change Among U.S. Children from 1997–1998 to 2003–2004

Percentage of Change

25
20
15
10
5
0
-5
-10

Massachusetts
Tennessee
Minnesota
New Hampshire
Delaware
Pennsylvania
Hawaii
Oregon
New Jersey
Virginia
West Virginia
Nebraska
Illinois
District of Columbia
Michigan
Georgia
Utah
North Dakota
New York
Connecticut
Ohio
Kentucky
Colorado
Kansas
California
Nevada
North Carolina
Iowa
Florida
Washington
Texas
Missouri
Vermont
Rhode Island
Alabama
Montana
Idaho
Maryland
Wisconsin
Arizona
South Dakota
Oklahoma
Louisiana
South Carolina
Indiana
Wyoming
New Mexico
Maine
Alaska
Mississippi
Arkansas

SOURCE: State Health Access Data Assistance Center, University of Minnesota School of Public Health, using data from the U.S. Census Bureau's Current Population Survey 1998, 1999, 2004 and 2005, *The State of Kids' Coverage*, August 2006.



Disparities

To ensure that all Americans get quality health care, we have been focused on finding practical, effective solutions that will help health care systems target racial and ethnic disparities as part of their overall quality improvement efforts.

The quality of health care in the United States is not what it should be. Research indicates that stark differences exist in how we deliver health care to patients from region to region—irrespective of factors such as the prevalence of certain diseases or cost—and moreover, that Americans from certain racial and ethnic backgrounds are more likely to experience lower quality health care overall.

One indicator we use to measure progress is whether health plans, hospitals and others increasingly use race and ethnicity data about patients to help inform their efforts to improve quality. Stratifying patient data by race and ethnicity can be a useful first step in understanding where gaps in quality are occurring, and why.

Many health care organizations initially expressed concern about collecting patient data by race and ethnicity, citing potential technical, legal and policy challenges to this activity. Indeed, any effort to make information about one's health and health care more widely available triggers these sorts of concerns. To analyze the legal and policy environment surrounding health information initiatives, the Foundation supported the Health Information Law Project at George Washington University, which categorizes and analyzes the most relevant legal and policy issues inhibiting greater transparency of health care information in today's world. In 2006 the Project affirmed the legality of collecting patients' race and ethnicity data for the purposes of improving health care quality.

Health plans play an essential role in tracking and monitoring the quality of care delivered to millions of patients, and are positioned to create programs that help physicians and patients manage specific diseases and coordinate care. RWJF has supported several projects involving health plans in collecting data to improve quality and identify racial and ethnic disparities. In 2006 America's Health Insurance Plans conducted a follow-up to its 2003–2004 survey that: (1) assessed the extent to which health insurance plans collect and use race and ethnicity data; (2) highlighted barriers to the collection of such data; and (3) assessed new trends and major differences from the prior survey. The 2006 survey showed that collectively, 30.9 percent of commercial, Medicaid, and Medicare plans are able to obtain or collect

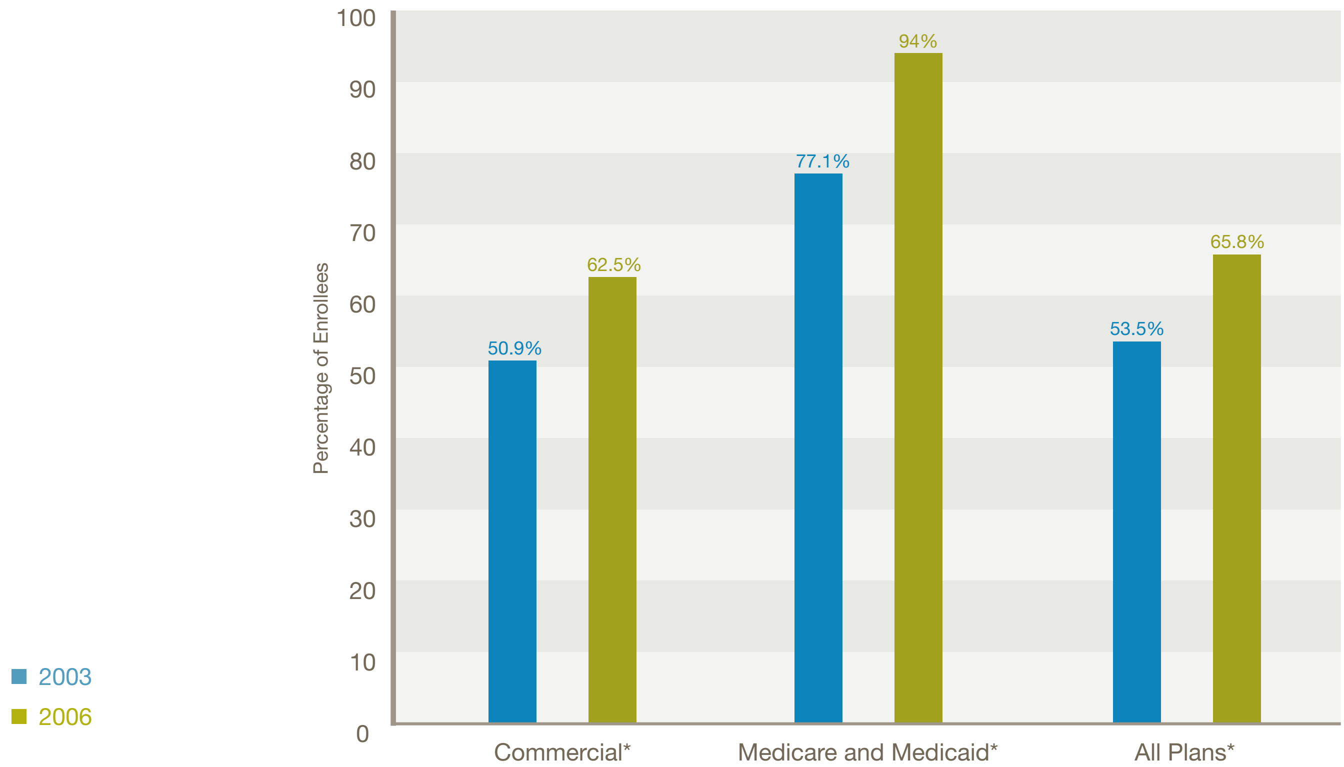
racial and ethnic data from enrollees directly; 39.4 percent are able to do it indirectly; and 29.8 percent obtain data both directly and indirectly. The survey also showed a significant increase in the number of plans that now collect racial and ethnic data as part of organization-wide initiatives, rather than having programs limited to specific departments.

The National Health Plan Collaborative's first phase of work brought together multiple organizations, including the federal Agency for Healthcare Research and Quality and nine major health insurance companies, to examine different methods of analyzing existing data to determine if insurers could more effectively target quality improvement activities to specific enrollee populations.

RWJF has also supported several projects focusing on how hospitals collect and use race and ethnicity data to reduce disparities in care. For example, *Expecting Success: Excellence in Cardiac Care*, is a national program that brings together 10 general acute care hospitals across the nation to improve quality and reduce racial and ethnic disparities in cardiac care. Expecting Success hospitals have begun to track data based on patient race, ethnicity and primary language as a tool to ensure consistent quality of care for diverse patient populations. The Foundation also supports the Health Research and Educational Trust (HRET) to link key patient demographic information to nationally recognized measures of quality health care. HRET works with the American Medical Association and four federally qualified community health centers serving over 65,000 clients to improve the flow of this critical information.

For additional information about our initiatives and objectives, visit *www.rwjf.org/disparities.*

Enrollees in Plans that Collect or Obtain Race and Ethnicity Data, by Year



2003
2006

SOURCE: America's Health Insurance Plans, Collection and Use of Race and Ethnicity Data for Quality Improvement: 2006 AHIP–RWJF Survey on Health Insurance Plans, November 2006.

NOTE: *Percentage-value of equal to or less than .05 is significant.
Data is weighted by enrollment.

Robert Wood Johnson Foundation

Nursing

Nursing is a major component of the Foundation's focus on improving the quality of health care for all Americans.

Having an adequate supply of nurses is essential to achieving care that is safe, effective, patient-centered, timely, efficient and equitable. One of our key objectives is to transform the way that care is delivered in hospitals to allow nurses to spend more time with their patients, with the ultimate goal of improving the quality of care in hospitals.

There is a clear link between the care that nurses provide and improved patient outcomes—fewer falls, reduced pressure ulcers, fewer unanticipated deaths. We need to do a better job of understanding and measuring nursing's contribution to high-quality care. *Transforming Care at the Bedside* (TCAB) is a program of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement (IHI) to increase nurse retention and improve the quality of patient care. Hospitals participating in TCAB are tracking measures of quality care that are linked to the work of nurses. The National Quality Forum (NQF), an organization focused on health care quality measurement and reporting, has identified and endorsed 13 of these nursing-sensitive measures. TCAB hospitals are using four of these: fall prevalence, pressure ulcer prevalence, failure to rescue (that is, death among patients with serious but treatable conditions) and voluntary nurse turnover. We are learning through TCAB how best to track these measures; our goal is for every TCAB hospital to see improvement in at least two of these measures by 2007.

The TCAB hospitals have already made good progress on one important indicator of high-quality care: a low rate of voluntary nurse turnover. Nurses are the health care professionals who spend the most time providing direct care to patients, so when turnover is high and experienced nurses leave, patient care is compromised. Across the hospitals currently participating in TCAB, IHI reports annual nurse turnover on TCAB units has decreased from about 15 percent when the program began in 2003 to about 5 percent in 2006.

As the TCAB hospitals continue their efforts to make progress on the other NQF-endorsed nursing-sensitive measures, they report reducing falls through changes to the design of patients' rooms (for example, the installation of safety bars) and changes to hospital culture

to ensure that every staff member—from the janitor to nurses to the chief executive officer—has a role and a responsibility in preventing patient falls.

And several TCAB hospitals report that they are improving rates of rescuing as they introduce rapid response teams—groups of experienced clinicians that nurses and other hospital staff (and, in some cases, even patients and their family members) can call on if they sense that a patient's condition is deteriorating. Because these teams intervene before a patient reaches a more critical point of distress, hospitals believe that rapid response teams are improving their rates of rescuing.

A key challenge to understanding and quantifying the hospitals' progress on nursing-sensitive measures has been a lack of consistent data and reporting. Tracking staff turnover rates is standard practice at almost any hospital. However, a common definition of a fall (for instance, does an "assisted fall"—when a nurse catches a patient and eases him to the ground safely—constitute a fall?), or a failure to rescue, requires more nuanced effort and attention. Through a national effort led by the NQF, we are tracking collection of the NQF nursing-sensitive measures, along with barriers and facilitators to using these measures for improvement. These results will both assist and be informed by the measurement efforts of the TCAB hospitals.

In 2006, with support from an evaluation team, TCAB hospitals began using a standardized reporting form to track their data, which we expect will provide a more efficient, less burdensome reporting system in the future. Hospitals track progress on the NQF-endorsed measures as well as other dimensions of care, such as percentage of nurses' time spent caring for patients, average length of patient stay, and staff and patient satisfaction.

Although we know anecdotally and intuitively that the work of nurses has a direct effect on length of patient stay and patient satisfaction, there is limited research that demonstrates the causal link between nurses' contributions and improved patient outcomes. In 2007 the Foundation's *Interdisciplinary Nursing Quality Research Initiative* will continue to build and share evidence of nurses' effect on care quality through processes such as care coordination, pain management and symptom assessment. As we continue to generate, disseminate and translate evidence that demonstrates nurses' direct link to improved patient care, the program will explore opportunities to reward nurses for high-quality outcomes such as offering pay-for-performance incentives.

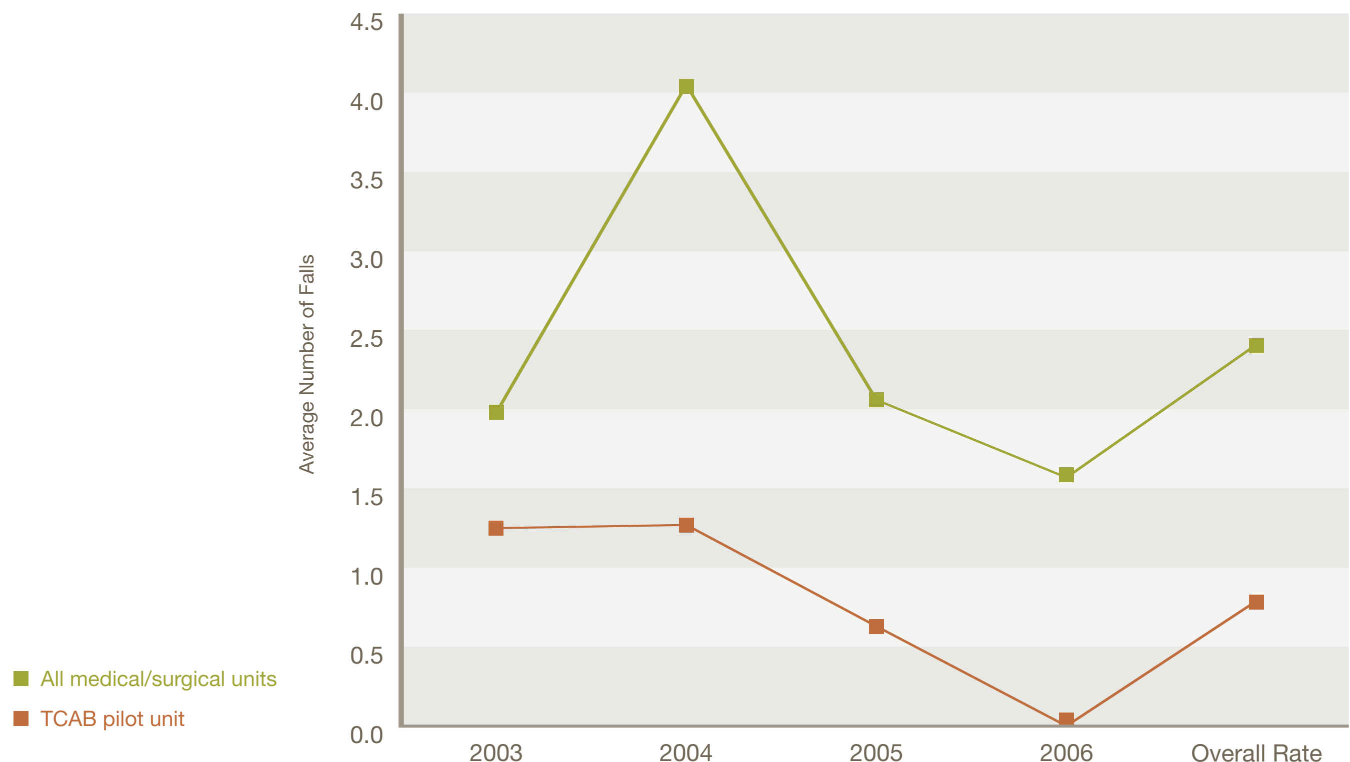
Looking ahead, as the nursing profession ages—the average age of a nurse is nearly 47—the Foundation is expanding its efforts beyond TCAB to identify successful strategies for retaining experienced nurses. In 2006 the Foundation launched a new program,

Wisdom at Work: Retaining Experienced Nurses, which will assess promising interventions to retain older nurses through human resources policies, the use of new technology, and changes in ergonomics and the physical design of the hospital.

Although we recognize the importance of retaining experienced nurses, we also understand that retention strategies alone will not be sufficient to curb the persistent nursing shortage in the United States. An aging faculty also creates tremendous challenges for the nursing workforce. With the majority of nurses educated at the associate degree level, with less than 12 percent going on for a baccalaureate degree, the pipeline for faculty is severely diminished. Moreover, a recent study by the National League for Nursing found that almost two-thirds of all full-time nurse faculty members are 45 to 60 years old and likely to retire in the next five to 15 years. Schools of nursing already report turning away more than 40,000 qualified student applications annually, largely because of a lack of faculty. In 2007 the Foundation will invest significant resources to address this critical shortage of nurse faculty.

For more information about our initiatives and objectives, visit *www.rwjf.org/nursing*.

Annual Patient Falls at Cedars-Sinai



NOTE: Average annual patient falls resulting in injury, per 10,000 patient days

SOURCE: Cedars-Sinai Medical Center

Robert Wood Johnson Foundation

Public Health

All Americans deserve a high-functioning, modern public health system that is capable of protecting them from everyday health threats like infectious diseases and exposure to second-hand smoke as well as less common, unsettling health emergencies like pandemic flu, bioterrorism or natural disasters.

We recognize the primacy of the public health system, with state and local public health departments at the system's core, in making our communities healthier places to live, work and play. This includes ensuring the safety of the air we breathe, the water we drink, and the food we eat, as well as advancing public policies to improve health, stimulating community involvement, triggering private action and changing, even inventing, systems of promoting and delivering the best health and health care to the most people.

In 2006 we focused on improving the performance and accountability of state and local public health departments. With the Centers for Disease Control and Prevention, the Foundation co-funded the Exploring Accreditation project, a first-of-its-kind initiative that brought together federal, state and local public health leaders to determine the viability of a voluntary national accreditation program, and if viable, its optimal structure. Exploring Accreditation is coordinated by the National Association of County and City Health Officials, the Association of State and Territorial Health Officials, the American Public Health Association, and the National Association of Local Boards of Health, in partnership with other stakeholders.

In September a 25-member steering committee released its accreditation recommendations, which are widely viewed as a groundbreaking development in public health. The recommendations propose that a nonprofit organization be established to oversee accreditation; call for the development of accreditation standards that promote continuous quality improvement, the pursuit of excellence, and accountability for the public's health; and suggest that initial financing for the program come from interested grantmakers, government agencies, and organizations of state and local health departments. An implementation plan will be developed in the coming year.

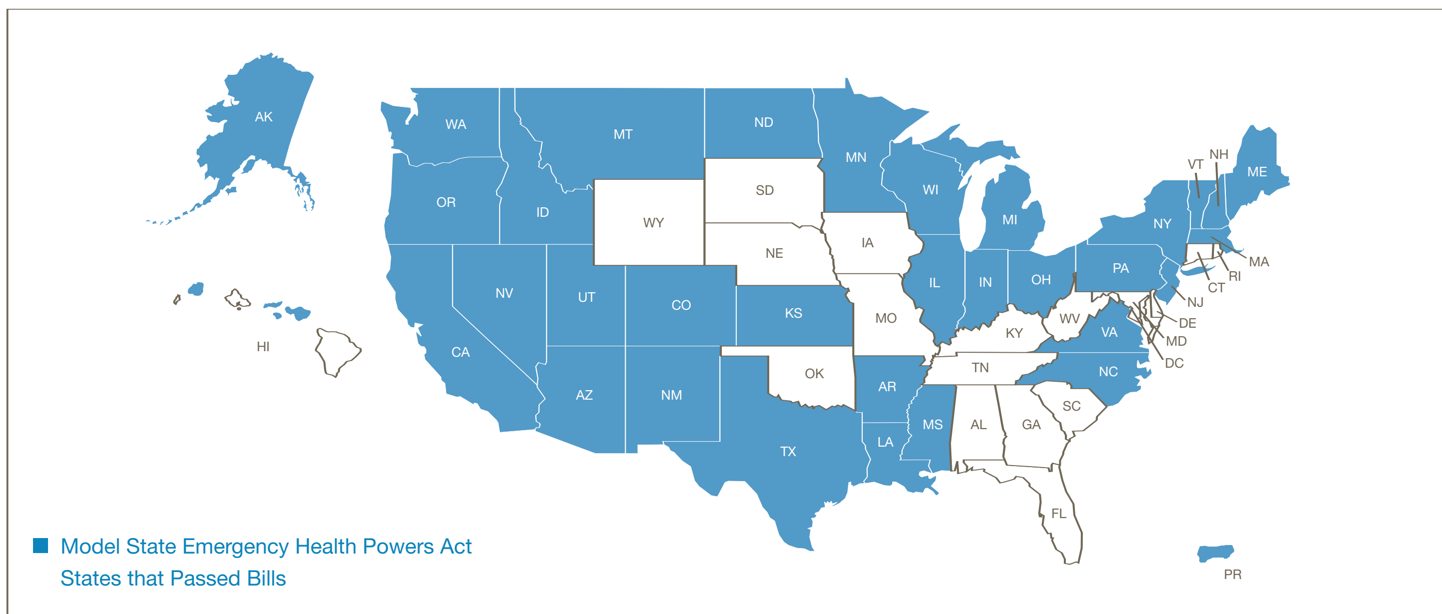
Other initiatives have contributed significantly to our ongoing efforts to increase knowledge about accreditation programs and define standards for public health agency performance. The Multistate Learning Collaborative, a partnership with the National Network of Public Health Institutes and the Public Health Leadership Society, seeks to gather and share important information about performance standards and accreditation efforts at individual state and

local health departments. Five states participated—Illinois, Michigan, Missouri, North Carolina and Washington. Lessons learned from these states contributed significantly to the work of Exploring Accreditation and will continue to enhance activities focused on accountability and performance in public health.

In 2007 we will continue to drive systems change in local and state public health agencies toward improved quality and performance. This will include advancing efforts for increased accountability, supporting advocacy for increased funding and other policy changes, modernizing information technology and improving the management of information, strengthening public health leadership, and prompting greater collaboration among public health agencies and others integral to the public health system, such as businesses, health care providers, educational institutions, and faith and community-based organizations. And we will focus on advancing public policies, such as smoke-free air laws, that improve health and benefit millions of Americans.

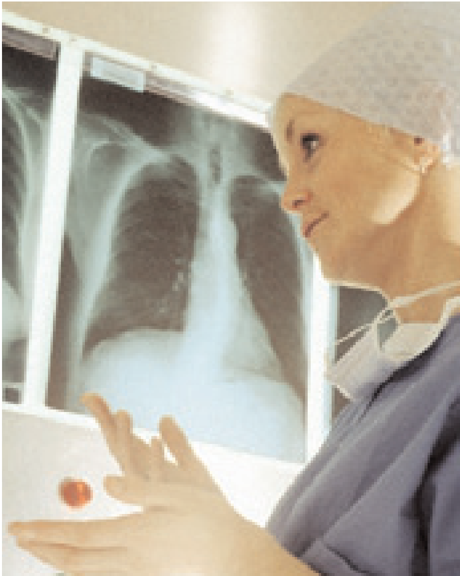
For more information about our initiatives and objectives, visit *www.rwjf.org/publichealth*.

States that Have Passed Emergency Response Laws



SOURCE: Center for Law & The Public's Health, Turning Point Act State Legislative Table, October 2006.

NOTE: Model State Emergency Health Powers Act grants public health powers to state and local public health authorities to ensure strong, effective and timely planning, prevention and response mechanisms to public health emergencies while also respecting individual rights.



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Quality Health Care

The quality of American health care is far from what it could or should be.

Although in recent years Americans have benefited from advances in medical technology and science, health care in this country still looks like a wildly uneven landscape. National research studies show that Americans do not get even half of the recommended care for many chronic conditions, and pressures such as rising health care costs shape concerns about the type of health care that is delivered to whom, and for what value.

The Foundation seeks to ensure that all Americans, especially those with chronic illnesses like diabetes or heart disease or depression, receive high-quality care. We have recently focused especially on improving the quality of care for chronic conditions in outpatient settings. Transparency in health care—a concept that encourages measuring and reporting on the delivery of health care services—has been a major underpinning of this work. Although some health care organizations, such as health insurance plans, regularly collect and report on standard measurements of health care quality (for example, the number of times a diabetic patient receives a foot or eye exam), other stakeholder groups are not involved in these efforts at all. Therefore, our drive towards measuring and reporting health care quality is premised on the idea that greater transparency can help providers, patients, and policy-makers understand what quality health care is and how to achieve improvements.

One of our indicators of progress was to track in 10 regions the increase of medical providers who are reporting measures of quality to employers, consumers and other relevant groups. We promoted a stronger regional focus in 2006 with the launch of a new $10-million program, *Aligning Forces for Quality: The Regional Market Project*, to seek substantial improvements in health care quality that can occur only in the context of local market forces.

Aligning Forces will help communities work on three key quality areas: performance measurement and public reporting; provider initiatives on improving the quality of care for chronic conditions in outpatient settings; and engagement of consumers on focused areas related to quality. In 2006 we initiated four pilot communities and launched a national competition to support work in six additional areas. The Foundation is supporting an evaluation to help assess the progress of the Aligning Forces communities, to learn more

about the extent to which public reporting on quality increases in these communities, and whether these initiatives translate to actual gains in the quality of health care.

Finally, we continue to support national efforts to engage providers and others in public reporting on health care quality. Our work with the National Quality Forum, which supports consensus-building among different stakeholder groups in approving measures that matter, produced new measures for different treatment areas for chronic illness care in 2006. The Foundation also supported the first-ever report that provides a comprehensive picture of how rapidly Americans are adopting health information technology titled, *Health Information Technology in the United States: The Information Base for Progress.* Although many health care providers face formidable barriers when it comes to adopting electronic health records and other information technology systems, most experts agree that health information technology innovations hold considerable promise for improving quality of care for patients.

For additional information about our initiatives and objectives, visit *www.rwjf.org/quality*.

Inpatient and Part B Spending per Decedent During the Last Two Years of Life for Chronically Ill Patients Dying During the Period of 2000–2003

Inpatient and Part B Spending per Decedent

Dollars Spent

$120,000

$100,000

$80,000

$60,000

$40,000

$20,000

SOURCE: Center for the Evaluative Clinical Sciences. *The Care of Patients With Severe Chronic Illness: An Online Report on the Medicare Program*. Dartmouth Atlas of Health Care, 2006.

Tobacco Use and Exposure

Smoking remains among the most pressing threats to America's health, and the Foundation is committed to saving lives by reducing tobacco use and exposure.

In pursuit of that goal, we are focused on advancing and sustaining policy changes that have been shown to prevent and reduce tobacco use and exposure to secondhand smoke and to help addicted smokers quit. The number of Americans protected by law from the dangers of secondhand smoke is one indicator we use to measure our progress.

Currently an estimated 37 percent of Americans are covered by comprehensive clean indoor air or "smoke-free" laws—those providing full workplace protections without exemptions, including bars and restaurants. Sixteen states and Puerto Rico have passed smoke-free laws that include restaurants and bars. Arizona, Colorado, Hawaii, Montana, New Jersey, Ohio and Puerto Rico took action in 2006, joining California, Connecticut, Delaware, Maine, Massachusetts, New York, Rhode Island, Utah, Vermont and Washington.

Hundreds of cities and counties have taken action as well, with Washington, D.C., Philadelphia, Houston and Louisville, Kentucky, a major tobacco growing state, being notable additions in 2006. Following passage of New Jersey's landmark Smoke-Free Air Act, the Foundation joined with the New Jersey Department of Health and Senior Services and public health organizations to support the Smoke-Free New Jersey: A Breath of Fresh Air campaign to increase public understanding of the health benefits of the new law and to help prepare businesses for the transition. The campaign included paid media, public education and outreach to businesses. Smoke-free laws are also sweeping the globe. In 2006 England, France, Scotland and Uruguay joined Bermuda, Bhutan, Ireland, Italy, Norway, New Zealand and Sweden as smoke-free countries.

In June 2006 the federal government released a landmark surgeon general's report on second-hand smoke. U.S. Surgeon General Richard Carmona stated, "The debate is over. The science is clear: Secondhand smoke is not a mere annoyance, but a serious health hazard that causes premature death and disease in children and nonsmoking adults."

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The report found that secondhand smoke:

- Is a proven cause of lung cancer, heart disease, serious respiratory illnesses such as bronchitis and asthma, low birthweight, and sudden infant death syndrome.
- Contains more than 4,000 chemicals and at least 60 carcinogens.
- Is responsible for at least 38,000 deaths in the United States each year.
- Has no risk-free level of exposure.

The report also concluded that smoke-free workplace policies are the only effective way to protect nonsmokers from secondhand smoke; that other approaches, such as air ventilation systems and smoking and nonsmoking sections, are not effective and do not eliminate exposure; and that smoke-free laws protect health without harming business.

New research on the health impact attributed to smoke-free air policies was released in 2006. According to a study in *Circulation: Journal of the American Heart Association*, Pueblo, Colorado experienced a dramatic decrease in the number of people suffering heart attacks after the city banned smoking in workplaces and public buildings. Researchers compared admissions at Pueblo's two hospitals from 18 months before and 18 months after the comprehensive smoke-free ordinance took effect. Both hospitals provide care for all recognized heart attacks in Pueblo and the surrounding county.

In the 18 months following passage of the law, admissions for heart attacks for Pueblo City residents dropped 27 percent compared with the 18-month period before the ordinance. In the same period, heart attack hospitalizations did not change significantly for residents of surrounding Pueblo County or in the comparison city of Colorado Springs, neither of which have nonsmoking ordinances.

Together these measures mark significant progress toward eliminating a major threat to the public's health, but more needs to be done. We seek to have at least 50 percent of the total U.S. population protected from secondhand smoke by the end of 2007. We will use integrated strategies to help achieve this goal, including: (1) research that includes tracking and analyses of policies that affect tobacco use and exposure; (2) advocacy grants and technical assistance to states and communities for tobacco prevention and cessation; and (3) communications, including public education advertising, media relations, polling and message research, policy briefs, and news and information services to advance the public's understanding of research findings and support of advocacy efforts.

For additional information about our initiatives and objectives, visit *www.rwjf.org/tobacco.*

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Municipalities with Local 100 Percent Smoke-Free Clean Indoor Air Laws, 1990–2007

Cumulative Number

450
400
350
300
250
200
150
100
50
0

1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007*

Workplaces[1] Restaurants[2] Bars

*Year to Date

[1]Includes both public and private non-hospitality workplaces, including, but not limited to, offices, factories and warehouses.
[2]Includes any attached bar in the restaurant.

Since some municipalities have 100% smoke-free coverage in more than one category, the numbers are not mutually exclusive.
Includes all municipalities with ordinances or regulations that do not allow smoking in attached bars or separately ventilated rooms and do not have size exemptions.
Only ordinances reviewed and analyzed by ANR Foundation staff using standardized criteria are included on these lists. Omission of a particular ordinance may be the result of differences of opinion in interpretation, or because staff have not yet analyzed the ordinance.

SOURCE: American Nonsmokers' Rights Foundation, 2007. Available at: *www.no-smoke.org*.

Human Capital

The Human Capital Portfolio seeks to nurture a strong, capable and diverse health and health care workforce and leadership.

For more than 30 years, RWJF has supported programs that help develop leaders in health and health care, such as the *Robert Wood Johnson Health Policy Fellowships Program* and the *Robert Wood Johnson Executive Nurse Fellows Program*. Many program alumni in leadership positions today acknowledge the role RWJF has had in advancing their careers. But neither our programs, nor the health and health care leadership of our nation, are as diverse as they should be. Thus, in 2006 we looked at our leadership programming with fresh eyes, seeking to increase the diversity of our scholars and fellows, and the diversity of voices in leadership positions.

We initiated an effort to increase the diversity of the pool of qualified applicants to several of our leadership development programs. These programs had each been trying to do this, with limited success. We began work to identify and enhance the successful strategies of individual programs, but also to develop proactive marketing and outreach strategies. We plan to implement these enhanced outreach efforts for the programs' application cycles during 2007 and will track their impact.

As we looked at our history of investments in leadership development, we saw that most of our programs focused on leaders who work in large institutional settings. Another way to increase the diversity of leadership in health and health care is to expand the breadth and diversity of the settings on which our programs focus. Locally-based nonprofit organizations occupy an important role in our health and health care system, providing critical services and support. And the leadership of community nonprofits is often well-positioned to help the rest of the system appreciate the need for diversity.

Many community nonprofits are led by senior leaders who are aging out of the workforce at a time when demand for services from these organizations is increasing, along with the financial pressures they face. To combat these complex challenges, we believe that creating a leadership development experience for junior or emerging leaders that is focused on innovative, system-change thinking, will provide a model for these organizations in the future.

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We are currently supporting the design of a training program that can help develop a new cadre of competent leaders in community-based nonprofits. We hope to build their abilities to influence systems, bring about organizational change, adapt innovations from other fields, create more client-focused services, work across traditional organizational barriers, and build stronger, sustainable organizations that provide better health and health care services in underserved, under-resourced communities.

We also began an effort in 2006 to track the diversity of leaders in key positions in health and health care. We will continue to track this over time to help us understand where we need to target our future investments.

Not surprisingly, America's current group of leaders in health and health care are primarily white males in their mid-fifties, most with doctoral/professional degrees, who have occupied their current leadership positions for about six years. There are some "pockets" of diversity. Women occupy about 40 percent of senior leadership positions in state health departments and in America's major foundations. Nearly one-third of senior leadership positions in major foundations are held by African Americans.

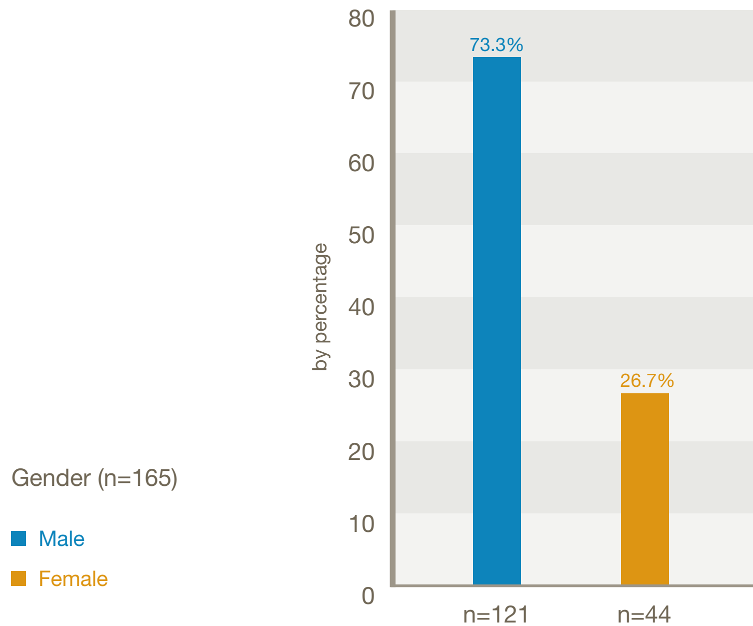
In the coming years, as our nation becomes increasingly diverse, we will continue to track the diversity of the leadership in our health and health care system, and in the programs we support.

For additional information about our initiatives and objectives, visit *www.rwjf.org/humancapital*.

U.S. Health and Health Care Leaders, by Gender

Gender (n=165)

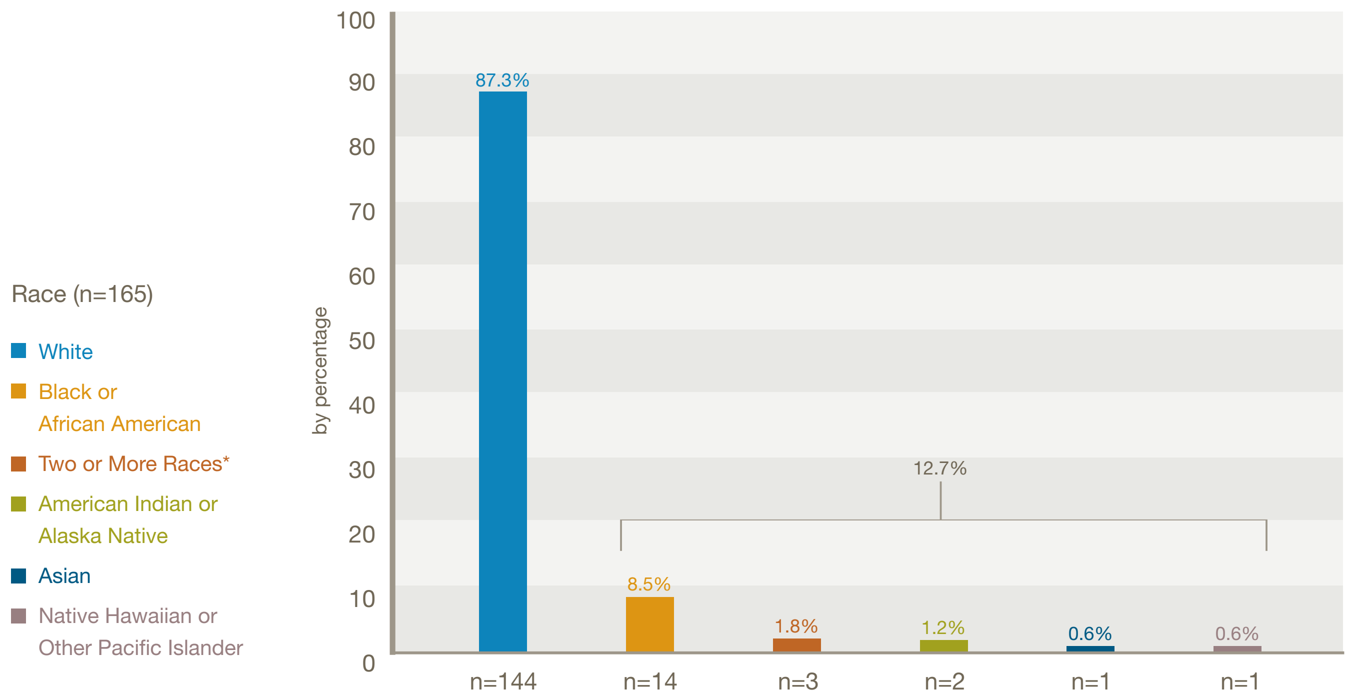
- Male
- Female



U.S. Health and Health Care Leaders, by Race

Race (n=165)

- White
- Black or African American
- Two or More Races*
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander



SOURCE: The Lewin Group, Health and Health Care Leadership Tracking Initiative Findings, Year One, November 2006.

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Vulnerable Populations

Good health means more than just good health care. Several social factors–poverty, race, education and housing–play a critical role in the health and health care problems that affect society's most vulnerable and often-neglected people.

Through our Vulnerable Populations efforts, we support promising new ideas at the intersection of health and social factors, with programs designed to help vulnerable Americans lead healthier lives.

In many cases, working at this critical intersection depends on building partnerships with organizations outside the traditional health sector, including schools, prisons, community groups working to reduce violence, and the legal system.

The Foundation has a strong interest in helping to meet the emerging health and social needs of vulnerable communities whose populations are changing. In 2006 we launched a new program, *Caring Across Cultures: Addressing Mental Health Needs of Diverse Children and Youth*, to bring school-connected mental health services to children who may not be served by traditional health and social services. Children from immigrant and refugee families often face economic, social and personal hardships—poverty, separation from family and challenges of acculturation—that may affect their mental health and overall well-being, but they are less likely than other children to get the services they need. In as many as 15 cities across the country, Caring Across Cultures will link schools with community organizations to reduce the cultural and language barriers to mental health services that children of immigrant and refugee families face.

Research shows that ex-offenders invariably return to their own neighborhoods upon release from jail. This population represents many of the highest-risk and hardest-to-reach individuals with serious physical and mental health problems. Their conditions often go untreated or get worse during incarceration, and they return to the community with expensive and debilitating health burdens. Community Oriented Correctional Health Services is a model that connects community health care to correctional health care so that an inmate receives care in the jail from the same community provider he or she will be referred to upon release. Through this model, inmates are seen as temporarily displaced members of the community and health centers serve as a connector for their re-entry into society.

How to pay for the ever-burgeoning costs of long-term care is a problem that haunts families and state policy-makers alike. Originally funded by RWJF in 1987, the Program to Promote Long-Term Care Insurance for the Elderly created a unique model in which consumers, private insurers and state Medicaid agencies joined together in insurance arrangements that guaranteed coverage and financial security for beneficiaries, business for insurers, and budget protection for Medicaid. This model, known as the Long-Term Care Insurance Partnership, was a great success in the four states that piloted it. Thanks to recent federal legislation, this option is now available to other states, and many are interested in developing their own partnership models. RWJF will support up to 10 states in developing these new partnerships, making affordable long-term-care insurance available to more Americans.

Reducing violence in a community requires more than an increased police presence and tougher gun laws. CeaseFire, originally funded through RWJF's *Local Initiative Funding Partners Program*, has reduced shootings in some Chicago neighborhoods by as much as 62 percent. CeaseFire works with all parts of the community—residents, local businesses, service organizations and faith-based leaders—to develop and implement strategies that reduce and prevent violence, particularly shootings and killings. These strategies include street-level outreach, public education and community mobilization to intervene in conflicts, deflect potential conflicts and promote alternatives to violence. Through additional RWJF support, CeaseFire will expand to new neighborhoods in Chicago and other communities throughout the United States.

We are committed to supporting innovative ideas for improving the health of America's most vulnerable people. Working with organizations outside the traditional health sector is an important part of this effort—for example, by bringing needed health care services into schools, creating better long-term-care options for the elderly, and creating supportive housing to reduce homelessness and help keep troubled families together. At the same time, we will focus new philanthropic investments on meeting the needs of families struggling with complex social problems, helping new immigrants and refugees make the transition to life in America, bridging the gap in mental health services for children, and addressing the toll of intimate partner violence.

For additional information about our initiatives and objectives,
visit *www.rwjf.org/vulnerable.*

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Number of Homicides in Chicago Compared with Other Major U.S. Cities, 1998–2005

Number of Homicides

800
700
600
500
400
300
200
100
0

1998 1999 2000 2001 2002 2003 2004 2005

New York
Los Angeles
Chicago
Philadelphia
Detroit
Houston
Baltimore
Phoenix
Dallas
Washington, D.C.
St. Louis
San Diego

SOURCE: CeaseFire: The Campaign to STOP the Shooting. Data from the Department of Justice—Federal Bureau of Investigations, Crime in the United States. Available at: *www.fbi.gov/ucr/ucr/htm*.

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Pioneer

We face a growing chronic disease burden borne by an aging population, potential disease pandemics, and health care institutions struggling to harness the information revolution to improve the quality and coordination of patient care. The Pioneer Portfolio looks down the road toward future health and health care challenges, seeking and supporting innovative, often unconventional ideas that may lead to breakthrough solutions.

Several Pioneer Projects may be leading potentially transformative change in addressing health and health care problems. In July we launched *Project HealthDesign: Rethinking the Power and Potential of Personal Health Records*, a program designing next-generation personal health record (PHR) systems in ways that empower patients to better manage their health and health care. Patients may find today's PHRs useful in tracking medical conditions with their providers or obtaining prescription renewals; those functions, however, typically operate in isolation. If a patient moves to a new provider using a different PHR, her existing records may not transfer effectively. Project HealthDesign teams, working with patients and caregivers, will design and test distinct PHR applications that operate in sync to help people achieve varied health goals in an integrated fashion. The vision is that a patient managing asthma and diabetes, for example, uses a PHR system outfitted with tailored tools that remind her to take medications, monitor glucose levels and even incorporate air quality updates into daily decisions. Beyond giving patients access to their health information, smart PHR systems will help them manage and apply that data to improve their health, care and quality of life.

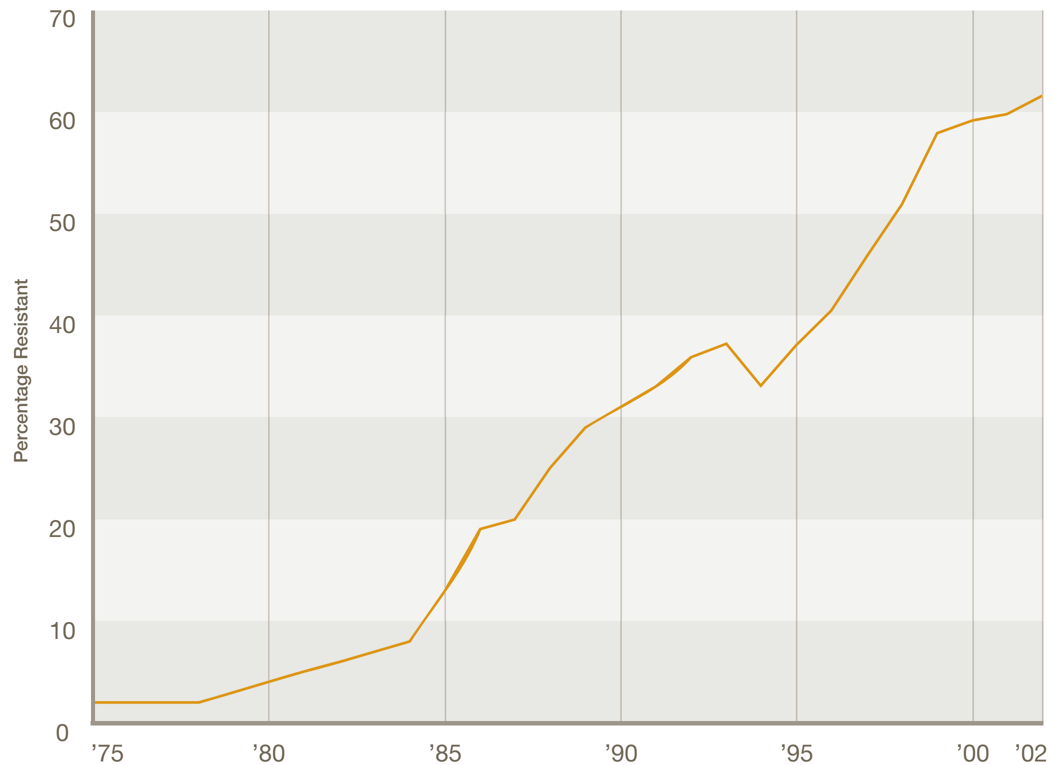
Other grantees are testing novel ways to improve disease surveillance and response efforts. At the University of Iowa, business school professors teamed up with an infectious disease expert to test whether the Iowa Electronic Markets—markets that aggregate information and are best known for predicting election and box office results—can target ahead of time what strain of, and where, influenza may strike. Having successfully piloted the program in Iowa with traders ranging from pharmacists and local health officials to school nurses, grantees are now working with the state epidemiologist to run a North Carolina market. The Navy also is exploring how flu markets may help it to accurately predict strains and vaccinate personnel appropriately. This innovative forecasting approach may supply public health officials and policy-makers with a valuable tool to complement traditional disease surveillance methods and guide decisions in fighting both conventional influenza and other disease threats. Toward that end, we recently supported the Iowa team to test the market's effectiveness in forecasting the probability of a human-transmitted avian flu outbreak.

Pioneer grants also explore out-of-the-box solutions to entrenched problems such as antibiotic resistance. Ramanan Laxminaryan, an economist with Resources for the Future, believes that a natural resource economics approach holds greater promise for combating antibiotic resistance than mainstream strategies, such as changing doctors' prescribing behaviors or dampening consumer demand for drugs. Working with regulatory, health, pharmaceutical and economic experts, Laxminaryan is identifying policy alternatives for managing the nation's antibiotic supplies and reversing the crisis in drug resistance.

At the institutional level, Pioneer supported the Plexus Institute to test "positive deviance" (PD) approaches to fighting Methicillin-Resistant *Staphylococcus Aureus* (MRSA) infections in health care facilities. PD is based on the observation that, in most communities, there are certain individuals or groups whose uncommon behavior or practices allow them to find better solutions to seemingly intractable problems than peers and colleagues who have access to the same resources. Often, approaches emerge from people at all levels of an organization that are more effective in addressing a problem than complex, top-down interventions. In hospitals fighting MRSA, this could mean that nursing aides highlight how food trays could spread bacteria from room to room and suggest preventive solutions, or an orderly notes that hand-washing all but disappears when an emergency situation occurs and communicates that to clinical staff. Plexus is working with six hospitals to identify successful PD approaches and their goal is ambitious: They want to spur a nearly 75 percent reduction in MRSA infections among participating facilities. This could reap dramatic benefits for patient health and safety and cost savings for hospitals.

For additional information about our initiatives and objectives, visit *www.rwjf.org/pioneer.*

Emerging Prevalence of Methicillin-Resistance Among *Staphylococcus Aureus* in U.S. Intensive Care Units



SOURCE: Centers for Disease Control and Prevention, National Nosocomial Infections Surveillance System, October 2006.

NOTE: Methicillin-resistant *Staphylococcus Aureus* (MRSA) is a type of bacteria that is resistant to certain antibiotics. These antibiotics include methicillin and other more common antibiotics such as oxacillin, penicillin and amoxicillin.

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New Jersey

Supports programs mainly in New Brunswick and the surrounding Middlesex County communities as well as health initiatives throughout the state.

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Other

Supports programs that are consistent with the Foundation's overall mission but are not aligned with a portfolio or targeted objective.