

- The Robert Wood Johnson Foundation Quarterly Newsletter

Creating Universal Symbols For Health Facilities

PAGE 7



Karel Honored by Grantmakers In Health

PAGE 13



Kean Named New Chair Of Board of Trustees

PAGE 16



FOCUS on Disparities

OVERVIEW

Eliminating Disparities Using a Quality-Improvement Focus

When the Institute of Medicine (IOM) convened a committee to look at the problem of racial and ethnic disparities in health care it was seeking the answer to one critical and hotly debated question: Is there definitive evidence indicating that patients from diverse racial and ethnic backgrounds, particularly African Americans and Latinos, are more likely to receive worse care?

The report produced by the committee in 2002,

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, presented a clear answer. After reviewing hundreds of research reports and taking great pains to include the most skeptical perspectives among its members, the committee concluded in its report that minorities were more likely to receive worse treatment even when other factors, such as insurance coverage and socioeconomic status, were equal.

Like many other organizations in the field, the Robert Wood Johnson Foundation saw the publication of the report as an opportunity for action. However, in forming a new team to address this problem, RWJF was confronted with the same major barrier that others were: While the evidence of disparities is plentiful, there are few solutions readily available in the health care marketplace.

While other organizations and policy-makers have focused on a range of different approaches to the disparities problem—such as diversification of the health care workforce, for example—RWJF chose to frame it as a quality-of-care problem. For years, the Foundation has supported efforts to improve the quality of health care by changes at the health care system level—to create systems where performance is measured and where

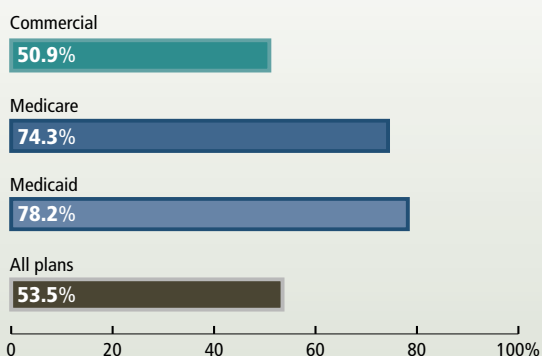
patients, plans, providers and purchasers understand what quality health care is and how to make it happen. Now, the Foundation is tackling the disparities problem using the same framework.

“The Foundation’s strategy is developed out of a belief that you cannot adopt high-quality health care practices without acknowledging or addressing disparities,” says Risa Lavizzo-Mourey, M.D., M.B.A., Foundation president and CEO. (See Q&A, page 5.)

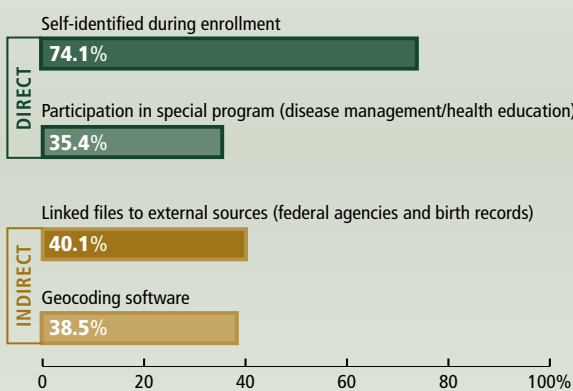
Lavizzo-Mourey, who served as co-chair of the IOM committee that produced *Unequal Treatment*, has played a major role in the development of the Disparities team’s strategy. The team has initiated a multipronged effort to eliminate racial and ethnic disparities in targeted diseases by 2008. Much of

See **Eliminating Disparities**—page 2

Percentage of Individuals Enrolled in Health Insurance Plans That Collect Data on Race and Ethnicity



Most Common Direct and Indirect Methods Used by Plans to Collect Race and Ethnicity Data About Enrollees



Source: *Collection of Racial and Ethnic Data by Health Plans to Address Disparities*, America’s Health Insurance Plans, 2004.

FEATURES

- Q&A 5
- ABridge 9
- Grants 15

ISSUE 1, 2005

Published quarterly by the Communications Department of the Robert Wood Johnson Foundation®
College Road East, P.O. Box 2316
Princeton, NJ 08543-2316

PRESIDENT

Risa Lavizzo-Mourey,
M.D., M.B.A.

CHIEF OF STAFF

Calvin Bland, M.S.

VICE PRESIDENT FOR

COMMUNICATIONS

David J. Morse

EXECUTIVE EDITOR

Larry Blumenthal

MANAGING EDITOR

Trish Leader

ASSISTANT MANAGING EDITOR

Hedda Colossi

PRODUCTION ASSOCIATE

Joan Barlow

WRITERS, *ABRIDGE*

Karin Gillespie

Jane Koppelman

DESIGN

DBA Design

Washington, DC

www.dbadesign.com

NOTE TO READERS:

Subscriptions for *ADVANCES* are now managed online.

To receive *Advances*, go to subscribe.rwjf.org.

You also can choose to receive an e-mail alert when the electronic version of the newsletter has been posted to the Web site.

If you are already registered on RWJF's Web site and need to change your address, sign in at www.rwjf.org.

As a registered visitor, you also can sign up for e-mail services such as Funding and News Alerts.

Reproduction of material published in *ADVANCES* is encouraged with the following attribution:

"From *ADVANCES*, the Robert Wood Johnson Foundation quarterly newsletter."

Printed on recycled paper.



THE
ROBERT WOOD
JOHNSON
FOUNDATION®

OVERVIEW

From *Eliminating Disparities*—page 1

this effort has been informed by the grantmaking under the Foundation's Quality team, although that team focuses on quality of health care using different lenses than the ones provided by the disparities problem.

"A key focus of the Foundation is on quality of health care delivery," says John Lumpkin, M.D., M.P.H., senior vice president in charge of the Foundation's Health Care Group. "Our work in both disparities and quality is focused on systematic improvement through evidence-based practices."

A central premise of the Foundation's work in disparities has to do with the question of intention. Although attitudes of bias and stereotyping, and cultural differences undoubtedly play a role in creating gaps in health care, these gaps are also due to system-level issues—like why one geographic area in the country has better-quality hospitals than another, for example. "While all these factors need to be addressed, they are not easily solved," Lumpkin says.

Given the complex nature of the problem, the Disparities team's work is guided by several principles. First, the team is choosing to work on areas where evidence of disparities is robust and recommended standards for care are clear. Initial areas for focus have included cardiovascular disease, diabetes, asthma and other chronic conditions.

Second, the team is trying to promote a central principle of quality improvement, not only in the health care context but in other fields as well: If you can't measure what is happening, you can't improve it. However, measuring disparities in care means that hospitals, health plans and others need the capacity to identify patients by their race and ethnicity. In many instances, this capacity does not exist. In addition, identifying individuals by their race and ethnicity raises questions about whether this is legal (it is, except in a few states) and how consumers will feel about their privacy.

The Disparities team's work has focused on the following:

- Promoting the collection of racial and ethnic data on patients for quality-improvement efforts.
- Working with health plans on strategies to examine data on their patients, to identify disparities and improve quality.
- Working with hospitals and other providers to design interventions that can be replicated widely.
- Actively disseminating results of research and demonstration projects and convening experts representing the disparities and quality fields.
- Commissioning critical research to fill in the knowledge gaps in disparities. (See Research sidebar, page 3.)

Information Collection Priority

Initially, the team focused on finding out to what extent health plans and providers were collecting information on the race and ethnicity of their members and patients. To develop interventions to narrow disparities, health plans and providers need to know who their patients are.

"We were originally most interested in understanding whether health plans and providers collected racial and ethnic identifiers in data—the premise being if you don't collect the data, you can't measure the problem," says Kelly Hunt, M.P.P., a research officer and a member of the Disparities team.

The Foundation worked with America's Health Insurance Plans (AHIP) to discover, in the wake of the IOM report, whether health plans were collecting these data and how they were doing it. Disparities in care can be reduced only when health care systems are equipped to identify and address disparities where they occur. Health plans and providers play essential roles in tracking the quality of care patients receive, as well as undertaking initiatives to improve care for members.

The common wisdom was that few managed care organizations were

collecting racial and ethnic data, citing real and perceived barriers to such efforts. Surprisingly, the survey of 302 health plans, which accounted for a majority of the total enrollment in U.S. managed care plans, revealed that 53 percent of plans were collecting such identifiers.

The Foundation expects results soon from a related initiative with hospitals collecting such data. RWJF is working with the Washington-based National Public Health & Hospital Institute to study hospital practices in collecting racial and ethnic data on patients.

Since the team's strategy was built on getting plans and providers to collect and measure the problem, it raised the basic question of how comfortable patients are in giving this information. RWJF commissioned Public Opinion Strategies, Alexandria, Va., to measure how consumers react to such data-collection efforts.

When asked whether they favored legislation for collecting racial and ethnic data in health care, only 34 percent of those surveyed responded favorably. However, 54 percent supported such legislation when told it would be used only to identify gaps in care and to improve health care quality for all Americans. While clearly there is a need for patient education on racial and ethnic data collection efforts, the results are promising.

Improving Quality of Data

The results from both the health plans and consumer surveys helped inform the Disparities team's plan to move into a demonstration phase of the work. For example, the AHIP survey of health plans revealed challenges involved in collecting racial and ethnic identifiers. Medicaid and Medicare plans collect such data to a far greater degree than do commercial health plans. What's more, plans use a variety of methods to collect such identifiers, some more accurate than others. Some plans don't collect these data, citing member resistance, perceived legal restrictions or unreliability of data.

RESEARCH

Understanding Why While Seeking Solutions to Disparities

The two-year-old RWJF Disparities team has established an aggressive research agenda aimed at better understanding why minorities receive lower quality care while seeking quality improvement-focused solutions to end treatment disparities. The ultimate goal: Reducing disparities in targeted diseases by 2008.

Findings from two RWJF-funded initiatives over the last year provide the cornerstones for the research agenda. The findings: Most health plans are collecting race and ethnicity data on enrollees, and a majority of Americans support the collection of such identifiers when used to close treatment gaps and to improve health care quality.

An RWJF-commissioned survey found that slightly more than half of enrollees (53.5 percent) are enrolled in health insurance plans that responded to the survey and collect data on race and ethnicity—data that are an essential tool in efforts to eliminate unequal medical treatment among the races. The survey also revealed how plans were collecting data and reasons why other plans weren't.

"We've since broadened our focus," says Kelly Hunt, M.P.P., research officer and Disparities team member. "We've funded researchers to measure the number of lives lost due to disparities in care, for example.

This type of work helps build the case for reducing disparities in health care. We're also funding research to get at the why of disparities."

The Disparities team research agenda's 18 projects include efforts to:

- Determine whether disparities are getting better or worse.
- Understand further the role of geographic variations on disparities in care.
- Study an employer-based intervention.

"We know that it will be difficult to pinpoint the factors that contribute to disparities in ways that suggest possible interventions that we can fund," says RWJF President and CEO Risa Lavizzo-Mourey, M.D., M.B.A. "Therefore, our research agenda is ambitious, aimed at both understanding the multiple factors that have an impact on disparities in treatment and evaluating possible solutions."

Before getting to solutions, work still is needed to better understand opportunities, barriers and needs regarding the collection of racial and ethnic data. Knowing and tracking populations and the care they receive is essential in eliminating health care disparities. Six of the Disparities team's research projects are focused in this area, including projects closely examining technical and legal issues of racial and ethnic data collection.

"If there is a single 'take-away,' it is that health plans can do something about and have a positive effect on disparities within a reasonable time frame," says David Nerenz, Ph.D., director of health initiatives for the Henry Ford Health System in Detroit.

Nerenz led an effort, which resulted in five white papers, to summarize the current state of health plan race and ethnicity data-collection efforts, the accuracy of data on race and ethnicity, the strengths and weaknesses of various data-collection methods, and ways existing data may or may not be used for specific purposes.

While the project identified challenges—such as an inability to identify some subpopulations (Russians, Dominicans or Arab Americans) using standard race and ethnic categories, and lack of uniformity in Medicaid data among states—the conclusion should motivate the field "to push toward action," Nerenz concludes.

Other groundbreaking work in this area has researchers assessing the legal barriers to using quality and disparities data.

"Some people assert that the mere collection of data by race could somehow violate federal law—and that's just not true," notes Sara Rosenbaum, J.D., director of the George Washington University Center for Health Services Research

and Policy, and director for an RWJF project exploring the legal barriers to using quality and disparities data.

That's not to say there aren't serious concerns. One of the biggest concerns providers face today in collecting such data is one of legal liability. Many are worried that if their data show they provide inferior care to certain populations, then that data could be used to sue them.

"It's a very different world than in the days of just paper data," Rosenbaum notes. In addition to liability concerns, other legal issues including civil rights and discrimination, privacy and confidentiality, antitrust issues, even tax laws can interfere with the development of health care quality database initiatives. "The law hasn't really caught up with the potential here," she says.

This summer, a workgroup of legal, health care, policy and information technology experts will complete a detailed road map of legal issues, along with a framework for possible legal reforms to strengthen public reporting practices.

"Going forward, the team wants to focus its research on identifying solutions toward reducing or eliminating racial and ethnic disparities in care," Hunt says.

— CHRISTOPHER GEARON

For more information on RWJF disparities research, see www.rwjf.org/research.

To help improve the effectiveness of data collection by health plans and link those efforts to quality-improvement efforts to reduce disparities, RWJF recently funded two initiatives of the Center for Health Care Strategies (CHCS), Princeton, N.J.

Both projects—one focused on Medicaid health plans and Medicaid purchasers, and the other on health plans that offer products for the commercial and Medicare population—focus on enhancing participants' ability to collect and use reliable race and ethnicity data to drive quality improvements, while also helping health plans develop innovative strategies to

narrow disparity gaps and improve care for all enrollees.

CHCS is using its nationally recognized Best Clinical and Administrative Practices (BCAP) model to assist 14 Medicaid plans selected through a competitive process to develop interventions for identifying and reducing health care disparities in diabetes, asthma, birth outcomes and adolescent immunizations. The center is simultaneously conducting a Purchasing Institute to train 12 state Medicaid agencies and their managed care contractors on data-mining techniques and contracting incentives that support quality-improvement efforts for racially and ethnically diverse beneficiaries.

"Medicaid plans are very much in a position to turn those data around to match quality initiatives," says Stephen Somers, Ph.D., CHCS president. For many Medicaid plans, racially and ethnically diverse populations comprise the bulk of their membership. While the AHIP survey showed Medicaid plans are collecting race and ethnicity data more regularly than other plan types, Somers says the data are uneven among these plans. Although all state Medicaid agencies have race- and ethnic-identifier data on beneficiaries, with some passing on good data to their plans, other states pass on either error-riddled data or none at all.

Meanwhile, CHCS is supporting activities for a two-year initiative that has nine of the nation's biggest health plans—Aetna, Cigna, Harvard Pilgrim, HealthPartners, Highmark Blue Cross Blue Shield, Kaiser Permanente, Molina, UnitedHealth Group, and the recently merged WellPoint and Anthem Blue Cross Blue Shield (now WellPoint)—collaborating to improve racial and ethnic data collection and reduce disparities in diabetes treatment among their members. This is significant because it gets major health plan competitors working in unison to address quality improvement.

See *Eliminating Disparities*—page 4

From *Eliminating Disparities*—page 3

With funding from RWJF and guidance from the U.S. Agency for Healthcare Research and Quality (AHRQ) and RAND, CHCS and the Institute for Healthcare Improvement will help plans improve their capacity to 1) collect these data, both directly from members and via indirect efforts such as geocoding and other techniques; 2) link data to quality measures; and 3) develop quality-improvement interventions to close gaps in diabetes care.

Diabetes is a condition with well-established clinical guidelines and management strategies. Yet only 20 percent of Americans with diabetes receive routinely recommended health care services, according to AHRQ, and the quality gap is especially evident for African Americans, Hispanics and Native Americans. For example, compared to the total population, minorities are more likely to require lower limb amputations for complications from diabetes, and death rates for diabetes run significantly higher for certain populations of color.

“At some point, you want to get operational, and these two initiatives will get us there,” says Somers. “That’s what BCAP is designed to do for health plans.”

On the provider front, RWJF has recently funded a new national program, *Expecting Success: Excellence in Cardiac Care*, that will help 10 hospitals and health systems, along with their community partners, develop and demonstrate effective quality-improvement strategies for cardiovascular care in inpatient and outpatient settings for underserved minorities. (See story, page 6.)

“The Foundation has traveled beyond identifying the problem to solving it,” says Bruce Siegel, M.D., M.P.H., director of *Expecting Success* and research professor at George Washington University. “By bringing in basic quality-improvement techniques, we can close the disparity gap.”

Looking Ahead

As the work of the Disparities team and its research partners progresses, the field will get a better understanding in coming months of the opportunities and barriers regarding the collection of race and ethnic data, as well as the factors that contribute to and have an effect on disparities.

For example, plans and providers will get a road map of the legal barriers to racial and ethnic data collection, an effort intended to establish a case for legal reforms needed to support work to narrow

the disparities gap. Other efforts will include campaigns to raise awareness among physicians about unequal care, and research initiatives giving society a better understanding of how geography plays a role in health care disparities.

While many of the Disparities team’s efforts are focused on health plans and providers, the team also is undertaking work in examining the disparity issue and health care quality from consumers’ and purchasers’ viewpoints.

While Disparities team efforts will strengthen knowledge of

the issue of racial and ethnic disparities in health care, ultimately RWJF wants to eliminate those barriers by developing quality-improvement solutions that can be easily replicated.

“We’re trying to build the momentum,” says Lumpkin. “We’re trying to move it from small interventions into the mainstream and build the evidence base for intervention.”

—CHRISTOPHER GEARON

For more on the Foundation’s disparities work, see www.rwjf.org/disparities.

GRANT RESULTS REPORTS

A Look at the Foundation’s Previous Work in Disparities

Before launching its current focused efforts, the Robert Wood Johnson Foundation had a history of work in disparities. Below are brief summaries of grant results reports available on some of the key grants that were made. The grants were made before the Disparities team decided on its current strategic objectives, but findings and lessons from the grants described helped inform some of the Foundation’s current thinking on this issue.

The Racial Segregation of Health Care in the United States: Assessing the Legacy, Impact and Remedies. David Barton Smith, Ph.D., studied between 1995 and 1998 the historical link between racial segregation and discrimination in health care, described efforts through the courts and U.S. regulation to end discrimination in health care, and examined possible approaches to address—through regulatory and health care reform—certain continuing discrepancies and the persistence of segregation. For full report, see www.rwjf.org/reports/grr/026426.htm.

Inequality and Health: Patterns and Dynamics. In 1995–96, David R. Williams, Ph.D., M.P.H., studied the relationship between socioeconomic status and health for his project in *Investigators Awards in Health Policy Research*. Williams and his colleagues examined how income, occupation, gender and race affect health status and predict mortality. For full report, see www.rwjf.org/reports/grr/026422.htm.

Research on U.S. Culture, Ethnicity and Health Care. Harvard Medical School’s Center for the Study of Culture and Medicine explored from 1994 to 1997 the influence and effects of culture and ethnicity on the access

to and quality of health care services. The center found that the medical profession has largely failed to address the disadvantages suffered by poorer (predominantly minority) Americans in the areas of health and health care. For full report, see www.rwjf.org/reports/grr/022031.htm.

Facilitating Focus Group Sessions for Diabetics. In 2000, independent consultant Pamela J. Blake conducted 13 focus groups to better understand barriers to diabetic patients’ capacity to manage their health and health care. Focus group participants were categorized by age, insurance status, race or ethnicity, and geographic locale to help discern differences and similarities among patient groups. For full report, see www.rwjf.org/reports/grr/039457.htm.

Using Quality Assurance Techniques to Overcome Racial and Ethnic Differences in Health Care. From 1998 to 2000, researchers at the City University of New York analyzed previous research on racial and ethnic disparities in health care delivery and created an annotated bibliography of the research. The researchers found that there is widespread evidence of significant and persistent disparities in the treatment of African-American and Hispanic patients. There are substantially fewer studies documenting similar findings for Native Americans and those from Asian subgroups, but the same patterns are apparent. For full report, see www.rwjf.org/reports/grr/033373.htm.

Analysis of Best Practices in Community-Based Approaches to Reducing Health Disparities. The New School University in New York conducted a study in 2001 of community-based health care

initiatives that were designed to reduce disparities in the health and health care of racial and ethnic minority populations. Through this work, they identified and surveyed 89 community-based programs for diabetes, breast cancer or cervical cancer, and they visited six of the sites to compile in-depth case studies and identify “best practices.” For full report, see www.rwjf.org/reports/grr/041085.htm.

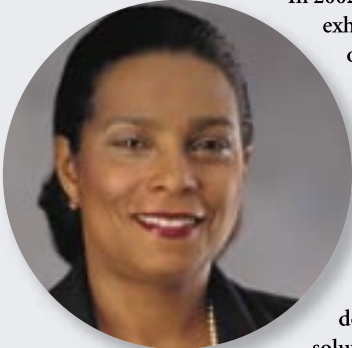
Developing and Applying Claims-Based Process of Care Measures for Medicaid-Enrolled Children with Asthma. From 2000 to 2002, researchers from Georgetown University developed measures to assess the process of care provided to Medicaid-enrolled children with asthma living in Massachusetts. Because asthma affects low-income, inner-city and African-American patients disproportionately, the researchers also studied disparities in care provided to African-American and Hispanic children relative to white children. For full report, see www.rwjf.org/reports/grr/037307.htm.

Researching the Role of State Purchasers and Regulators in Reducing Racial and Ethnic Health Disparities. In 2001 and 2002, researchers with the National Academy for State Health Policy at the Center for Health Policy Development examined the ways in which states can use their power to purchase and regulate health care services to reduce disparities in health due to racial and ethnic differences. For full report, see www.rwjf.org/reports/grr/041395.htm.

To view all disparities-related grant results reports, see www.rwjf.org/disparities and under Resources choose Grant & Program Reporting.

Q & A

RWJF President Explains Foundation's Approach To Disparities Problem



In 2002, the Institute of Medicine (IOM) issued an exhaustive review of hundreds of research studies on disparities. The report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, confirmed what many already knew: Minority patients are more likely to receive lower-quality medical treatment compared to white patients, even when other factors are equal, such as insurance status and income level. While the IOM report galvanized much discussion and activity on what to do about unequal treatment, little consensus on solutions has emerged. The Robert Wood Johnson

Foundation believes that racial and ethnic disparities are a key part of the larger problem of the overall quality of health care delivery, and that the solutions to disparities can be successfully incorporated into quality-improvement efforts already familiar to health care systems. In this interview, Foundation President and CEO Risa Lavizzo-Mourey, M.D., M.B.A., a co-chair of the IOM committee that produced the report, discusses the Foundation's approach to this issue.

Could you talk about your experience as co-chair of the committee that prepared the 2002 Institute of Medicine report?

LAVIZZO-MOUREY—The charge to the IOM committee was to determine whether racial and ethnic disparities in health care existed among people who are already insured, who theoretically have access to quality care. It was a fairly narrow charge because the committee wanted to pinpoint the existence of racial and ethnic disparities apart from the multitude of factors that could explain why minority patients get worse treatment, such as lack of insurance.

The IOM took great pains to recruit a committee that represented very different points of view. Disparities is a complex subject—anything involving racial inequalities is potentially fraught with politics and history, and therefore, the IOM wanted to ensure that we would be looking at the research evidence with the broadest range of perspectives possible. At the outset, some people on the committee did not think disparities existed, and others thought they existed but that they were due to “unsolvable” factors such as bias and prejudice. In the end, the evidence really spoke for itself. After the second meeting, it was quite clear that racial and ethnic disparities in care existed. This was especially troubling in treatment areas where the recommended standard of care is quite clear—foot and eye exams for diabetics, for example. This experience made me understand that educating people about the presence of disparities is not something to be discounted. These were well-educated senior people, experts in the field, and they were not fully aware of the issues.

Can you describe the strategy of the Foundation's Disparities team?

LAVIZZO-MOUREY—The starting point for our disparities strategy was the work that we've already supported to improve the quality of health care. We recognize that the problem of racial and ethnic disparities is a problem of quality. Meaning, there are serious problems with the overall quality of health care in this country and that embedded in the quality issue is the disparities issue—that minorities suffer the quality problem even more. We believe the quality-improvement strategies that we've already supported can be adapted to also take care of the disparities problem.

What are some of these strategies? The quality field is pushing the concept of measurement forward as a central principle of quality improve-

ment. In other words, if you can't measure the care you're delivering, you can't measure your performance against the best and the worst. In the disparities context, this translates to also being able to measure what care is being delivered to specific racial and ethnic groups. So the team's strategy includes a strong position on the need to collect patient data by race and ethnicity so that health care systems can identify disparities where they are happening and develop targeted interventions to address them.

How will the Foundation's approach foster solutions to racial and ethnic disparities in health care?

LAVIZZO-MOUREY—We plan on having demonstrations in hospitals that will implement an improvement process, measure it and, if successful, encourage those processes to be used as templates for other organizations.

Why did you decide to focus on the quality-improvement aspect of this issue?

LAVIZZO-MOUREY—We have learned a lot through our quality-related projects, particularly in the areas of chronic illness and outpatient care. We have learned that there are techniques for improving quality—such as developing better models for how to coordinate care for chronic illness—and that you also must create incentives for different players in the health care system to demand better quality, such as consumers, purchasers and providers. Some of our quality initiatives are starting to show real results—Don Berwick at the Institute for Healthcare Improvement is showing results through the *Pursuing Perfection* program's work with hospitals. Ed Wagner's model of chronic illness care has been adopted widely. Therefore, it seemed to make more sense for us to try to develop disparities initiatives that built on the best lessons from these ongoing quality-improvement efforts, rather than create disparities projects that relied on entirely new strategies.

The fact of the matter is that if a certain subpopulation is getting poorer care, you are not going to be able to raise overall quality if you do not improve care to that subpopulation.

Does the Foundation plan to play a role in promoting the other approaches included in the report, such as diversifying the health care workforce or training hospital staffs to be more culturally sensitive?

LAVIZZO-MOUREY—One of the overall conclusions of the IOM report was that the solutions are going to have to be comprehensive and sustained. There is not going to be one approach that solves all the problems. RWJF has a long-standing commitment to diversifying the health care workforce through programs for undergraduate students and faculty development programs. We recognize that some approaches, like diversifying the health care workforce, are going to need some time to bear fruit in order to demonstrate an impact on the quality of care that minority patients receive. And we applaud the efforts of others to take the lead on different approaches, such as fostering cultural competence. In addition to our ongoing programs to diversify the workforce, we now have focused efforts on quality-improvement demonstrations that rely on data collection and making the best use of standard quality-improvement techniques.

What are the biggest challenges to the quality-improvement approach?

LAVIZZO-MOUREY—I think there are three big challenges. One is that some organizations do not have the infrastructure or the experience to do quality improvement. The second challenge is that collecting data

See Approach—page 6

PROGRAM HIGHLIGHT

RWJF Expects Success in Improving Cardiac Care

Cardiovascular disease is one of the leading causes of death for all populations in the United States, but its impact is even greater for minorities. The heart disease death rate among black men, for example, was 29 percent higher than for white men in 2002, according to the Centers for Disease Control and Prevention. However, white patients are more likely to receive screening and treatment for cardiac risk factors than are blacks and Hispanics who seek treatment. Other research shows that Mexican Americans received 38 percent fewer recommended medications when hospitalized for a heart attack.

These disparities exist despite the fact that the health professions agree on the recommended care for much of cardiovascular disease. RWJF is trying to change this situation with a new program, *Expecting Success: Excellence in Cardiac Care*.

“This is a flagship effort to find out what works to reduce disparities,” Pamela Dickson, M.B.A., Disparities team leader, says of *Expecting Success*.

Although evidence that minorities receive inferior heart disease treatment is overwhelming, solutions to narrow the disparity gap are paltry. Under the leadership of George Washington University Research Professor Bruce Siegel, M.D., M.P.H., *Expecting Success* will work with 10 hospitals, along with their community partners, to show that providers can improve care for all patients, and particularly for minorities.

“We’re creating the nation’s first real laboratory for addressing disparities in a very structured way,” says Siegel, who also is director of the RWJF-funded *Urgent Matters* program. That effort resulted in a series of proven strategies for hospitals to reduce emergency department overcrowding.

Expecting Success is just getting under way (the application deadline has passed and awardees will be announced in late summer). Siegel expects to have a stable of proven, effective quality-improvement strategies and models available for other hospitals to adopt by late 2007.

Interventions coming out of *Expecting Success* are expected to raise the quality bar for all patients. The participating hospitals will implement strategies for all cardiovascular patients coming through their doors. However, the program’s potential to test quality improvement as an effective disparities-reduction solution is stronger because it is targeted toward institutions serving large numbers of minorities.

“The bottom line is better care for all,” Siegel says. The initiative will be able to capitalize on Medicare’s new policy to link payment to hospital submission of performance data on measures related to heart attacks and heart failure.

Standardizing the collection of race and ethnicity data will be a major part of the project. “Some hospitals have never collected this information or they collect it in many different ways,” says Siegel.

The hospitals selected for *Expecting Success* will be general acute-care hospitals or hospital consortia serving substantial num-

bers of black and Latino patients with cardiovascular disease. Participating hospitals will receive grants of \$200,000 and technical assistance and training in collecting and standardizing race- and ethnicity-specific data on a uniform set of measures, undertaking rapid-cycle change techniques and improving the quality of inpatient care, as well as initiating innovations to improve cardiovascular care in community settings.

Siegel and Dickson are encouraged by the number of institutions that expressed commitment to quality improvement. “Institutions willing to take this on will have to feel comfortable talking about these issues to their boards and physicians,” notes Dickson. “This is not simple but it has the potential to produce breakthroughs, changing the quality of health care for many minorities in this country.”

—CHRISTOPHER GEARON

For more information on the program, see www.expectingsuccess.org.

From *Approach*—page 5

related to race and ethnicity raises issues for institutions and individuals, such as whether the information could somehow be used against individuals. When we conducted a survey last year, we found that when people know why they are being asked about race and ethnicity—and are made aware that the information is likely to help improve the quality of health care—most do not object to providing the information. It shows that an educational process is needed to inform institutions about how folks think about this issue. The third challenge is that there are a limited number of conditions that have tested and proven quality measures that can be used to track performance. In choosing to begin our work in disparities in the area of cardiovascular disease, we were mindful that there are now measures of the quality of care in cardiovascular care that virtually all hospitals are collecting.

One issue that comes up often is whether attitudes of bias or prejudice on the part of providers play a role in disparities. What is your take on this issue?

LAVIZZO-MOUREY—It is really hard to know whether any individual has bias. There are not any studies that have directly addressed this, and it is hard to develop interventions to address something for which you do not have baseline measures. Our approach looks at how you improve quality of care, independent of whether there is bias involved. If there is bias, the solution is to put systems in place to protect against those biases. If there is not bias, the solution is still to put effective systems in place. Our goal is to ensure, at the end of the day, that people get the care they need.

What are the biggest factors in racial and ethnic disparities?

LAVIZZO-MOUREY—The biggest factor, which we skirted around in the IOM report, is the huge number of people who don’t have insurance. We know being uninsured, or having serious financial barriers to care, is a big cause of disparities. You cannot have a discussion about disparities in health care without addressing the fact that 25 percent of African Americans and 33 percent of Hispanic Latinos are uninsured. However, while the Disparities team strategy acknowledges the role that being uninsured plays, we have chosen to make our investments in increasing coverage through another team.

Also, research has shown there is tremendous variation geographically in the kinds of care delivered. Often you can see certain hospital settings where providers do a good job in one area of care, maybe in a region highly populated by racial and ethnic minorities, and do a terrible job in others. Institutional variations may account for some of it, and provider-to-provider variation may also play a role.

Since the IOM report was released, what progress has been made in regard to racial and ethnic disparities? What has stagnated since then?

LAVIZZO-MOUREY—I think there has been attention to the problem; there has been legislation introduced to further highlight some of the issues. What we have not seen are changes in the trends or specific demonstrations that show how to make a difference—and that those successes can get adopted more widely. The reality is that we are stagnated at producing solutions. RWJF plans to play a major role in getting us past this roadblock, by putting our research and demonstrations of solutions into the hands of the people and organizations that need them.

—INTERVIEW BY LAURIE JONES

PROGRAM HIGHLIGHT

Overcoming Language As a Barrier to Quality Health Care

Stories of medical miscommunication are plentiful among physicians who treat non-English-proficient and limited-English-proficient patients.

At a Robert Wood Johnson-sponsored focus group in 2003, a Falls Church, Va., pediatrician told about a baby brought in with a cough and runny nose. The doctor told the mother to buy nose drops and instructed her to put the drops in the baby's nose and suction it. She returned a week later with her baby, who wasn't any better. The mother had been putting cough drops in the baby's nose, making it more difficult for the baby to breathe.

More than 44 million Americans speak a language other than English at home; 27 million of them speak Spanish. Studies have found that patients who speak limited or no English often lack awareness of medical services and how to access them, have difficulty making appointments, receive less information about therapeutic regimens and understand less of their medication instructions than other patients. In one study, Latino parents cited language barriers as the cause of misdiagnoses, poor medical care and inappropriate medications and/or hospitalization of their children.

Providers cite difficulties making accurate diagnoses, meeting informed-consent responsibilities, explaining care options and giving basic patient education.

To meet the needs of both patients and providers, RWJF is funding a national program, *Hablamos Juntos: Improving Patient-Provider Communication for Latinos*. In English, *Hablamos Juntos* means "we speak together."

The purpose of the \$18.5-million program, started in 2001, is to break down language barriers by:

- Increasing availability and quality of medical interpreters for Spanish-speaking patients.

- Providing useful materials in Spanish.
- Developing universal signage so non-English speakers can physically navigate health care facilities.

"There are many variables that impede a patient's receiving the right health care at the right time, but one of the most obvious is when patient and physician speak different languages," says Pamela Dickson, M.B.A., senior program officer and leader of RWJF's Disparities team. "Given the significant increase in Americans who speak limited English or no English at all, figuring out how to address language barriers is an issue for health care systems across the country."

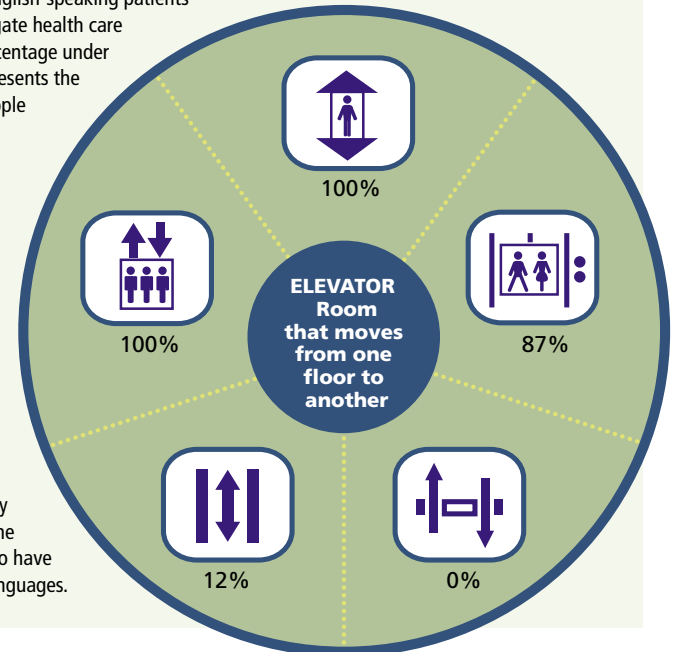
Led by Program Director Yolanda Partida, D.P.A., at the University of Southern California's Tomás Rivera Policy Institute, the program's focus is on developing affordable models for language services—interpreters, Spanish materials and signage—at 10 rural and urban pilot sites with fast-growing Latino populations.

"We know that organizations are struggling to provide language services," says Partida. "Our work is to figure out how to do this."

Hablamos Juntos found few formal training programs for health care interpreters. Often children or family members who lack understanding or the vocabulary to interpret medical conditions are brought to appointments as translators.

In response, five pilot sites have partnered with local colleges to train medical interpreters. Other sites have developed cards with a picture and phrase, such as "I'm hot" or "I have a temperature" for patients to use. Rigorous testing and credentialing standards are also being developed for medical interpreters.

The graphic to the right is a sample of the type of public information symbols *Hablamos Juntos* is testing as signage to help limited English-speaking patients and visitors navigate health care facilities. The percentage under each symbol represents the proportion of people that respondents thought would understand the graphic. The survey applies a design (the wheel with a definition in the center) that has been used internationally with groups of different languages and cultures for use by people living in the United States who have varied primary languages.



Written health care materials in Spanish are another issue. When grantees were asked to submit their best Spanish-language medical forms, documents and instructions, "there were an extraordinary number of errors," says Partida.

"We are talking about a uniquely American health system where many words don't have Spanish equivalents, so translators will invent new words that readers might not recognize," she says. "Although English and Spanish have many similarities, they are two different languages with different grammar and syntax rules. What we often find is Spanish text following English language structure."

Translators unfamiliar with the content often have a difficult time converting social and cultural context embedded in the patient education materials developed for English-speaking audiences, she said.

In another area of concern, the project is creating universal symbols, such as those on roadways and in national parks, for navigating through health facilities. About 158 symbols representing 28 different references, such as emergency, immunizations, internal medicine, laboratory, oncology, pediatrics and waiting room are being tested (see graphic above).

Hablamos Juntos is already bearing fruit. At one grant site, Neighborhood Health Plan of Rhode Island, Providence, a health maintenance organization (HMO) serving three hospitals and one health center with five sites, a formal translation training program is in place and providers have been taught how to work with interpreters.

Brenda Whittle, the health plan's senior director of membership development, cites their business case study showing that among their HMO members, stays in the neonatal intensive care unit for Latino babies were several days longer and readmissions higher than for babies born to English-speaking mothers.

"There wasn't access to an interpreter every day, and sometimes a family had to wait a day or two for discharge. So we'll shift money from high-end care into interpreters," Whittle says.

Concludes RWJF's Dickson: "The bottom line is you can't have good health care encounters unless you have good communications between the patient and provider."

— ANNE E. STEIN

See www.hablamosjuntos.org for more information on this project.

America's Public Health System Is Still Struggling

If the United States suffered a bioterrorism attack today, most states would not be fully prepared to respond, leaving millions of Americans at risk. Just six states would be ready to provide vaccines and antidotes in the event of a chemical or biological emergency, and as many as 20 states would lack plans for dealing with a flu pandemic.

This worrisome profile of the nation's public health system and its capacity to deal with public health emergencies draws on a recently published report by Trust for America's Health (TFAH). The report, *Ready or Not? Protecting the Public's Health in the Age of Bioterrorism—2004*, concludes that, despite \$3 billion in federal funding and some modest improvements over the past three years, the public health system remains ill-prepared to meet the country's myriad health needs, urgent or not.

TFAH's first edition of *Ready or Not* appeared in 2003, two years after the attack on the World Trade Center and after the federal government pumped \$2 billion into public health budgets nationwide. It revealed that states were not prepared for bioterrorism. One year and an additional \$1 billion in funding later, a follow-up report finds that states remain poorly equipped overall to deal with bioterrorism or other major health issues, such as disease epidemics or chronic illnesses and conditions, including obesity, asthma and cancer.

"You never know what health challenge is going to get thrown at you in this country," says Shelley A. Hearne, Dr.P.H., executive director of TFAH, who presented the report at a congressional briefing in December 2004.

The Robert Wood Johnson Foundation, which provides funding to TFAH, sponsored the briefing in collaboration with another RWJF grantee, the Alliance for Health Reform. "There must be a public health system in place that, regardless of where the emergency hits, is ready to go on all fronts," Hearne says.

The report shows that since 2003, states' public health systems have made improvements. Yet much more progress is needed to fully prepare the public health system for emergencies. "We've made baby steps rather than the giant leaps that are needed," Hearne says.

To measure the extent of states' improvement, TFAH developed report cards with 10 indicators and graded states from one to 10. Indicators included whether states made full use of federal bioterrorism funds; how well they communicate with local health departments; their laboratories' capacity to respond to chemical, biological or radiological attacks; and plans for dealing with a flu pandemic. Most states scored six or less. Florida and North Carolina scored nine, while Alaska and Massachusetts scored three. In general, the report found that many basic bioterrorism detection, diagnosis and response capabilities are still not in place. Many states scored poorly on communicating with local health departments, employing and training a stable public health workforce, making their laboratories bioterrorism-ready, and continually monitoring disease surveillance equipment. While every state but Alaska has statutory authority to quarantine in response to a hypothetical bioterrorism attack, concerns remain that states are unprepared to implement such a quarantine.

James Marks, M.D., M.P.H., senior vice president and director of the Health Group at RWJF, sees the poor scores as a direct result of dramatic budget cuts. States have had to compete with other

national interests for federal funding—war in Afghanistan and Iraq, and strengthening fire and police departments after September 11th. "We've asked a public health system, badly in need of repair after years of neglect, to shoulder the tremendous added burden of being on the front lines for preventing terrorist threats at home," Marks says.

"In last year's report, two-thirds of state health agencies had their budgets cut. This year, one-third had cuts, some for the second year in a row. This is a little like pouring water to fill a bucket that has a hole in the bottom," Marks says. "Why should we be surprised that progress is not as great as we expect?"

Such progress depends on the government making public health funding a top priority, Hearne says. "Whether it's bioterrorism or defense for pandemic flu or the growing epidemic of chronic diseases, we have not made it a national priority."

In addition to calling for increased funding, the TFAH report

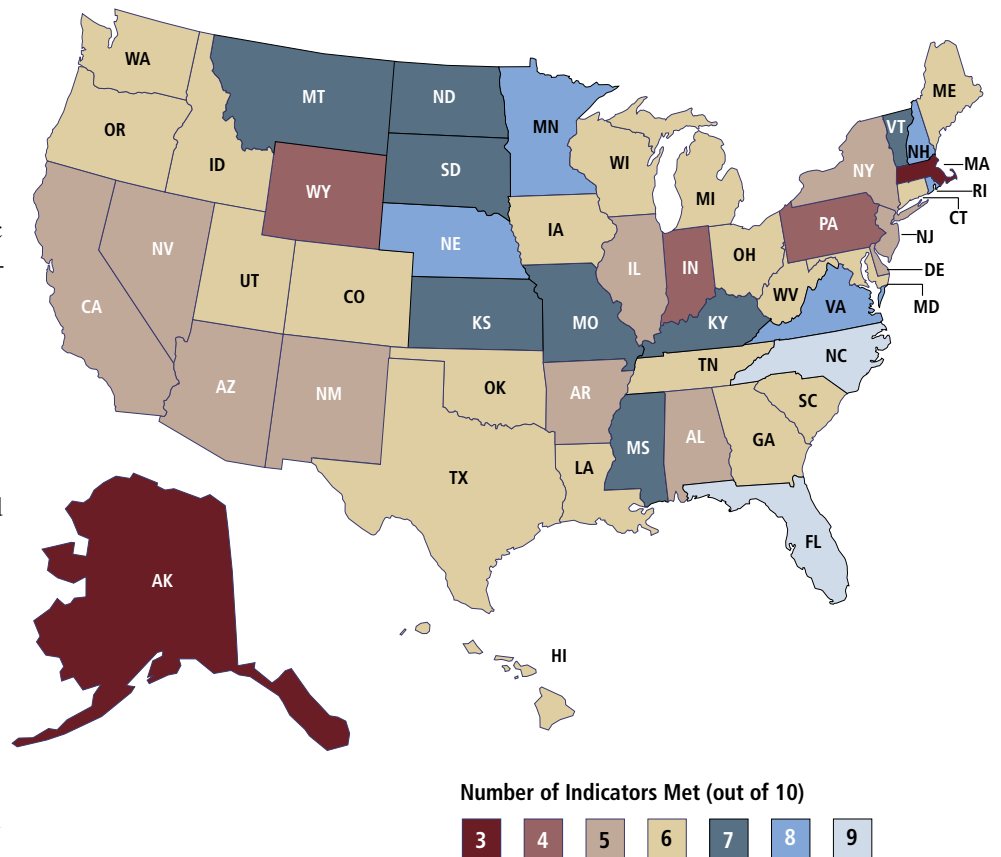
urges health and public policy-makers to strengthen the public health system by mandating that states show how they use federal funds to improve their public health systems and to create standards of improvement that can be measured. The report calls for a "comprehensive public health system" that is ready to meet all health issues, from biological contamination to the flu to West Nile virus to cancer.

It advises state and local health agencies to conduct practice drills to measure their strengths and weaknesses. It also advocates liability protection as well as expedited or temporary approvals for antidotes and vaccines.

"We know how to do public health in this country," Hearne says. "We need leadership to step in and a commitment in dollars so we have modern health defense for 21st-century challenges."

—ANDREA KOTT

For the full report, see <http://healthyamericans.org>. For an interactive map go to www.rwjf.org/publichealth and choose Multimedia.



To search our database of Foundation-funded research, visit the RWJF Research Center at

www.rwjf.org/research

Child Health and Parental Relationships: What Is the Link?

Research shows that children raised in poverty have poorer health over their lifetimes than do children raised in families with higher incomes. Thus, family socioeconomic status has an impact on child health. Is the converse true? Can a child's poor health cause parents to separate, which may affect family income? To answer this question, a recent study looked at the effect a child's health has on the parents' commitment to each other. The impact may be most acute for unmarried parents.

The investigators examined data on parents' relationships, living arrangements and demographics from the national Fragile Families and Child Wellbeing Study, which followed new, mostly unwed parents in 20 U.S. cities from 1998 to 2000. The Fragile Families Study included in-person interviews with new mothers and fathers at their child's birth and again by phone 12 to 18 months later. The researchers focused their analysis on how having children in poor health affects parents' relationships. They used three criteria to define poor health:

- A birthweight of less than four pounds.
- A physical disability such as cerebral palsy or Down's syndrome.
- Significant developmental delay.

Changes in Parents' Relationships

The analysis showed that parents' levels of commitment to each other decreased for 28 percent of parents by the time their child was 12 to 18 months old. For example, they may have been cohabiting at the time of the child's birth, but were living apart by the time of the follow-up. "In general, the less committed the initial relationship, the greater the likelihood that the level of commitment decreased," the researchers reported.

Using econometric modeling, the investigators determined that having a child in poor health:

- Decreases the likelihood that parents live in the same household by the time the child reaches 18 months of age.
- Decreases the likelihood that parental commitment to the relationship stays the same or increases.

In addition, the father having children with another partner and the mother being younger than 21 are risk factors for decreased commitment to the relationship.

These results, the authors contend, "have important implications for understanding the processes underlying the intergenerational transmissions of health and poverty."

Reichman NE, Corman H and Noonan K. "Effects of Child Health on Parents' Relationship Status." *Demography*, 41(3): 569-584, 2004.

Three Surveys of Fitness-Friendly Communities Deemed Reliable

Each year in the United States about 200,000 to 300,000 people die prematurely because they are physically inactive. Despite the proven health benefits of exercise, more than 25 percent of Americans remain completely inactive. Previous research has shown that people exercise more when they have greater opportunities to be active. To craft public policies that encourage exercise, researchers are being asked to design surveys that measure the public's perception of the fitness-friendliness of their communities.

The researchers in this study assessed whether three telephone surveys—all of which measure how suitable people believe their social and physical environments are for exercise—are reliable for broad use. The study involved 289 adults who were interviewed via telephone and then asked the same questions one to three weeks later to see whether they offered the same answers. Questions included whether their neighborhoods had bike paths and sidewalks, shopping within walking distance, safe streets and social support for physical activity.

The study found that all three surveys were generally reliable and concluded that most questions "are now ready for use in research

and in public health surveillance." Here are the specific findings:

- Most survey questions that asked about physical characteristics of the neighborhoods—presence of sidewalks, distance between destinations—were moderately to highly reliable.
- Questions about the social environment, such as whether a neighborhood feels safe, were less reliable.
- Certain types of questions were more reliable for urban or rural respondents. For instance, urban respondents more reliably reported on residential density.

The researchers recommend that the next research priority for crafting fitness policies is to determine whether perceived access to exercise, or more objective measures such as counting the number of parks and sidewalks in neighborhoods, are better predictors of physical activity.

Brownson RC, Chang JJ, Eyster AA, Ainsworth BE, Kirtland KA, Saelens BE and Sallis JF. "Measuring the Environment for Friendliness Toward Physical Activity: A Comparison of the Reliability of 3 Questionnaires." *American Journal of Public Health*, 94(3): 473-483, 2004.

Fewer Exercise Areas in Low-Income, Minority Neighborhoods

The number of obese and overweight people in the United States has reached epidemic proportions, with nearly 65 percent of adults and 15 percent of children being overweight and almost one in three adults weighing in as obese.

A new study provides some insight into why Americans who are at greatest risk of being overweight—those who are low-income and minority—may not be getting the exercise they need to stay fit: They are less likely to be living in neighborhoods that are equipped with areas for exercise.

The researchers assessed 409 communities in 2002 and 2003 to see how many sports areas (baseball diamonds, basketball and tennis courts, and soccer fields), parks, public pools or beaches, and bike paths they had. They then determined the ethnic composition and economic standing of each neighborhood using Census Bureau data.

Income Matters

They found that the wealthier the community, the greater the number of exercise areas. Neighborhoods with a median household income of \$25,000 had an average of 6.2 exercise areas; those with household incomes of \$75,000 had 7.6. Neighborhoods with poverty rates of 1 percent had on average 7.5 exercise areas while those with poverty rates of 10 percent had 5.2—a 50 percent difference.

Interestingly, of the four types of exercise areas, neighborhood income differences had the greatest impact on the prevalence of bike paths, whereas the presence of sports areas did not differ across poverty levels or household income.

Ethnicity Matters

In terms of ethnic and racial makeup, researchers found that neighborhoods with higher numbers of African Americans and non-Asian, non-Hispanic minorities had fewer exercise areas. Hispanic neighborhoods, by contrast, had more exercise areas than other racial and ethnic minorities.

Researchers suggest that, along with antipoverty fiscal policies, "interventions to improve the health of low-income individuals should include proactive urban planning policies to reduce barriers related to physical activity."

Powell LM, Slater S and Chaloupka FJ. "The Relationship Between Community Physical Activity Settings and Race, Ethnicity and Socioeconomic Status." *Evidence-Based Preventive Medicine*, 1(2): 135-144, 2004.

The Rise and Fall of Uninsurance Rates for Children: 1977–2001

While the rate of uninsured children was virtually the same in 2001 (8.3 percent) as it was in 1977 (8.5 percent), children living in poverty are more likely to be insured today than before.

Using data from three national medical expenditure surveys, researchers examined coverage rates for children living at three different income levels. Overall, uninsurance rates increased between 1977 and 1987—from 8.5 percent to 11 percent, and then declined to 8.3 percent by 2001. In general, during the 1980s and 1990s, expansions in Medicaid and the State Children's Health Insurance Program (SCHIP) were able to compensate for steady declines in private coverage.

Below the Poverty Line

Fluctuations were most dramatic for children in poverty, whose uninsurance rates soared from 16 percent to 24 percent between 1977 and 1987, and then fell to 10.5 percent by 2001. The increase between 1977 and 1987 coincided with hikes in the child poverty rate and a weakening of the safety net. In 1981, Congress tightened income eligibility standards for welfare, which left fewer children eligible for Medicaid. Huge gains in insurance coverage after 1987 for this group were due largely to a series of Medicaid eligibility expansions.

Near-Poor

Meanwhile, in 1977, some 13 percent of children between poverty and 200 percent of poverty were uninsured; the rate climbed to 19.5 percent by 1997 and then dropped to 15.5 percent by 2001. Researchers say this happened because private coverage continued to erode during the 1980s and 1990s and most near-poor were not eligible for the early expansions of Medicaid. Due to increasing health care costs, fewer low-income workers were opting to pay for higher premiums. The picture improved somewhat after 1997 because states began to implement the federal SCHIP program, which targeted low-income children not traditionally eligible for Medicaid.

Children at or above 200 percent of poverty began and ended this period with an uninsurance rate of 5.3 percent, although at the end of 25 years fewer of them had private insurance and more had public coverage.

Children's Health Insurance Coverage, by Income

	1977	1987	1997	2001
All children under age 18				
Percentage with private insurance	79.1 ^b	74.8 ^a	69.7 ^a	68.4
Percentage with employer coverage	72.4 ^b	69.9	65.5 ^a	65.1
Percentage with public coverage	12.4 ^b	14.2	19.8 ^a	23.3 ^a
Percentage uninsured	8.5	11.0 ^a	10.5	8.3 ^a
Family income less than 100% of poverty				
Percentage with private insurance	32.3 ^b	37.1	24.5 ^a	20.9
Percentage with employer coverage	25.9	31.7	22.2 ^a	19.7
Percentage with public coverage	51.8 ^b	38.8 ^a	64.5 ^a	68.5
Percentage uninsured	15.9	24.1 ^a	11.0 ^a	10.5 ^b
Family income 100–200% of poverty				
Percentage with private insurance	69.8 ^b	61.9 ^a	56.9	48.5 ^a
Percentage with employer coverage	62.6 ^b	55.8 ^a	52.9	44.8 ^a
Percentage with public coverage	17.1 ^b	21.9 ^a	23.6	36.0 ^a
Percentage uninsured	13.0	16.3	19.5	15.5
Family income 200% of poverty or higher				
Percentage with private insurance	92.3 ^b	92.5	89.5 ^a	87.7
Percentage with employer coverage	85.7 ^b	88.3	84.7 ^a	84.1
Percentage with public coverage	2.4 ^b	2.9	3.4	7.0 ^a
Percentage uninsured	5.3	4.6	7.1 ^a	5.3 ^a

Source: National Medical Care Expenditure Survey, 1977; National Medical Expenditure Survey, 1987; Medical Expenditure Panel Survey, 1997 and 2001.

^a Significantly different than the preceding year at $\alpha=0.05$

^b Significant difference between 1977 and 2001 at $\alpha=0.05$

Cunningham P and Kirby J. "Children's Health Coverage: A Quarter-Century of Change." *Health Affairs*, 23 (5): 27–38, 2004.

Racial Differences in Surviving Prostate Cancer

Previous research has shown that African-American men with prostate cancer have lower survival rates than white men. They seek treatment when their cancer is more advanced, but they also have lower survival rates at different stages of the disease.

This study set out to test the hypothesis that black men have lower survival rates than whites from prostate cancer because they have additional ailments at the time that they are diagnosed (comorbid conditions). The researchers examined the records of 864 patients diagnosed with prostate cancer at four Chicago area hospitals between 1986 and 1990. About 40 percent of the cohort was black.

They found that the rate of comorbid conditions was higher for black men than for whites. Black men with prostate cancer were one-third more likely to have diabetes and were also more likely to have renal disease, than white men. However, among blacks and whites with comorbid conditions, there were no racial disparities in survival rates.

But, when controlling for comorbidity, medical treatment, nature of the tumor and age, blacks were still more likely (about 1.5 to 2 times) than whites to die from prostate cancer and from other ailments.

Researchers suggest what may account for their findings: "Race may act as a surrogate for social and cultural forces that influence the probability, content and quality of relationships between health care systems and providers." It is possible that more black men with prostate cancer have other comorbidities, but that those conditions are underdiagnosed, the study suggests.

Freeman VL, Durazo-Arvizu R, Keys LC, Johnson MP, Schafernak K and Patel VK. "Racial Differences in Survival Among Men with Prostate Cancer and Comorbidity at Time of Diagnosis." *American Journal of Public Health*, 94(5): 803–808, 2004.

Vincent Freeman, M.D., M.P.H., was a fellow in the Harold Amos Medical Faculty Development Program at the time of this research.

Adolescents and Smoking: Who Is at Risk?

Risk factor research attempts to predict the individuals most likely to start smoking, so that health professionals then can target prevention programs to these high-risk groups. But decades of investigation have shown that multiple pathways or "etiologies" can lead to smoking and other substance use. In other words, there is "no single risk factor or constellation that is necessary or sufficient for the development of substance use." This study examined the process among adolescents of becoming a smoker to identify characteristics that may help predict their progression.

The investigators used data on 9,449 adolescents, mostly ages 12 to 19, who participated in the National Longitudinal Study of Adolescent Health, a survey of students in grades seven through 12 from more than 130 middle and high schools in the United States. In the survey, participants reported on their smoking behavior at baseline and one year later, and were categorized by these investigators as:

- **nonsmokers**, if they did not smoke at either time period
- **experimenters**, if they progressed from not smoking to smoking irregularly
- **regular smokers**, if they were experimenters at baseline and began to smoke regularly
- **rapid regular smokers**, if they progressed from not smoking to smoking regularly
- **continued experimenters**, if they remained experimenters throughout the survey period

Who's Likely to Smoke?

- Similar to past studies, these findings indicate that clusters of risk factors—or patterns—are predictive of progression in an adolescent's smoking behavior.
- Adolescents who exhibited more deviant behavior (e.g., vandalism, lying, stealing, truancy) and reported using alcohol without adult supervision were more likely to become experimenters.
- Adolescents who had three or more smoking friends and reported a grade-point average of 2.7 or less were more likely to become rapid regular smokers.
- Adolescents who smoked more frequently as experimenters and had one or more smoking friends were more likely to become regular smokers.

These patterns correctly predicted over half of adolescents who started to smoke or began smoking more regularly.

These findings, the authors suggest, "may provide clues into the major mechanisms at work for different groups of adolescent smokers."

Dierker LC, Avenevoli S, Goldberg A and Glantz M. "Defining Subgroups of Adolescents at Risk for Experimental and Regular Smoking." *Prevention Science*, 5(3): 169–183, 2004.

Physicians' Training and Resources May Affect Racial Disparities in Health Care . . .

The existence of racial disparities in health care in the United States has been clearly established: for example, blacks generally receive lower quality care than whites. However, the underlying causes of these racial differences are not well understood. This study hypothesized that differences in the "clinical qualifications and clinical resources" of the primary care physicians who treat black patients and those who treat white patients may play a role in racial disparities in health care.

Using physicians' unique provider identification numbers, the researchers combined data from two sources: the Robert Wood Johnson Foundation-funded 2000–01 Community Tracking Study Physician Survey, a biannual telephone survey of a nationally representative sample of physicians who provide direct patient care; and a sample of 2001 Medicare claims for physician office visits and consultations for black and white beneficiaries.

They examined a range of physician characteristics, including medical education, board certification, practice setting, payer mix, age, sex, race and self-reported ability to provide quality care to patients and access necessary health care resources for them.

Different Physicians, Different Care

The investigators' findings for the nearly 45,000 primary care physician visits included in the study support their hypothesis:

- Black and white patients received care from different clusters of physicians: black patients mostly obtained care from a small subgroup of physicians, who provided little care to white patients. White patients mostly obtained care from physicians who primarily treated few black patients. In fact, 78 percent of physicians who treated very few black patients accounted for 78 percent of the visits by white patients; the other 22 percent of physicians accounted for 80 percent of all visits by black patients.

- Only 77 percent of the physicians treating black patients were board-certified in their specialty compared to 86 percent of the physicians treating white patients.
- Physicians treating black patients provided more charity care and were more likely to practice in low-income neighborhoods.
- Physicians treating black patients more often reported that they could "not always" provide high-quality care or access high-quality specialty care.

"The care of black patients and white patients rests to a large extent in the hands of different physicians," the authors conclude, and "the poorer quality of care received by black patients may in part result from the fact that their physicians are less well trained than those who treat white patients."

Bach PB, Pham HH, Schrag D, Tate RC and Hargraves JL. "Primary Care Physicians Who Treat Blacks and Whites." *New England Journal of Medicine*, 351(6): 575–584, 2004.

. . . But There Is More to the Story Than Physician Differences

Physician characteristics alone cannot explain the differences in treatment among Medicare beneficiaries across the nation, another group of investigators contends. Most studies that document racial disparities in health care are national in scope and therefore "mask sizable variation across regions and across procedures."

Examined Three Kinds of Care

Using 1998–2001 Medicare claims data for hospital stays and physician office visits in the 79 hospital referral regions with the largest black populations, the researchers looked at the utilization rates for three kinds of care:

- 1. Low-intensity, high-benefit care** such as mammograms for women and eye exams and hemoglobin blood testing for people with diabetes. According to the authors, the "right" utilization rate for these procedures should be nearly 100 percent.
- 2. High-intensity, higher-risk care** such as hip replacement surgery, back surgery and coronary procedures. Because the benefits and risks for these procedures differ by population and by patient, the authors contend that "it is less clear what the target rate should be."
- 3. End-of-life care**, which, according to the authors, is typically driven by the number of physicians and hospital beds in a region rather than by patient preference or need.

"There is no simple story that explains or captures the regional patterns of racial disparities in health care," the authors state. They conclude:

- Racial disparities may be driven by differences within regions or differences between regions. In some cases, racial disparities are driven by blacks living disproportionately in regions with low rates for all patients. In other cases, blacks receive less care than white patients in the same region. In many regions,

racial disparities are small for some procedures but large for others.

- Utilization rates for low-intensity, high-benefit care are lower than they should be for both blacks and whites.
- Black Medicare beneficiaries have more money spent on them overall and at the end of life

in particular, but they receive less low-intensity, high-benefit care than whites. According to the authors, for blacks, "the reduced provision of effective care may result in more interventions later in life."

- Large racial disparities in surgery, on the other hand, are mostly driven by higher-than-average surgery rates among whites rather than lower-than-average rates among blacks.

Level and Disparities in Care for Different Treatments

	Black Rate		Disparity Measure	
	Mean	Standard Deviation	White-Black Rates	Ratio of Black/White
Expenditures (year 2000 dollars)				
Total	\$ 8,436	\$ 2,113	-\$ 1,675	1.25
Last 6 months of life	\$ 1,7048	\$ 6,201	-\$ 3,855	1.29
Diabetic utilization				
Eye exams	54.93	4.79	4.85	0.92
Hemoglobin blood testing	57.32	6.78	7.80	0.88
Mammograms (for women)				
Hip replacement	35.05	6.27	14.19	0.71
Back surgery				
Back surgery	0.14	0.03	0.11	0.56
Catheterization				
Catheterization	0.22	0.06	0.19	0.54
Angiography				
Angiography	2.36	0.51	0.99	0.70
Percutaneous coronary intervention				
Percutaneous coronary intervention	1.81	0.39	0.68	0.73
Coronary artery bypass graft surgery				
Coronary artery bypass graft surgery	0.56	0.17	0.50	0.53
Carotid endarterectomy				
Carotid endarterectomy	0.33	0.07	0.36	0.48
End-of-life care (last 6 months of life)				
Percentage admitted to intensive care unit	0.13	0.04	0.25	0.34
Hospital days	4.06	0.60	-0.37	1.10
	1.57	0.34	-0.34	1.28

Notes: Data are from 79 Hospital Referral Regions with largest black population (representing 80 percent of black elderly population), and come from Medicare claims, 1998–2001. Diabetic utilization and mammograms are measured as percentage of enrollees having at least one procedure annually. Other utilization is measured as discharges per 100 enrollees.

Different Policy Reforms Should Be Considered for Different Kinds of Care

Policy reform, the investigators conclude, should vary by the kind of care under consideration. For low-intensity, high-benefit care, reform should focus on identifying all patients in need of the care and ensuring that they receive it. For higher-intensity care, the goal should be a system in which fully informed patients can make treatment choices. These reforms "will ensure that differences in patient care are driven by differences in needs and preferences, not by a legacy of discrimination or by where patients happen to live."

Baicker K, Chandra A, Skinner JS and Wennberg JE. "Who You Are and Where You Live: How Race and Geography Affect the Treatment of Medicare Beneficiaries." *Health Affairs* (Web Exclusive), October 7, 2004, VAR 33–44.

New National Initiative Launched To End Chronic Homelessness

For most of the 3 million Americans who are homeless, it is a temporary condition. Some, however, live on the streets for years. From time to time, they pass through shelters, emergency rooms, hospitals, treatment centers and jails. They tend to have multiple problems: a severe mental disorder, for example, compounded by substance abuse and a chronic illness such as HIV/AIDS, or by trauma caused by domestic violence. Experts estimate that about 250,000 individuals and as many as 15,000 families are chronically without a home.

Research confirms that an option known as supportive housing can often stabilize these highly vulnerable people by giving them both a permanent home and supportive services, some right on the premises. Among other things, the services may include health care, case management and help finding a job. Eighty percent of the chronically homeless will stay in supportive housing for at least a year and use the costly public safety net much less during that time.

In November 2004, nine national organizations, including the Robert Wood Johnson Foundation, announced that they had formed the Partnership to End Long-Term Homelessness and had committed more than \$37 million to a campaign to create 150,000 units of supportive housing within the next 10 years to end chronic homelessness.

Seven of the nine members of the partnership will fund the campaign. Besides RWJF, they are the Conrad N. Hilton Foundation, the Rockefeller Foundation, Fannie Mae, Melville Charitable Trust, the Fannie Mae Foundation and Deutsche Bank. The other two partners, the Corporation for Supportive Housing and the National Alliance to End Homelessness, will help develop much of the housing

and raise awareness of the problem and of supportive of housing as a solution. The partnership hopes to raise at least \$30 million more from other organizations.

For RWJF, the campaign is the culmination of 20 years of experience. Nancy Barrand, M.P.A., an RWJF senior program officer, explains that the Foundation came to the current model of supportive housing through two decades of programs that were aimed at homelessness, mental illness, HIV/AIDS and service integration. "We learned from these different interventions that the populations we were trying to reach may have presented different problems but they all shared a need for permanent supportive housing. Without housing, the treatment interventions were not effective. And without treatment, we could not reach these populations because they could not stay housed."

In 1991, RWJF, the Ford Foundation and the Pew Charitable Trusts jointly created the Corporation for Supportive Housing (CSH) to serve as an intermediary and provide grants, loans and expertise to those who wanted to develop supportive housing.

Over the years, RWJF continued to fund the corporation, helping it hone the model with demonstrations like the Health and Housing Integrated Service Network in California. In 2002, a \$6-million grant challenged CSH to lay the groundwork for a national campaign that would attract other funders and promote the development of 150,000 units of supportive housing nationwide. The Partnership to End Long-Term Homelessness is the result.

A rare consensus has developed around permanent supportive housing as a way to end long-term homelessness. The Bush administration has acknowledged that

chronic homelessness is a special problem and has adopted a 10-year goal of creating 150,000 housing units. After federal officials urged state and local governments to join the effort, many drew up their own 10-year plans. Meanwhile, analysts at the Washington-based Lewin Group highlighted supportive housing as a cost-effective intervention. They found that in nine cities, it was always the least expensive option compared to the alternatives. In New York City, for example, a day in supportive housing costs about \$42, as against \$54 per day for a shelter, \$165 for jail, and \$1,185 for 24 hours in a community hospital.

"Ultimately, we want supportive housing to become an integral part of the public safety net," Barrand says. She adds that the social innovation of bundling services with housing has made the Foundation think differently about how to help high-need, vulnerable populations. Says Barrand: "In the future, if we learn not to think of services separately, we may someday see housing as an integral aspect of health and health care."

—FLORA DAVIS

For more on RWJF's work with vulnerable populations, see www.rwjf.org/vulnerable.

Cover The Uninsured Week • May 1-8

Her mom gets cancer. They find the tumor early. Her mom is OK.

Her mom gets cancer. She's diagnosed too late. Her mom is gone.

When you're uninsured, life turns out differently.

There are 45 million Americans with no health insurance. More than 8 million are children. May 1-8 is Cover The Uninsured Week in your community. Get involved. Visit www.CoverTheUninsuredWeek.org

Cover The Uninsured Week 2005
Let's Get America Covered

U.S. Chamber of Commerce • AHA • AHA • Healthcare Leadership Council • IHRF • United Way of America
American Medical Association • National Medical Association • American Nurses Association • Families USA
Blue Cross and Blue Shield Association • America's Health Insurance Plans • American Hospital Association
Federation of American Hospitals • Catholic Health Association of the United States • Service Employees
International Union • National Council of La Raza • The California Endowment • W.K. Kellogg Foundation
The Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation is joining with some of the most influential organizations in the United States to organize Cover the Uninsured Week 2005 from May 1 to 8, 2005. During the week, hundreds of thousands of Americans will speak out for affordable, reliable and high-quality health care for all Americans. To get involved, please visit www.CoverTheUninsuredWeek.org.

New Data from Nurse-Family Partnership Shows Continued Success

Sharon Sprinkle always knew the Nurse-Family Partnership program she directs in Greensboro, N.C., worked well. After two-and-a-half years of having a nurse visit them and their new babies, many of the young, impoverished mothers in the program had secured jobs, had attended college, and had become better mothers than they ever thought they could. But until Sprinkle read the results of a randomized controlled trial of a similar program in Memphis, Tenn. (published in the December 2004 issue of the journal *Pediatrics*), she had no idea that the impact of the program extended so far beyond the child's 2-year birthday, when the nurse visits ended. The Memphis site was one of two original Nurse-Family Partnership study sites (the other being Elmira, N.Y.) partially funded by the Robert Wood Johnson Foundation that eventually led to replication programs like Sprinkle's program in Greensboro.

The *Pediatrics* study, "Effects of Nurse Home Visiting on Maternal Life-Course and Child Development: Age-Six Follow-Up of a Randomized Trial," followed 743 primarily African-American women residing in urban communities who were randomly assigned to receive either nurse visits or comparison services beginning in midpregnancy and continuing throughout their child's first two years of life.

The study found that four years after the program ended, it continued to produce positive effects on the women, children and families that participated. Specifically, nurse-visited women had fewer subsequent pregnancies and births, lesser use of welfare services, and longer relationships with their partners than women who did not receive the nurse visits. The children had sustained benefits as well: most had higher IQ and language scores and fewer behavioral prob-

lems in the borderline or clinical range than children who did not receive visits, and many exhibited behaviors suggesting they would adjust well both academically and behaviorally in their elementary schools.

"I was really excited about that," says Sprinkle.

So was the program's founder and the study's lead author, David Olds, Ph.D., professor of pediatrics and director of the Prevention Research Center for Family and Child Health at the University of Colorado Health Sciences Center.

"The conventional wisdom is that home-visiting programs, because they are focused on parental behavior and not on altering the child's day-to-day experience like in a classroom, will have limited impact on things like cognitive performance and language functioning," he says.

"But we find that with a program that is well crafted and that alters several domains of risk for compromised intellectual functioning, we have not only improved children's intellectual functioning, but this effect endures for years after the program ends. These children are simply better prepared to enter school."

Results like these led Invest in Kids, a nonprofit Denver-based organization that identifies research-based programs that benefit children, to adopt the Nurse-Family Partnership program in 1998 and work to implement it throughout the state. To obtain sustainable funding, Invest in Kids convinced the state legislature to earmark about \$350 million in tobacco-settlement funds to pay for Nurse-Family Partnership programs over the next 25 years.

According to Jennifer V. Adler, Invest in Kids executive director, to date the programs have served more than 4,000 families, a figure that should grow 25 percent next

year as matching Medicaid funding is added to the tobacco money.

"The breadth of outcomes this program is able to produce is like nothing else we have been able to find," says Adler. "This is the gold standard for early-intervention programs."

Colorado continues to support the program. Although funding for nearly all state programs has been cut in recent years as the state's fiscal crisis worsened, the Nurse-Family Partnership program continues to be fully funded. "That's because its outcomes are phenomenal," says Adler. "We feel honored and privileged to help communities bring this program to families because we know it's going to make a lifelong difference for parents and kids."

One reason for the program's impact, says Olds, is its ability to affect prenatal health. "We think that has a bearing on a child's later development, particularly neurological functioning," he says.

For instance, the nurses are very good at helping the mothers quit smoking during pregnancy. That can have a major impact on the

developing child, he notes, as at least seven longitudinal studies show a relatively unique relationship between tobacco exposure in the womb and severe antisocial behavior once children reach adolescence.

The research shows that children exposed to tobacco in the womb are also fussier and more irritable following delivery, are at greater risk of having colic, and exhibit exacerbations in the typical "terrible two" behavior, all of which can affect their relationship with their mother.

"We also know that the nurse-visited parents provided better care for their children in the first two years of life," says Olds. "And that the mothers started to improve their own living conditions by spacing subsequent births, working more and staying off welfare more. Those kinds of changes in prenatal health and family economic resources, and in the home environment, in addition to improvements in parenting, are domains of functioning that other home visiting programs have had a hard time affecting."

— DEBRA GORDON

Frank Karel (pictured at right) received the 2005 Terrance Keenan Leadership Award from Grantmakers in Health at the organization's annual meeting on February 24 in San Francisco. The award recognizes an individual grantmaker whose leadership and thoughtful application of philanthropic resources has had an impact on human health at the local, regional, national or international level. A former vice president of communications for the Robert Wood Johnson Foundation, Karel pioneered using communications strategies as an integral part of project and program decisions, creating a new paradigm in health philanthropy. His innovative vision for communications transformed how the Foundation does its work.



What Smokers Don't Know: Lower Tar Does Not Lower Health Risks

Despite public health campaigns and limits on cigarette advertising, smokers remain uninformed—and often misinformed—about the products they use.

Two recent survey-based studies funded by the Robert Wood Johnson Foundation and reported in a special issue of the journal *Nicotine & Tobacco Research* found that smokers need more information about the health risks of cigarettes.

“When we asked smokers if they felt they were informed, 94 percent of them said yes,” according to K. Michael Cummings, Ph.D., M.P.H., lead author of the studies and chair of the Department of Health Behavior, Division of Cancer Prevention and Population Sciences,

Roswell Park Cancer Institute, Buffalo, N.Y.

“But then when we asked specific questions about what is in cigarette smoke or whether certain types of cigarettes were ‘safer,’ most people did not know the answers.”

One-third of respondents said that cigarettes still had not been proven to cause cancer, and nearly two-thirds thought nicotine could cause cancer. More than 60 percent of smokers also thought that light cigarettes were less dangerous than regular cigarettes.

In a second study, Cummings and colleagues also found that only 13 percent of Marlboro Lights smokers (the most popular brand in the survey) knew that light cigarettes delivered about the same

amount of tar as regular ones. Nearly half said that regular cigarettes were “more than twice as likely” as light cigarettes to cause illness.

“If you ask an adult if they think that smokers understand that there are significant risks associated with smoking, they will say yes,” says William Corr, executive director of the Campaign for Tobacco-Free Kids. “But if you ask specific questions, people do not understand many aspects of the risks associated with tobacco use.”

In 2001, the National Cancer Institute released a report stating, among other findings, that smokers of light cigarettes remain at high risk for health complications due to smoking. The report also found that these smokers inhale

the same amounts of toxins as smokers of regular cigarettes.

Though the report received substantial press coverage at the time, the information in it has not been communicated to smokers, says Karen Gerlach, Ph.D., M.P.H., a senior program officer at RWJF and Tobacco team leader. “The scientific evidence is there, but smokers do not know it or do not believe it,” she says. “Either way, they are making decisions based on misinformation.”

Next steps? Regulation and education, says Corr. “Tobacco products themselves, as well as the marketing and any health claims, must be regulated by the Food and Drug Administration.”

See **Smokers Don't Know**—page 16

GRANT RESULTS REPORTS

The Robert Wood Johnson Foundation generates a Grant Results Report on almost all its independent grants after they are closed, as well as regular reports on its national programs. These reports detail the results of the Foundation's work, including the products produced. Since October 2004, one National Program Report and 56 Grant Results Reports have been added to the RWJF Web site, www.rwjf.org. You can search the entire database of reports at www.rwjf.org/grantresults. Recent reports include the following:

- **Coordination for Youth Tobacco-Cessation Partnerships**

The Youth Tobacco-Cessation Collaborative was formed in 1998 to coordinate the efforts of major national funders involved in designing and disseminating effective youth tobacco-cessation programs. The collaborative developed a *National Blueprint for Action* with a 10-year goal of ensur-

ing that every young tobacco user has access to appropriate and effective tobacco-cessation interventions by the year 2010. To view the blueprint and read about other activities of the collaborative, visit the Center for Tobacco Cessation Web site at www.ctcinfo.org/resources/blueprints.asp.

- **Studying the Feasibility of Developing Health Impact Statements**

From March 2001 through December 2003, researchers at the University of California, Los Angeles, School of Public Health assessed the feasibility and usefulness of health impact assessments in policy-making at the local, state and federal levels. The researchers identified lessons that could be applied from environmental impact assessments. They determined that health impact statements could quantify the health effects of proposed legislation and have the potential to become a useful

tool for public policy decision-makers. Health impact statements would help support or refute claims about benefits, use agreed-upon rules of evidence and provide a common language to discuss proposals. For comprehensive information about the project, visit www.ph.ucla.edu/hs/health-impact.

- **Promoting the Benefits of Walkable Communities**

Project staff at the Pedestrian and Bicycle Information Center of Chapel Hill, N.C., a clearinghouse for information about health and safety, engineering, advocacy, education, enforcement, access and mobility, created the Partnership for a Walkable America Web site to promote the benefits of walking and walkable communities, www.walkableamerica.org. Staff members of the center also assisted with RWJF's “The Shape We're In” media campaign at www.shapenews.org.

- **Development of the National Resource Center for End-of-Life Physician Education**

From September 1999 through December 2003, project staff at the Medical College of Wisconsin developed, launched and expanded a Web site called the End of Life/Palliative Education Resource Center, www.eperc.mcw.edu. The site provides users with educational materials, training opportunities, funding sources, conferences and links to other Web resources. The site contains more than 260 abstracts that describe available education materials, including syllabi, evaluation tools, videos, case studies and presentations. Among the tools specifically for educators: overviews of education concepts and strategies, sample exam questions and standardized patient cases. Physicians may download information from the site onto their PDAs (personal digital assistants) to use immediately in clinical settings.

— HEDDA COLOSSI

Search all active RWJF grants at

www.rwjf.org/grants

RWJF national programs are denoted by italics.

Addiction Prevention and Treatment

- > For expanding quality addiction treatment for teens, \$250,026 to Drug Strategies, Washington.
- > For strengthening the Faces & Voices of Recovery coalition, \$390,000 to the Legal Action Center of the City of New York.
- > *Paths to Recovery: Changing the Process of Care for Substance Abuse Programs.* Awards to 13 sites, totaling \$1.2 million.
- > For the Oklahoma State *Paths to Recovery* National Program Collaborative Project, \$200,021 to the State of Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma City.
- > For an alternate model of the *Paths to Recovery* program, \$130,745 to the University of Wisconsin, Madison, College of Engineering.
- > *Substance Abuse Policy Research Program.* Awards to eight sites, totaling \$653,166.

Building Human Capital

- > For preparing the physician workforce for 21st-century health care, \$498,000 to the American Board of Medical Specialties Research & Education Foundation, Evanston, Ill.
- > For the *Summer Medical and Dental Education Program*, a renewal award of \$299,947 to Yale University School of Medicine, New Haven, Conn.

Childhood Obesity

- > For evaluating school policies to combat childhood obesity in Arkansas, \$1.2 million to the University of Arkansas for Medical Sciences College of Public Health, Little Rock.
- > For statistical modeling to estimate the changes in energy balance needed to reverse the epidemic of obesity and overweight in United States children, \$102,388 to Harvard University School of Public Health, Boston.
- > For addressing childhood obesity in Michigan through after-school programs, \$100,000 to the State of Michigan Department of Education, Lansing.
- > For follow-up activities to a report on preventing childhood obesity, \$700,000 to the National Academy of Sciences—Institute of Medicine, Washington.
- > *Active Living Leadership.* Renewal awards to three sites, totaling \$282,419.
- > For the *Active Living Leadership* Coordination Center, a renewal award of \$172,906 to the San Diego State University Foundation.
- > *Active Living Research.* Awards to six sites, totaling \$1.7 million.

Disparities

- > For studying the role of private purchasers in reducing racial and ethnic disparities in health care, \$392,640 to the Henry Ford Health System, Detroit.

- > For a study of hospital practices in the collection of race and ethnicity data, \$189,039 to the National Public Health and Hospital Institute, Washington.
- > *Expecting Success: Excellence in Cardiac Care.* For an evaluation of the program, \$2 million to New York University, Robert F. Wagner Graduate School of Public Service, New York.
- > *Southern Rural Access Program.* Award of two grants from the Revolving Loan Fund, totaling \$1 million.
 - For an evaluation of the program, one renewal award of \$225,217 to the University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.

Health Insurance Coverage

- > For preparing Medicaid for the future, \$397,309 to the Center for Health Policy Development/ National Academy for State Health Policy, Portland, Maine.
- > For research comparing state administrative records to census data systems to uncover the Medicaid enrollment undercount, \$340,000 to the University of Minnesota School of Public Health, Minneapolis.
- > *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps.* For development of an eligibility process improvement collaborative, \$548,535 to the Support Fund for the Southern Institute on Children and Families, Columbia, S.C.

Nursing

- > For measuring the impact of communications technologies on nurses, \$150,000 to the University of California, San Francisco, School of Nursing.
- > For improving the performance of health care teams using simulation team training, \$105,908 to the University of Chicago, Pritzker School of Medicine.
- > For developing standardized technical specifications for nursing-sensitive performance measures, \$161,493 to the Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Ill.
- > *Transforming Care at the Bedside.* For developing financial tools to assist improvement efforts for transforming care at the bedside, \$156,655 to the Institute for Healthcare Improvement, Boston.

Pioneer

- > For assessing the impact of neuroscience advancements on the delivery of nonprofit behavioral health services, \$225,000 to the Alliance for Children and Families, Washington.
- > For exploring the role of video and computer games as a medium for health and health care messaging, \$250,000 to Digitalmill, Portland, Maine.
- > For using complexity science concepts to enhance health care quality, \$214,440 to Plexus Institute, Allentown, N.J.

Public Health

- > For a communications and advocacy toolkit and story bank for public health issues, \$100,000 to the Trust for America's Health, Washington.

- > *Public Health Informatics Fellowship Training Program.* One award of \$3.7 million to the Foundation for the National Institutes of Health, Bethesda, Md.

Quality Health Care

- > For developing a summative report on progress in the end-of-life field, \$266,085 to the Hastings Center, Garrison, N.Y.
- > For developing a framework and set of best practices for quality palliative care, \$249,000 to the National Quality Forum, Washington.
- > For planning and testing a co-management learning network, supplemental support of \$116,884 to Health Research & Educational Trust, Chicago.
- > For improving pain policy through collaborations with the state pain initiatives, \$112,880 to University of Wisconsin, Madison, Medical School.
- > *Depression in Primary Care: Linking Clinical & System Strategies.* Awards to three sites, totaling \$530,055.
- > *Health e-Technologies: Building the Science of eHealth.* For evaluating an online patient portal to facilitate improved diets, increased fitness levels and weight loss among Hispanics, \$400,000 to HispaniCare, Roswell, Ga.
- > For dissolution of the partnership, \$402,500 to the *Last Acts* partnership, Washington.
- > *Partnerships for Quality Education.* For training future clinicians on health care systems and practice improvement, \$347,443 to Harvard Pilgrim Health Care, Boston.

Tobacco Use and Exposure

- > *Tobacco Policy Change: A Collaborative for Healthier Communities and States.* Awards to 25 sites, totaling \$2.2 million.

Vulnerable Populations

- > For a conference to create consensus for family caregiving guidelines, \$265,000 to the Family Caregiver Alliance, San Francisco.
- > For engaging stakeholders and leaders to develop strategies for improving the health status of people in the mid-South, \$125,030 to the Foundation for the Mid South, Jackson, Miss.
- > For addressing domestic violence, abuse and neglect among Native-Alaskan families through training and education, \$323,000 to Southcentral Foundation, Anchorage, Alaska.
- > *Cash & Counseling.* Awards to 11 sites, totaling \$2.8 million.
- > *Community Partnerships for Older Adults.* Awards to 11 sites, totaling \$1.65 million.

Other

- > *Changes in Health Care Financing and Organization.* Awards to six sites, totaling \$1.7 million.
- > *Health Tracking.* For addressing unmet needs in substance abuse treatment and mental health care through community collaborations, a renewal award of \$199,947 to the University of California, Los Angeles, Center for Health Sciences.
- > Centennial campaign support of \$250,000 for the Visiting Nurse Association of Somerset Hills, Bernardsville, N.J.

PEOPLE

JAMES S. MARKS, M.D., M.P.H., became a senior vice president and director of the Foundation's Health Group in December 2004. Marks is responsible for the overall planning, budgeting, staffing, management and evaluation of all program and administrative activities of the group. Prior to joining the Foundation, Marks was the acting director of the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC). From 1995 until 2004, he was director of the CDC's National Center for Chronic Disease Prevention and Health Promotion. Throughout his career at the CDC, he developed and advanced systematic ways to address the nation's growing epidemic of obesity, reduce tobacco use, and prevent diseases such as cancer, heart disease and diabetes. Marks also has served on the National Advisory Committee for the *Robert Wood Johnson Health & Society Scholars Program*. Marks received his M.D. from the State University of New York at Buffalo. He trained as a pediatrician at the University of California, San Francisco, and was a Robert Wood Johnson Clinical Scholar at Yale University, where he received his M.P.H.

MICHAEL W. PAINTER, J.D., M.D., joined RWJF in January as senior program officer, Health Care Group. Prior to coming to the Foundation, Painter was a 2003–04 Robert Wood Johnson Foundation Health Policy Fellow with the office of Sen. William H. Frist, M.D., the majority leader. He also was the chief of medical staff at the Seattle Indian Health Board, a community health center serving urban American Indians and Alaska Natives. Painter earned a J.D. from Stanford Law School and an M.D. from the University of Washington. He completed his residency training at the Providence Family Medicine Residency program in Seattle and is a board-certified family physician.



FAREWELL

J. MICHAEL MCGINNIS, M.D., M.P.P., counselor to RWJF's president, retired from the Foundation in January to join the Institute of Medicine as senior scholar. In his new position, he will help explore the development of a program in clinical effectiveness research. McGinnis has been with the Foundation for the past six years, as senior vice president and director of the Health Group, and then as counselor.

VICTORIA WEISFELD, M.P.H., senior program officer in the Communications Department, retired from the Foundation in January. After more than 21 years of service to RWJF, Weisfeld has decided to look for new challenges.

SARA THIER, M.P.H., program associate in the Health Care Group, left the Foundation in November 2004 to become a project director at the Department of Health Policy at Jefferson Medical College in Philadelphia.

BOARD OF TRUSTEES

THE HONORABLE THOMAS H. KEAN, M.A., will chair the Robert Wood Johnson Foundation's Board of Trustees effective April 1, 2005. Kean is president of Drew University in Madison, N.J. He served as governor of New Jersey from 1982 to 1990. Kean also has served on the President's Education Policy Advisory Committee and as chair of the Education Commission of the States and the National Governors' Association's Task Force on Teaching. He is currently chair of the National Commission on Terrorist Attacks Upon the United States. Kean holds an A.B. from Princeton University and an M.A. from Columbia University Teachers College, as well as more than 25 honorary degrees. He succeeds Robert E. Campbell, who has been chairman since 1999 and who will remain on the Board as a trustee.

LINDA GRIEGO, a past RWJF trustee (1995–2004), rejoined the Board in January. She is the president of Zappo Entertainment Group, a television production company aimed at the young Latino market. Griego also is a former Los Angeles deputy mayor.

JAMES GAVIN III, M.D., PH.D., left the Board in January after having served since 1996. He is the national director of RWJF's *Harold Amos Medical Faculty Development Program*. From 2002 through 2004, Gavin was president of Morehouse School of Medicine in Atlanta.



From *Smokers Don't Know*—page 14

One focus for change, he says, is to prevent tobacco companies from using the terms “light,” “low-tar” and “mild,” among others, which make smokers think such products are less hazardous to their health.

Certain findings are important to communicate to the public health community as well, says Corr, such as the discovery that most smokers think nicotine causes cancer. “We have to then understand that when we try to help people quit smoking and are offering them nicotine replacement, they could be fearful.”

—NANCY VOELKERS

For the full text of these studies, see www.rwjf.org/research and click on Tobacco. For more on RWJF's work to reduce tobacco use, see www.rwjf.org/tobacco.

What's New on the RWJF Web Site

The Robert Wood Johnson Foundation Web site is now sporting a new look and structure that should make it an even more useful resource for grantees, policy-makers, researchers, the media and other visitors.

Perhaps the most visible change is in the enhanced program interest areas. Each interest area now features an overview written to help visitors better understand the work and strategies of the various Foundation teams. Over the months ahead, those areas will grow to include more content. Prominent on these newly designed pages are interactive photo essays. Each essay dramatically demonstrates the connection between the Foundation's grantmaking activities, the work of its grantees and the resulting impact on the lives of everyday people. Look for more photo essays in the future.

The Research Center continues to be expanded. Check back in the months ahead for some exciting changes in that section, which already contains abstracts of more than 400 articles based on research funded by the Foundation.

The site navigation overall is more streamlined to make it simpler for visitors to quickly find what they want—including clearer grant application guidelines.

We invite you to visit www.rwjf.org and let us know what you think at webfeedback@rwjf.org.

—JEFF MEADE

