ADVANCES®

The Robert Wood Johnson Foundation Quarterly Newsletter

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Strengthening a Stress Point in the Health Care Safety Net

FedEx® is synonymous with efficiency and speed. So when officials at Regional Medical Center at Memphis, Tenn., began working to streamline the hospital's emergency department procedures and reduce over-crowding, they turned to their corporate neighbor for guidance.

"FedEx is the guru for making deliveries in the shortest possible time while maintaining extremely high quality," says Rhonda Nelson, vice president of patient care services for Regional Medical Center. "We're going to see if we can apply some of those same principles to the emergency department.

"We realize, of course, that moving packages from place to place and moving patients through an emergency department are two different things," says Nelson. "But we think there are some basic, practical steps we can learn from FedEx to streamline our operations."

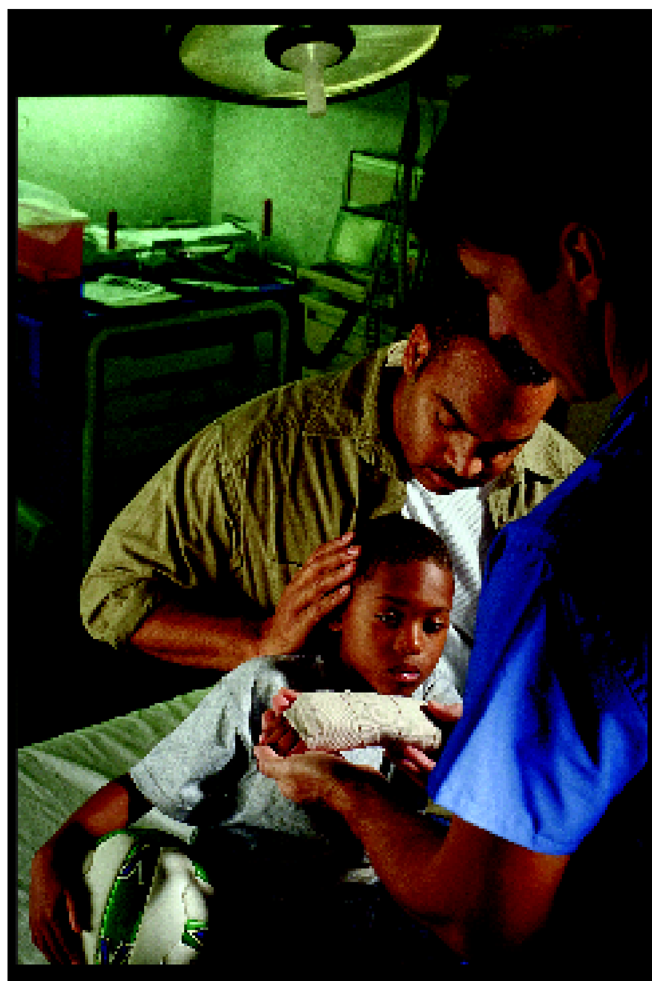
To that end, Nelson and her colleagues are working with experts from FedEx's Center for Supply Chain Management at the University of Memphis to develop and implement a comprehensive bar coding system to track and improve patient flow within the emergency department.

The project is part of The Robert Wood Johnson Foundation's national program, *Urgent Matters,* launched in May 2003. The goal is to help hospitals eliminate emergency department crowding and raise awareness in local communities about the challenges facing the health care safety net. The safety net comprises those health care providers or agencies—by mandate or mission—that provide a disproportionate amount of care to people who are poor and/or uninsured. Most emergency departments provide care regardless of ability to pay, and thus play one of the most crucial roles in the safety net.

The idea for the program stemmed from a 2000 Institute of Medicine report, *America's Health Care Safety Net: Intact but Endangered*, says Bruce Siegel, M.D., M.P.H., national program director of *Urgent Matters* and research professor at the George Washington University's Center for Health Services Research and Policy (see *Q&A*, page 4).

"We essentially have a perfect storm," says Siegel. "A lot of factors are swirling around at once, all of them combining to put enormous stress on the health care system, and on the safety net in particular."

See Safety Net—page 2



The emergency room is often the primary source of health care for many people.

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From Safety Net—page 1

These factors include the growing number of uninsured people who often have no choice but to use emergency departments as their source for primary care; the severe national nursing shortage; and a reduction in the number of hospital inpatient beds, which can make it difficult to admit a patient from the emergency department into the hospital.

In addition, the number of visits to emergency departments is climbing while the number of emergency departments is dropping. A Centers for Disease Control and Prevention study released in June 2003 found that the number of emergency department visits per year grew from 89.8 million in 1992 to 107.5 million in 2001, a 20 percent increase. At the same time, the number of hospital emergency departments in the United States decreased by about 15 percent.

And a 2002 General Accounting Office study found that two out of every three hospitals in the nation reported asking ambulances to be diverted to other hospitals because of inadequate capacity at some point in fiscal year 2001. One out of every 10 hospitals reported being on diversion status for more than 20 percent of the year.

"The reality is that the emergency departments have become the keystone of the health care safety net and, in many cases, they are being overwhelmed," says Siegel. "With *Urgent Matters*, we're trying to do something about that."

Ten hospital systems across the nation have been selected to participate in the year-long initiative. Each will receive emergency department patient flow consulting services valued at $125,000. Each grantee will also work with a local, community-based organization to assess the state of the community's safety net and to raise awareness of the connection between the safety net and the functioning of the overall health care system.

"I think there is a common, but mistaken view that safety-net issues do not affect middle-class people who have health coverage," says Pamela Dickson, M.B.A., an RWJF senior program officer.

"When an emergency department is overcrowded, it affects every person who goes there, whether he or she is insured or not. We need people to be more aware of how the safety-net role played by the health care system in their community affects the services everyone receives," says Dickson.

In Memphis, the University of Tennessee Health Sciences Center is the community organization grantee.

"We're reaching out to the community, especially our growing Hispanic population, to educate them about the safety net, but also, to get their feedback about their experiences with the health care system," says Alicia McClary Ed.D., director of outreach and education at the University's Center on Health Disparities.

Of the 10 hospitals receiving *Urgent Matters* grants, four will receive up to $250,000 in additional demonstration grant funding to pilot a specific innovation aimed at lessening emergency department crowding, such as the FedEx approach in Memphis.

At Boston Medical Center, for example, officials are studying whether tracking and adjusting the number of elective surgeries, which often use the same resources as the emergency department, such as labs, x-rays and intensive care beds, could help ease overcrowding in the emergency department.

At Inova Fairfax Hospital in Virginia, they are testing a system in which early emergency care would be provided in the triage area.

At Grady Health System in Atlanta, they are piloting a clinical management unit within the emergency department that would provide intensive care management services for patients with specific chronic conditions, such as asthma.

The overall goal is for *Urgent Matters* to create lasting improvements.

"We hope, in these 10 communities, that people in leadership positions will know more and care more about the state of the safety net and there will be a better understanding in the community about things people can do to build a better safety net," says Siegel.

In the 10 participating hospitals, the objective is to achieve real, measurable performance improvements, such as shorter wait times for hospital admission and quicker intervention using such treatments as antibiotics and pain medications. The four demonstration projects are expected to yield innovative results that potentially could be replicated by many other hospitals.

"All of these hospitals have a mission to serve everyone, regardless of the individual's circumstances, and they have risen to that mission," says Minna Jung, J.D., an RWJF communications officer. "These institutions are trying to do better and raise awareness of the larger issues. They are determined not to swerve from their mission."

—LAURIE JONES

For more information on Urgent Matters, visit www.urgentmatters.org.

Grantees Make Washington Connections

When grantees of The Robert Wood Johnson Foundation (RWJF) travel to Capitol Hill, they may give their legislators a surprise by what they *don't* ask. They don't ask for money and they don't push for legislation.

Instead, the RWJF-sponsored Connect Project brings together grantees and policy-makers to find ways to work together that benefit them both. For legislators, it is a welcome change and a chance to hear about important work being done in their districts. For grantees, it is a way to showcase their work and engage their lawmakers' support to further their mission.

Because grantees are barred from lobbying with Foundation funds, many are leery about even approaching their legislators. But legislators can do much to spread the work begun by grantees, says Ann Christiano, the RWJF communications officer heading up the Connect Project.

"It's tremendously important to know who your members of Congress are and have a relationship with them before you need them," Christiano says. "They are natural problem solvers and can connect you with solutions."

Legislators benefit too, by learning about cutting-edge solutions to some of the most difficult health issues and by gaining entrée to new groups of constituents.

In one recent example, representatives from the RWJF national program *Pursuing Perfection: Raising the Bar for Health Care Performance,* which seeks to improve quality in health care institutions, had the opportunity to share ideas with their legislators.

"The grantees began talking about ways to improve quality that members of Congress had not thought about before," Christiano says. "But they also said there is already enough money in the system. The members were fascinated. Here were leaders from among their constituents who are trying to make a difference without asking for money to do it. It tremendously increased [the grantees'] credibility when they said that the resources are already out there but they need these policy changes so that they could tap into them."

Grantees who participate in the Connect Project receive intensive training before they meet with their legislators to help them learn about their members' interests, hone their message, develop effective leave-behind materials and clearly communicate what they want their meeting to accomplish to advance their programs. In their training, grantees learn to develop a strategy to follow up on their requests and ensure that their relationship with their member of Congress doesn't begin and end with a single meeting.

"It's somewhat intimidating to contact your senator if you have no clue how to do it," says Ruth Hamlin, executive director of Presbyterian Outreach in Omaha, Neb., and a *Faith in Action* grantee. *Faith in Action* is an RWJF national program that brings together volunteers with people who are chronically ill.

In 2000, Hamlin took part in a Connect Project day of training and celebration of *Faith in Action* work in Des Moines, Iowa. Sen. Tom Harkin (D-Iowa), Gov. Tom Vilsack and legislative representatives also participated. Afterward, Hamlin asked Harkin and others to write letters of support for a grant.

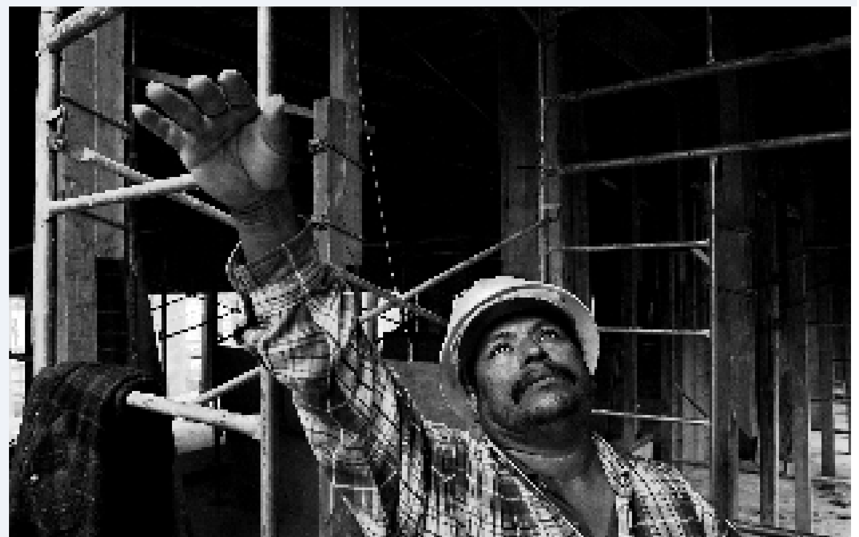
See Washington Connections—page 12

These photos were taken by Ed Kashi and appeared in the book *Denied: The Crisis of America's Uninsured* with text by Julie Winokur, published by Talking Eyes Media.The book, funded by the Nathan Cummings Foundation, was developed in conjunction with RWJF's Covering the Uninsured Week in March 2003.

Marcia Felts Wimberly uses emergency department services to monitor her hyperthroidism. Without health care insurance, she tries to control her condition using alternative medicine, exercise and nutrition.

Terminal illness, job loss and the high cost of health insurance has forced **Sheila Wessenberg** to panhandle to buy groceries for her family. Being unable to afford medical care may cost her her life.

After being hit by a bus, **Frank Sardoni** suffers from chronic pain. Without health care insurance, he is subject to inferior care and has accrued enormous medical debts.



Workers without health insurance often have serious health problems that go untreated. They often put off care until it is too late.

Q&A with Bruce Siegel, M.D., M.P.H.

Emergency Department Crowding Impacts Whole Health Care System

Once a week, millions of fans watch as the doctors and nurses of the television show "ER" valiantly grapple with the colorful characters packed into their fictional emergency department. But in hospitals across the country, the drama is real every night, and the crowds of emergency patients can be overwhelming. By federal law, the emergency department must serve every patient who walks through the door. But as patient numbers rise and resources shrink, that responsibility becomes more and more of a burden. In response, The Robert Wood Johnson Foundation has launched *Urgent Matters*, a $4.6-million initiative to improve the availability and timeliness of care in hospital emergency departments. In this interview with ADVANCES, *Urgent Matters* National Program Director Bruce Siegel, M.D., M.P.H., talks about the growing crisis in America's emergency departments. Siegel is a research professor in the Department of Health Policy at the George Washington University Medical Center, School of Public Health and Health Services. Previously, he has held the positions of New Jersey Commissioner of Health, president of the New York City Health and Hospitals Corporation and president of Tampa General Healthcare.

The problem of overcrowding seems fairly simple: Too many people go to the emergency department (ED) with nonemergency health problems.

SIEGEL—Certainly, there are better places to get routine care. But emergency departments have become a central part of the health care safety net. You have an aging population, more people without insurance, and not enough primary care. Doctors are under more pressure from crowded schedules, increasing paperwork and decreasing reimbursement. When patients call their doctors' offices, they're told: "Go to the ED, they'll see you tonight." That ED has a whole lot of diagnostic equipment and technology that it didn't use to have. As a physician, you know your patient is going to get good care there.

If patient overuse isn't the problem, what is?

SIEGEL—Over the last 10 years, hospitals have downsized because of managed care. The number of EDs dropped by 15 percent from 1992 to 2001, while the number of ED visits increased by 20 percent. So there are fewer beds, while demand is going up across the board. And with the nursing shortage, many hospitals just don't have enough professionals to do the job. There are real quality issues when patients are forced to wait to get emergency care.

Then isn't this really an arithmetic problem—reduce patient numbers or find the money to add new beds?

SIEGEL—While many factors that drive ED crowding are outside the hospital, some can be controlled from inside, such as the flow of patients across the entire hospital. There are sick patients in the ED who need to be put into hospital beds. But you can't do that when you don't have nurses to staff those beds, or you don't have housekeeping staff to get those beds ready for the next patient. Over the last few years, a lot of hospitals downsized their housekeeping staffs as part of cost-cutting. That saves very little money, and it can have a profound impact on a hospital's overall performance. The same problem backing up their ED is preventing them from admitting elective patients who are profitable for the hospital. It makes financial sense for the institution to begin to fix these problems.

Why haven't hospital administrators worked to solve these internal problems?

SIEGEL—To most administrators, ED overcrowding is something that happens every night and gets solved every morning. The ED starts to back up about the time those administrators are going home; by 7 a.m. the next morning, everyone is pretty well cleared out. The problem is off the administrators' radar screens. They only think of the ED as a money loser. If it's overcrowded, that's the ED's fault. Nobody considers that the ED is jammed up because the lab is working too slowly or the inpatient units don't want to take more patients. *Urgent Matters* is trying to change that culture. Our job is to help administrators understand just how important the ED is in terms of quality and economics.

You can't get patients seen and treated in a timely fashion if there aren't enough doctors and nurses to take care of them. How do you reduce burnout in the ED?

SIEGEL—EDs are chaotic, fast-paced environments. You're dealing with very sick patients, with little room for error. There are also a lot of physical demands—the lifting, being constantly on your feet. It's a very different place from the rest of the hospital and burnout is a real problem. Some EDs we visited had nurse vacancy rates of 25 percent. We have to rethink the way we deliver care, particularly emergency care, so that people who abandoned working in hospitals will want to come back.

Sometimes patients are left waiting in the ED for hours because an on-call specialist is not responding to his pager. How do you convince other physicians in the hospital that a backup in the ED is everybody's problem?

SIEGEL—That's the crisis of the "on-call specialist." It's a big issue, especially in orthopedic surgery and neurosurgery, because those are specialties that often are needed in the ED. Those specialists may feel that leaving the office and going to the ED to see a patient who doesn't have insurance is something they simply can't afford to do. So they want the hospital to pay them. For a good-sized ED, that can easily cost a million dollars a year for a single specialty. It's a tug of war, where the specialists say, "We'll come to the ED, but you're going to have to pay us," and the hospital says, "We don't have the money."

Some hospitals are using patient education programs to encourage nonemergency patients to stay out of the ED. Is that a priority for *Urgent Matters?*

SIEGEL—You can solve some of this problem in the hospitals, but the missing ingredient is primary care capacity. Part of this program is about assessing the safety net overall in these communities: What's the availability of primary care? What's going on with the uninsured? What do people think about the quality of care they receive from different doctors and clinics? We need to give patients meaningful alternatives to coming to the ED. That's where the rubber meets the road.

—INTERVIEW BY ELIZABETH AUSTIN

Medicare Spending: Is More Better?

Over the next decade, total health care spending in the United States will continue to climb. It is expected to reach 17 percent of gross domestic product by 2011, up from 13 percent in 2000. Yet across the country, health care spending varies significantly. Per-capita Medicare spending is just one example. While Medicare spent more than $8,400 per enrollee in 1996 in Miami, it spent less than $3,400 per enrollee in Minneapolis. Differences in the quantity of medical services—rather than differences in the price of medical services or the levels of illness—account for most of this variation. Are the regions that spend more on health care getting their money's worth? Do more services result in better care and better outcomes? In this large study, researchers compared Medicare spending and care outcomes in different geographic regions to determine whether higher-spending regions provide better care and see more significant gains in enrollee health.

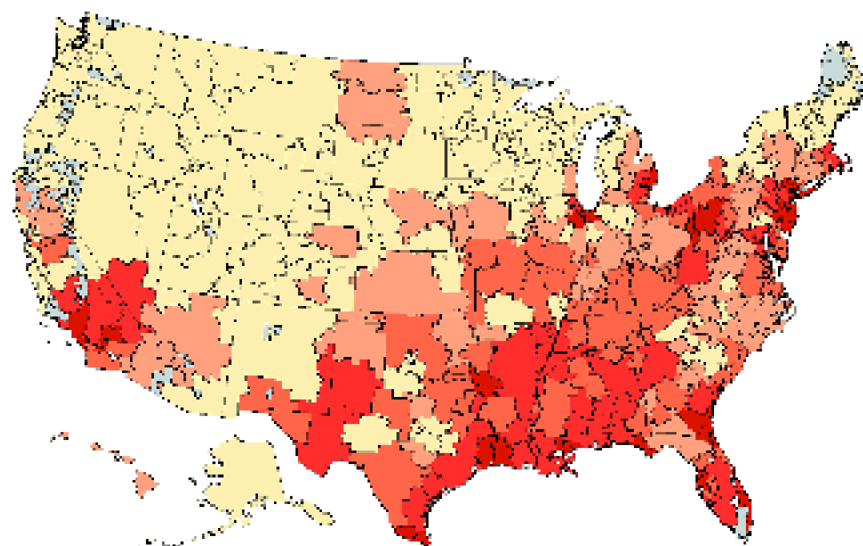
Previous research has shown that health care spending for Medicare enrollees during their last six months of life reflects variations in "physician practice rather than regional differences in illness or price" and that end-of-life spending predicts overall per-capita Medicare spending. Therefore, the investigators used per-capita end-of-life care spending for Medicare enrollees as a proxy for overall Medicare spending and grouped 306 geographic regions (called Hospital Referral Regions) into five quintiles of spending. As expected, illness levels were similar in each quintile, but average per-capita spending increased from $3,922 in the lowest-spending quintile to $6,304 in the highest-spending quintile.

The researchers subsequently examined costs and outcomes of care across the quintiles for nearly 970,000 patients hospitalized between 1993 and 1995 for acute myocardial infarction (MI), hip fracture and colorectal cancer. The study enrolled patients with these three conditions because they were "likely to be similarly ill in different communities," and because if more medical care were to make a difference, one would expect to see the benefits more clearly in patients with chronic conditions. In addition, a general population of more than 18,000 Medicare patients was drawn from the Medicare Current Beneficiary Survey (MCBS). Sufficient clinical information was available for all four study populations to ensure adequate control for baseline differences in health status across regions.

The investigators followed study patients for up to five years. The investigators drew on patient information from medical records, discharge abstracts, and Parts A and B Medicare claims; patient satisfaction information from the MCBS; and demographic information from the 1990 U.S. Census.

The data showed that although the health status of patients was similar across the five spending groups, patients in the highest-spending quintile received about 60 percent more care than those in the lowest-spending quintile. Overall use of hospital and physician services was between 52 percent (patients from the MCBS sample) and 77 percent higher (patients with acute MI) in the

Average Per-Capita Medicare Spending and Physician Supply of U.S. Hospital Referral Regions



Attributes of Hospital Referral Regions in Different Quintiles of the End-of-Life Expenditure Index

	Low ← Quintile of EOL-EI → High 1	2	3	4	5 High	Ratio High to Low
End-of-Life Expenditure Index *	$9,074	$10,636	$11,559	$12,598	$14,644	1.61
Per-Capita Medicare Spending**	$3,922	$4,439	$4,940	$5,444	$6,304	1.61
Physician Supply (per 10,000)†	184.8	189.4	184.4	204.6	242.4	1.31
Medical Specialists	26.9	28.8	28.6	34.8	44.4	1.65
Internists	21.3	23.4	22.6	28.5	37.3	1.75
Family practitioner	35.9	31.3	29.6	25.9	26.5	0.74
Surgeons	43.8	45.6	46.0	50.3	56.4	1.29
All other specialties	56.8	60.3	57.5	65.1	77.7	1.37

* Average age-sex-race adjusted per-capita fee-for-service spending on hospital and physician services in the HRRs within each quintile for Medicare enrollees age 65–99 who were in their last six months of life.

** Average age-sex-race adjusted 1996 per-capita fee-for-service spending in the HRRs within each quintile on all Medicare services among enrollees age 65–99. (Source, *Dartmouth Atlas of Health Care*, 1999.)

† Key attributes and average per-capita supply of the specified medical resource in the Hospital Referral Regions within each quintile. (Source, *Dartmouth Atlas of Health Care*, 1999.)

Note: Download a free printable copy at www.annals.org/content/vol138/issue4/index.shtml.

highest quintile than in the lowest quintile. These differences in utilization across spending groups were explained by a more inpatient-based and specialist-oriented pattern of practice: Patients in higher-spending regions had more frequent physician visits and specialist consultations, more tests and minor procedures, and spent more time in the hospital than those in lower-spending regions.

Despite the higher-intensity use of resources, the higher-spending geographic regions did not provide better quality of care or access to care based on commonly accepted measures. Patients in the higher-spending regions were less likely to receive flu vaccines and PAP smears, and were slightly less likely to have a usual source of care. For patients with myocardial infarction, the care provided in higher-spending regions was of slightly but significantly lower quality on most measures, and those in higher-spending regions were no more likely to receive angiography or coronary revascularization. In addition, "the findings suggest a general pattern of slightly lower access to care in [Hospital Referral Regions] with higher expenditure[s]." Patients in these regions were slightly less likely to have a usual source of care and faced significantly longer waiting times for emergency department, outpatient facility and office visits.

In each of the three chronic disease cohorts, increased spending was associated with a small increase in the risk of death, raising the possibility that the higher-intensity practice pattern was leading to harm.

The authors add a note of caution for the interpretation of their findings: "From a policy perspective, our study does not tell us definitively that it is possible to reduce Medicare spending within a particular region without affecting patient care or outcomes." However, they conclude, "The financial implications are clear: Savings of up to 30 percent of Medicare spending might be possible, and the Medicare Trust Fund could remain solvent into the indefinite future."

Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL and Pinder EL. "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care." *Annals of Internal Medicine*, 138(4): 273–287, 2003.

Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL and Pinder EL. "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care." *Annals of Internal Medicine*, 138(4): 288–298, 2003.

Psychiatric Problems and HIV Risk Among Juvenile Detainees

Two new studies find a high prevalence of psychiatric problems and HIV risk behavior among youths in juvenile detention, and they warn that the justice system is ill-equipped to deal with either.

In 1999, about 2.5 million juveniles were arrested in the United States, according to the Federal Bureau of Investigation. There are currently 163,200 cases per year of juveniles convicted and serving sentences. Almost 60 percent of detained youths are African American and Hispanic; the number of girls in juvenile detention is increasing at a faster rate than that of boys.

Both studies relied upon data from longitudinal research of 1,829 youths 10 to 18 years old arrested and detained between 1995 and 1998 at the Cook County Juvenile Temporary Detention Center in Chicago. The study of mental health problems found that nearly two-thirds of males and nearly three-quarters of females had one or more of the following psychiatric disorders: affective disorders (including depression and mania); anxiety; psychosis; attention-deficit/hyperactivity; disruptive behaviors and substance abuse.

Half of males and almost half of females had a substance use disorder and more than 40 percent of all detainees had disruptive behavior disorders. Affective disorders were more prevalent among females (more than 20 percent of girls had suffered a major depressive episode). "The juvenile justice system is not equipped to provide adequate mental health services for the large numbers of detainees with psychiatric disorders," the researchers note.

Researchers say that two recent changes in health policy may have caused more youths with mental disorders to go untreated and, subsequently, to be arrested and jailed. Welfare reform, they note, has disrupted Medicaid coverage that enables many low-income children to receive psychiatric treatment. (Many parents who left welfare for work obtained jobs with no health coverage or coverage with copayments they could not afford.) In addition, the growth of managed care in public and private insurance has led to more restrictive coverage for children's psychiatric disorders.

The study of HIV-risk behavior found that more than 90 percent of males and 87 percent of females were sexually active. About 61 percent of males and 26 percent of females reported more than one sexual partner. In addition, 35 percent of males and 41 percent of females reported that they recently had unprotected vaginal sex (the incidence was highest among Hispanic males and white females). Sharing needles or equipment was rare (under 3 percent); however, more than 40 percent of males and females had been tattooed. Overall, 95 percent of the sample had

Research Note

Gatekeeping in Pediatrics Not Necessarily the Cost-Saving Panacea

Gatekeeping arrangements became very popular with managed care organizations (MCOs) in the 1990s. MCOs implemented such arrangements as a cost-savings measure, using primary care providers to mete out referrals to specialty care on an as-needed basis. Children disproportionately ended up in MCOs as the dependents of parents with employer-sponsored health insurance coverage. Amidst concerns that gatekeeping added an additional administrative layer to the pediatric delivery system—possibly without improving the care delivery—the big question was: Does it control costs? These investigators examined medical expenses for children from the mid-90s to begin to answer this question.

Using data on more than 3,200 privately insured children collected in the Agency for Healthcare Research and Quality's 1996 Medical Expenditure Panel Survey, the researchers compared total per-capita annual expenditures for children in gatekeeping plans and children in traditional indemnity plans. Under an indemnity plan, parents are free to access specialty care as they deem necessary and pay a portion of the cost of that care. The researchers looked at total costs, out-of-pocket costs for parents, and costs to third-party payers.

Their analysis showed that children in these two different types of health insurance plans did not differ in health status. Total per-capita annual expenditures were very similar as well. In gatekeeping plans, the average annual health expenditure was $887 per enrolled child, while in indemnity plans, it was $881—a difference of less than 1 percent. In 1996, the potential savings from gatekeeping represented less than 1 percent of total annual national health expenditures for children.

There were some cost differences by health care service. Children in gatekeeping plans had higher average annual expenditures for ambulatory care and prescription medicines and lower expenditures for inpatient care than their counterparts in indemnity plans.

Costs to parents and third-party payers also differed. Annual out-of-pocket costs were lower for families with children enrolled in gatekeeping plans: $205 compared to $267 for families with children enrolled in indemnity plans. Average annual costs to the third-party payer were actually higher in gatekeeping plans—$636 versus $595 for indemnity plans—largely because children in gatekeeping plans incurred more ambulatory care expenses.

The authors point out that with the recent rise in health care costs, some gatekeeping proponents are again touting the benefits of this system. They contend that their analysis shows that "gatekeeping is not an effective cost containment method for children."

Pati S, Shea S, Rabinowitz D and Carrasquillo O. "Does Gatekeeping Control Costs for Privately Insured Children? Findings from the 1996 Medical Expenditure Panel Survey." *Pediatrics*, 111(3): 456–460, 2003.

Olveen Carrasquillo, M.D., M.P.H., was a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar at the time of this research.

engaged in three or more HIV-risk behaviors; 65 percent reported 10 or more risk behaviors.

The researchers call on the public health system to provide HIV interventions in juvenile detention centers. Providing such help "could reduce HIV and AIDS among general population youths. Most detainees return to their communities within two weeks." Researchers also suggest that interventions should be available for detainees age 13 and under to try to avert the most serious risk behaviors, and that interventions should account for gender and ethnic differences in behavior.

Teplin LA, Mericle AA, McClelland GM and Abram KM. "HIV and AIDS Risk Behaviors in Juvenile Detainees: Implications for Public Health Policy." *American Journal of Public Health*, 93(6): 6–12, 2003.

Teplin LA, Abram KM, McClelland GM, Dulcan MK and Mericle AA. "Psychiatric Disorders in Youth in Juvenile Detention." *Archives of General Psychiatry*, 59: 1133–1143, 2002.

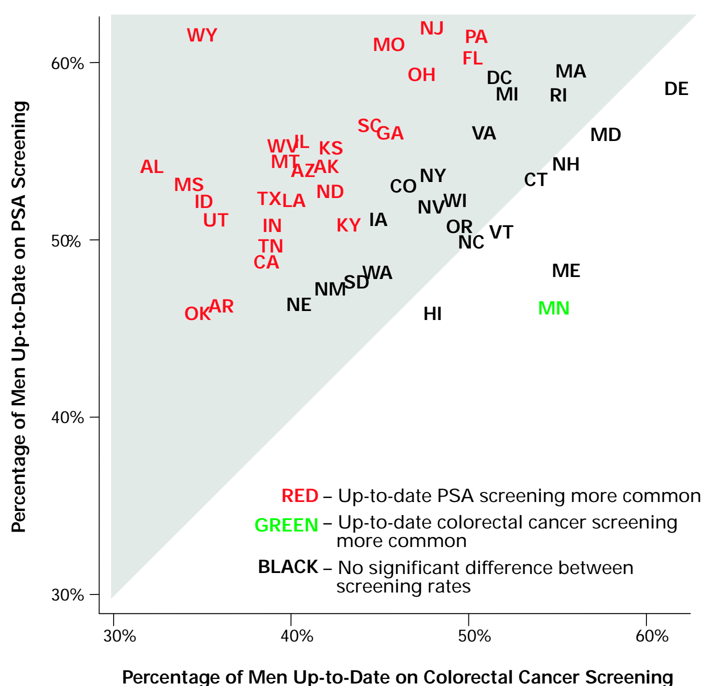
Mismatch Between Medical Evidence and Practice in Cancer Screening

If medical practice followed what science has proven to be effective, more American men would be screened for colorectal cancer than for prostate cancer. But researchers find the opposite.

Three-quarters of men age 50 and older reported having had a prostate-specific antigen (PSA) test while only 63 percent reported having a colorectal cancer test, according to data from the 2001 Behavioral Risk Factor Surveillance System, an annual survey conducted by the U.S. Centers for Disease Control and Prevention. In 47 states, men were significantly more likely to have ever had a prostate cancer test than to have ever been screened for colorectal cancer.

Each year, prostate and colorectal cancers kill comparable numbers of American men (about 30,200 and 27,800 respectively in 2002). But colorectal cancer is responsible for many more premature deaths and accounts for 2.5 times as many years of potential life lost before age 75 than does prostate cancer. And three large-scale studies have found that deaths from colorectal cancer decreased by 14 to 33 percent among men who had been screened. No similar evidence demonstrates the efficacy of prostate cancer screening. Researchers offer several reasons for the discrepancy in screening rates. Colorectal testing, they suggest, may be less acceptable to patients. In addition, PSA screening may have received more media attention.

Relationship Between Up-to-Date PSA and Colorectal Cancer Screening by State



Also, because prostate cancer is three times more prevalent than colorectal cancer among men over 40, men may be more likely to know someone with prostate cancer, which may make them feel more vulnerable to the disease.

Researchers suggest that physicians should inform men choosing to be tested for cancer about the benefits of colorectal screening and the uncertain advantages of testing for prostate cancer. This is especially the case for elderly men, who have high rates of prostate cancer screening but are least likely to benefit from it.

Sirovich BE, Schwartz LM and Woloshin S. "Screening Men for Prostate and Colorectal Cancer in the United States: Does Practice Reflect the Evidence?" *Journal of the American Medical Association*, 289(11): 1414–1420, 2003.

Attitudes Toward Depression Treatment: Exploring Ethnic Differences

Minority patients often don't get the same kind of care for depression that white patients get. They are less likely to be treated for their depression; and when they do receive care, it's more often through a primary care physician than a mental health specialist. In fact, African-American and Hispanic patients use outpatient specialty mental health services at about half the rate of white patients. What accounts for these racial differences in depression care? Previous research highlights some key barriers to accessing mental health care for African-American and Hispanic patients. They include the stigma associated with mental health, the propensity to keep problems within the confines of the family circle, and a general mistrust of health care providers. Do attitudes toward depression care also play a role? This study examined the differences among African-American, Hispanic and white patients in their acceptance of two treatment options for depression: individual counseling and antidepressant medications.

The investigators used data on more than 800 African-American, Hispanic and white patients from three studies on quality improvement in depression care funded by the National Institute of Mental Health. At the time of the survey, which was done by telephone, these patients reported that they had been depressed during the past month and had suffered a "major depressive episode" during the past year. The survey collected demographic information and information on the patient's physical and mental health, mental health treatment experiences, social support system, recent major life events, and beliefs and norms regarding depression treatment.

Overall, 70 percent of the patients surveyed said that antidepressant medication was an acceptable treatment option for depression. However, acceptance was significantly lower among African Americans and Hispanics. Some 51 percent of black patients and 59 percent of Hispanics found the use of antidepressant medications acceptable, while 74 percent of white patients were in favor of using antidepressants to treat depression.

Among all patients, individual counseling received higher scores as a treatment option for depression than antidepressant medications. Hispanics were most accepting of using individual counseling to treat depression. In fact, 95 percent of the Hispanic patients surveyed said that counseling was acceptable, compared to 79 percent of African Americans and 86 percent of white patients.

The patients who said antidepressants were an acceptable way to treat depression were younger, more severely depressed and reported poorer physical functioning than those who did not find them acceptable. Patients who found individual counseling acceptable were also younger; more likely to be divorced, separated or widowed; and had recently experienced major life events, such as illness, childbirth or unemployment.

There were other ethnic differences in attitudes toward depression care that the investigators examined in a subset of the survey population. Among 496 surveyed

patients, both Hispanics and African Americans were more likely to agree that "antidepressant medications are addictive" and less likely to agree that they are effective. In addition, 71 percent of Hispanic and African-American patients felt that "counseling brings up too many bad feelings like anger and sadness," compared to 50 percent of white patients. More than 90 percent of African-American patients agreed that "prayer can heal depression," while just 67 percent of whites and Hispanics agreed with this statement. African Americans were also more likely than the other ethnic groups to prefer to see a health professional of their same race or ethnicity.

The authors contend that although they identified "differences in beliefs and social norms for African Americans, Hispanics, and white persons, these differences did not generally explain differences in acceptability of treatment." They suggest that future research is needed to explore "additional attitudinal barriers to care" and that "culturally tailored interventions that incorporate culture-specific educational materials and patient-centered approaches may help address barriers to depression care."

Cooper LA, Gonzales JJ, Gallo JJ, Rost KM, Meredith LS, Rubenstein LV, Wang NY and Ford DE. "The Acceptability of Treatment for Depression Among African-American, Hispanic, and White Primary Care Patients." *Medical Care*, 41(4): 479–489, 2003.

Lisa Cooper, M.D., M.P.H., was a fellow in The Robert Wood Johnson Foundation Minority Medical Faculty Development Program at the time of this research.

Nursing Home Regulation: The Relationship Between Poor Quality and Terminations

As debate about how best to regulate nursing homes continues, the overall quality of nursing homes remains poor, despite some important quality gains over the last decade. Given this backdrop, researchers examined the relationship between reported nursing home violations of care standards and the likelihood that a facility would voluntarily or involuntarily lose Medicare/Medicaid certification.

Analyzing nationwide Online Survey Certification and Reporting data, researchers found that, from 1992 to 2001, 8.7 percent of nursing homes voluntarily left, and 2.4 percent got dropped from the Medicare/Medicaid program. Facilities that terminated were more likely to be urban, have a high proportion of Medicaid residents and be for-profit. Also, terminating facilities were more likely to have a higher number of reported violations than facilities that kept their certification. Nursing homes that were forced to leave Medicare had considerably more deficiencies than both the facilities retaining certification and those that willingly terminated.

The most striking characteristic of terminated facilities—either voluntary or forced—was their overall lack of resources. Terminated nursing homes had significantly higher proportions of Medicaid residents. In most states, Medicaid programs pay considerably less than the private pay rate. While some nonprofit facilities may offset their care of Medicaid residents with philanthropic efforts, most for-profits cannot. Resource-poor facilities were 2.5 times more likely to terminate.

Nursing homes that voluntarily left Medicare/Medicaid had relatively low occupancy rates, which suggest that market competition plays heavily in facility closures. Once poor quality becomes known, either through government reporting or by word of mouth, it becomes harder for a home to attract private patients, which increases the likelihood of having a higher proportion of Medicaid residents and, thus, a lower funding base. This can lead to a downward spiral of lower revenue, fewer residents and poorer quality that ultimately drives a facility out of business.

Since 1987, the federal government has taken a more punitive approach toward regulating nursing homes, using tactics such as recording and posting information about quality deficiencies, issuing citations and imposing sanctions. The approach has been controversial, with some calling for a more cooperative, less public arrangement between government agents and providers to improve the quality of care.

The research provides evidence that public reporting of nursing home violations may in fact improve quality by helping to force some homes out of business. At the same time, the study authors caution policy-makers not to help close the doors of underperforming nursing homes without plans to ensure that quality facilities are available to pick up the slack. "If we are to prune the tree of existing long-term care facilities, we must also make every effort to plant and nurture more humane alternatives," they write.

Angelelli J, Mor V, Intrator O, Feng Z and Zinn J. "Oversight of Nursing Homes: Pruning the Tree or Just Spotting Bad Apples?" *Gerontologist*, 43(Special Issue II): 67–75, 2003.

Electronic Medical Record Improves Pediatric Primary Care

Risk assessment, immunization, screening and education are critical components of quality pediatric primary care. In fact, guidelines developed by disparate organizations from the American Academy of Pediatrics to the U.S. Public Health Service agree on these "core elements." Despite this consensus, practice styles still vary considerably from physician group to physician group—and even within physician groups. Supporters of the electronic medical record (EMR) hold it out as an innovation capable of reducing this practice variation and improving the quality of care. This study looked at the effect of the introduction of an EMR on the quality of care in the Boston Medical Center Pediatric Primary Care Clinic, an inner-city clinic that serves primarily low-income minority children. The researchers at the clinic developed a pediatric EMR known as the Automated Record for Child Health or ARCH, and clinic providers adopted it in 1998 and 1999.

Comparing 235 patient visits in mid-1998 using a paper medical record to 986 patient visits in 2000 using the ARCH, investigators looked for changes in documentation for risk assessment; physical exam; educational guidance; developmental screening: immunizations; screening for hearing, vision, lead and anemia; and tuberculosis testing. They included only routine health maintenance visits for children younger than age 5 in their analysis.

Clinicians using the ARCH were significantly more likely to address diet, sleep and psychosocial issues during the patient visit, based on their documentation. In addition, risk assessment improved among the ARCH users; documented screening increased 16-fold for smoking in the family and 35-fold for domestic/community violence. ARCH-based clinicians also documented behavioral and social milestones and physical examinations more frequently.

ARCH users completed a two-page evaluation on the system. Overwhelmingly, they found it user-friendly, reported that it increased their thoroughness and "reminded them to do things they might otherwise forget," and indicated that ARCH was well accepted by families. They did highlight two potential drawbacks: Four of seven ARCH users felt the system increased the length of visits by an average of nine minutes and most agreed that using the system reduced their eye-to-eye contact with patients and parents.

The authors conclude that "it is likely that some physical adjustment in how physicians and patients relate will be necessary with an EMR." However, they "believe that the pediatric EMR will become the central component of the pediatric primary care office of the future."

Adams WG, Mann AM and Bauchner H. "Use of an Electronic Medical Record Improves the Quality of Urban Pediatric Primary Care." *Pediatrics*, 111(3): 626–632, 2003.

William Adams, M.D., was a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar at the time of this research.

Share the Success: Quality Improvements Go Online

Imagine a place where a pharmacist in Kansas can learn how to reduce medication errors from a gerontologist in New Zealand. Meanwhile, the director of a busy Los Angeles veterans' clinic discovers from an Alaskan doctor a new way to decrease patient waiting times.

Instead of traveling to conferences around the world, these health professionals are creating their own international forum in cyberspace. This type of exchange takes place every day on *www.qualityhealthcare.org*. The site, created by the Boston-based Institute for Healthcare Improvement (IHI) and the *British Medical Journal* (BMJ), was funded in part with a $550,000 grant from The Robert Wood Johnson Foundation.

Based on the robust activity in the *qualityhealthcare.org* chat rooms, the project—which launched in February 2003—already is meeting the goals set by IHI. "We wanted to create a place where people anywhere in the world could get access to information, connect with colleagues and share common problems," says Penny Carver, M.Ed., senior vice president at IHI and the project's director. "It has really become an online improvement community."

Qualityhealthcare.org works closely with another collaboration of the Foundation and IHI—the RWJF national program *Pursuing Perfection: Raising the Bar for Health Care Performance*. Seven RWJF grantees met in Boston in April to pursue the vision of Donald Berwick, M.D., M.P.P., IHI president and CEO. Berwick believes health care delivery systems should emulate companies like Toyota, which makes a concerted effort to turn out perfect products. (See *Advances* Issue 4, 2001.) "We were trying to help a handful of organizations to get their quality of care right all of the time," says Michael Rothman, M.P.P., an RWJF senior program officer. "No one has ever tried that in medicine."

During the *Pursuing Perfection* conference, IHI and RWJF leaders realized they needed to emphasize spreading their quality improvement information beyond the relatively small group of actively committed providers enrolled in their programs. Currently, IHI does most of its marketing and outreach through labor-intensive direct-mail campaigns. They decided that a Web site would be a more efficient vehicle. "We're very interested in spreading improvement more rapidly," Rothman says. "This is one of the best ways we've seen to share information in a low-cost way."

Content has been growing since the site went up with a patient safety section. Among the content areas: improving office practice, critical care and workforce development. The number of visitors also has been increasing. Carver estimates there are 40,000 users from 115 countries. "We're really excited about the initial response to the site," she says.

Many of the organizations that already participate in IHI seminars and conferences are using the Web site, but it aims to cast a wider net. "The feeling is that this will be a stimulant, not only for the early adopters and innovators," Rothman says. "We would like to strengthen the nurse or physician leader at a hospital, or the quality improvement director at a doctor's office—people who might have little support within their organization at present."

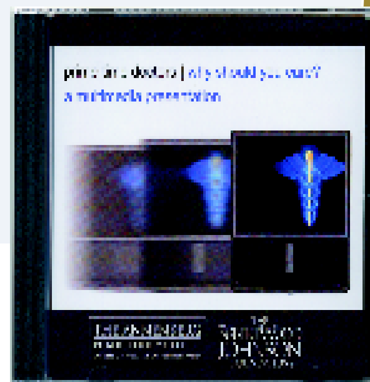
For individuals or smaller organizations, the Web site offers a wealth of resources for everything from decreasing doctor's office wait times to tracking patient errors. Each section contains tools, strategies and real-life case studies. Users can track their progress with forms and graphs or go online to chat with colleagues and experts.

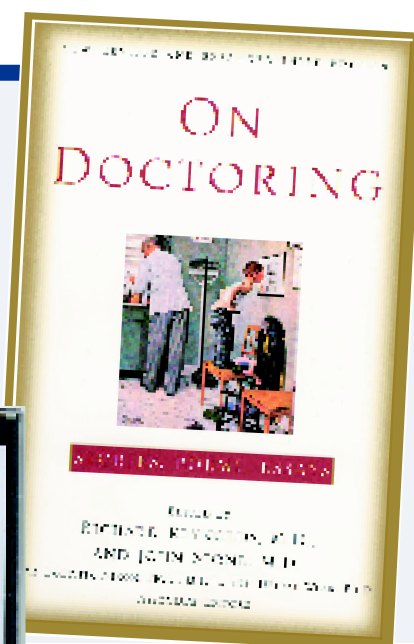
While *qualityhealthcare.org* is off to a lively start, IHI executives know that its long-term success depends on its becoming financially self-sustaining into the future. With the help of John Fiorillo of Health Strategy Group, a New York-based consulting firm that provides strategic planning, market analysis and marketing to the health care industry, IHI is considering a number of possible business models. Among them: saving money on marketing costs by using the Web site instead of direct mail; using the Web site to attract new paying IHI customers; exploring e-learning projects; and partnering with other paying clients to provide quality improvement content.

—Melissa Knopper

On Doctoring

Every year since 1989, The Robert Wood Johnson Foundation has provided a copy of the book *On Doctoring: Stories, Poems, Essays* to first-year students at all U.S. allopathic and osteopathic medical schools. The book, edited by Richard Reynolds, M.D., and John Stone, M.D., and published by Simon & Schuster, celebrates the humanity of medicine. This year a CD-ROM called *Prime-Time Doctors: Why Should You Care?* accompanies the book. The CD is intended to be used as a training tool to illustrate trends in how physicians are depicted in popular television shows. The CD raises ethical questions centering around end-of-life decisions, doctors' rights and malpractice, and provides new medical students and other doctors with a sense of the prevalent themes and myths that shape their patients' perceptions of the medical system. It was produced by Joseph Turow, Ph.D., professor of communications at the Annenberg School for Communication at the University of Pennsylvania through a grant from RWJF.





Grant Results Reports

Since July 2003, four new National Program Reports and 50 new Grant Results Reports and have been posted at *www.rwjf.org.* These reports, organized by topic area, detail the results of RWJF grants that are now closed. Among the newly posted reports are the following:

- ***Production of a Guide on Accessing Federal Funds for Improving Bicycling and Walking Opportunities.*** The Bicycle Federation of America's National Center for Bicycling and Walking, with RWJF funding, published a 48-page guide, *Increasing Physical Activity Through Community Design,* for public health agencies and professionals. The book describes community design issues, presents seven kinds of projects that can help create more bicycle-friendly and walkable communities, and discusses how such projects can get funded and implemented. The guide is available free at the center's Web site, *www.bikewalk.org/ PubHealth.htm.* See the Grant Results Brief at *www.rwjf.org/ reports/ grr/042089.htm.*
- ***Developing an Integrated Online Resource on Health, Financial and Employment Services for Low-Income Families.*** One Economy Corporation has developed the Web site *www.thebeehive.com* to offer information (in English and Spanish) on health care, education, employment and personal finance for low-income people. RWJF helped fund the project. In the first six months after its October 2001 launch, about 30,000 users visited the Beehive's health section, which includes information on weight loss, infant care, vaccinations, health insurance, smoking, alcohol and exercise. See the Grant Results Brief at *www.rwjf. org/reports/grr/041065.htm.*
- ***Manual to Assist Parents of Children with Disabilities to Create a Supportive Home Environment.*** The Center for Architecture and Building Science Research at the New Jersey Institute of Technology, with support from RWJF, has published *A House for All Children*, a book that provides guidelines for creating safe and accessible homes for children with disabilities, including illustrations, floor plans and photographs. The authors also present advice for meeting the changing social and emotional needs of children with disabilities as they grow and mature. The book and a companion video are available at *www. ahouseforallchildren. njit.edu* ($21.95 for the book, $17.95 for the video). See the Grant Results Brief at *www.rwjf.org/reports/ grr/036234.htm.*
- ***Improving Substance Abuse Treatment Within the Child Welfare System.*** The Child Welfare League of America produced a booklet, *Alcohol, Other Drugs & Child Welfare*, aimed at policy-makers, public agency administrators, members of the judicial system and the media. The 24-page publication highlights the problems that substance abuse causes for families and its impact on criminal behavior, and summarizes successful strategies in treating substance abuse. The booklet is available at *www.cwla.org/programs/bhd/ aodbrochure.pdf.* See the Grant Results Brief at *www.rwjf.org/ reports/grr/037953.htm.*
- ***Developing and Disseminating Guidelines for Restaurants on Employing People with Disabilities.*** *Meaningful Work: A Personal, Professional and Legal Guide to Hiring People with Disabilities* provides restaurant owners with guidance in hiring and training people with disabilities, discusses how they relate to their work, addresses legal issues and provides other informational resources. With a grant from RWJF, Nancy Christy, a restaurant owner and recipient of the Wisconsin Governor's Workforce Innovation Award, wrote the handbook. It may be ordered by sending an e-mail to *nanchristy @charter.net* ($27.50). See the Grant Results Brief at *www.rwjf. org/reports/grr/041657.htm.*

—Tedi Nessas

Robert Wood Johnson Community Health Leadership Program

Each year, The Robert Wood Johnson Foundation honors outstanding individuals who have overcome daunting odds to expand access to health care and social services for underserved and isolated populations in communities across the United States. For more information or to nominate a leader, visit *www. communityhealthleaders.org.* Letters of intent to nominate should be submitted online by September 22, 2003. For an RWJF Grant Results Report on the program, visit *www.rwjf.org/reports/npreports/chlp.htm.* The 2002 Community Health Leaders are pictured below.

Photo by Leslie Kossoff

Seated, left to right:

- **Risa Lavizzo-Mourey, M.D., M.B.A.**, RWJF president and CEO.
- **Sandra Cox, Ph.D.**, created a coalition to provide mental health services to the working poor of South Los Angeles.
- **John Gusha, D.M.D.**, launched an oral health initiative for low-income residents of his Massachusetts community.
- **Arnell Hinkle, M.P.H., M.A.**, supported efforts in communities throughout California that encourage healthy lifestyles with a focus on obesity among adolescents.
- **Alice Marie Slaven-Emond, R.N., M.S.**, opened a clinic to provide health services to uninsured working families in a rural New Mexico town.

Standing, left to right:

- **José Luis Garcia, R.Ph.**, created and runs a program focused on the needs of Chicano men with asthma and diabetes in El Paso, Texas.
- **Elroy Christopher**, along with Clayton Guyton, opened a community center in their Baltimore neighborhood to attempt to help save it from the devastation of crime and addiction.
- **Nina Lomely-Baker** teaches Wichita, Kan., parents how to navigate health care and education services for their emotionally disturbed children.
- **Martha Ryan, R.N., M.P.H.**, created a San Francisco program in which formerly homeless mothers provide outreach and supportive services to other homeless women.
- **Clayton Guyton**, along with Elroy Christopher, opened a community center in their Baltimore neighborhood to attempt to help save it from the devastation of crime and addiction.
- **Guadalupe Sanchez de Otero** founded a community center that offers a safe haven for children and hot meals for senior residents in her New Mexico border town.
- **Silvia Portillo** expanded health care access to her Northern Virginia Latino community by training health promoters and persuading hospitals to hire bilingual staff.

—Hedda Colossi

SELECTED GRANTS

Projects to Assure That All Americans Have Access to Quality Health Care at Reasonable Cost

- For the Health Insurance Reform Project: Medicare, Access and Quality, a renewal award of $200,000 to George Washington University, Washington.
- *Covering Kids and Families.* Award of four grants, totaling $199,232.
- For planning and designing a media campaign for the physicians' awareness initiative on racial and ethnic disparities, one renewal award of $179,221 to RAND Corp., Santa Monica, Calif.
- *Urgent Matters.* Award of four grants for demonstration, totaling $1 million:
  - Boston Medical Center
  - Fulton Dekalb Hospital Authority, Atlanta
  - Inova Health System, Falls Church, Va.
  - Regional Medical Center at Memphis, Tenn.
- *Urgent Matters.* Award of 10 grants for technical assistance support, totaling $250,000.
- *Depression in Primary Care: Linking Clinical and System Strategies.* Awards to 13 sites, totaling $2.5 million. Renewal awards to eight sites, totaling $4.4 million.

Projects to Improve the Quality of Care and Support for People with Chronic Health Conditions

- *Rewarding Results: Aligning Incentives with High-Quality Health Care.* For provider feedback strategies for promoting better quality of care, $254,420 to Boston University School of Public Health.
- To promote and strengthen grantmaking for an aging society, $195,000 to Grantmakers in Aging, Dayton, Ohio.
- *Changes in Health Care Financing and Organization.* Awards to three sites, totaling $516,227.
- Transition support for the end-of-life nursing education consortium, $366,987 to American Association of Colleges of Nursing, Washington.
- For a study of the impact of medical groups' use of care management processes on chronically ill patients, one renewal award of $145,503 to the University of California, Berkeley, School of Public Health.
- *Diabetes Initiative.* For evaluation of Phase I of the initiative, $499,994 to Research Triangle Institute, Research Triangle Park, N.C.
- *Faith in Action II.* Awards to 51 sites, totaling $1.1 million.

Projects to Promote Healthy Communities and Lifestyles

- *Active for Life: Increasing Physical Activity Levels in Adults Age 50 and Older.* One award of $972,460 to County of San Mateo Health Services Agency, San Mateo, Calif.
- *Pathways to Activity: Technical Assistance for Activity-Friendly Communities.* One award of $899,847 to the Bicycle Federation of America, Washington.
- *Living Cities: The National Community Development Initiative.* For a national partnership to build healthier communities, $2.9 million to Living Cities, New York.
- *Family Support Services Program.* Award of five supplemental grants, totaling $227,440.
- For assessing and providing technical assistance for emerging public health institutes, $375,000 to the National Network of Public Health Institutes, New Orleans.

Projects to Reduce the Personal, Social and Economic Harm Caused by Substance Abuse—Tobacco, Alcohol and Illicit Drugs

- *Tobacco-Free Nurses: Helping Nurses Quit.* One award of $1.8 million to the University of California, Los Angeles, School of Nursing.
- *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime.* Renewal awards to nine sites, totaling $9 million.
- *Bridging the Gap: Research Informing Practice for Healthy Youth Behavior.* Two renewal awards, totaling $9 million.
- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy.* One renewal award of $683,239 for the National Dissemination Office to the University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
- *Substance Abuse Policy Research Program.* Awards to seven sites, totaling $1.4 million.
- *Substance Abuse Policy Research Program.* For analyzing the prevalence and effects of substance abuse among current and former welfare recipients, one renewal award of $289,092 to the University of Michigan National Poverty Research Center, Ann Arbor.

Other Programs and Those That Cut Across Foundation Goals

- For the National Health Policy Forum, $1.8 million to George Washington University, Washington.
- For studying the feasibility of a healthy school report card to improve the health and well-being of school-age children, one renewal award of $290,463 to the Association for Supervision and Curriculum Development, Alexandria, Va.
- *Turning Point: Collaborating for a New Century in Public Health.* For the Turning Point National Excellence Collaboratives Communications and Dissemination Fund, one renewal award of $500,000 to the University of Washington School of Public Health and Community Medicine, Seattle.
- *Generalist Physician Faculty Scholars Program.* Awards to support 15 scholars, totaling $4.5 million.
- *Investigator Awards in Health Policy Research.* Awards to seven sites, totaling $1.9 million.
- *Minority Medical Faculty Development Program.* Awards to support eight fellows, totaling $2.9 million.
- *The Robert Wood Johnson Clinical Scholars Program.* Cohort renewal awards to seven sites to support the 2003–2004 cohort of scholars, totaling $4.7 million. Award of four planning grants for the 2005 cohort, totaling $899,836.
- *The Robert Wood Johnson Executive Nurse Fellows Program.* One award of $6.4 million to the University of California, San Francisco, Center for the Health Professions.
- *The Robert Wood Johnson Health Policy Fellowships Program.* Awards to support six fellows, totaling $930,000.
- For field-building activities for health services research, $150,000 to AcademyHealth, Washington.
- For providing data preparation and archiving services to RWJF, $275,043 to the University of Michigan Institute for Social Research, Ann Arbor.
- For improving health care quality in New Jersey, $150,000 to New Jersey Health Care Quality Institute, Trenton, N.J.
- For improving Central New Jersey disaster response preparedness and education, $177,997 to the American National Red Cross, Central New Jersey Chapter, Princeton, N.J.
- For a camping program for health-impaired children, $364,400 to Middlesex County Recreation Council (John E. Toolan Kiddie Keep Well Camp, Edison, N.J.).
- For a citywide program to strengthen human services and resources, $450,000 to New Brunswick Tomorrow, New Brunswick, N.J.
- Support for the 2003–2004 campaign, $292,500 to United Way of Greater Mercer County, Lawrenceville, N.J.

People

Caryl O'Dowd joined RWJF in June as a human resource generalist in the Human Resources Department. Previously, O'Dowd was the director of human resources administration for Fujitsu Consulting, Edison, N.J.

Farewell

Stephanie Berger, M.A.M.C., a Web editor, left the foundation in May to become the editor of *Counselor, The Magazine for Addiction Professionals* in Deerfield Beach, Fla. She can be reached at *editor@counselormagazine.com.*

From Washington Connections—page 3

She believes that those letters helped secure the funding.

"I would not have done that if I had not attended that event and felt safe doing it," Hamlin says.

The Connect Project began in 1998 and at first focused on matching legislators to a handful of programs working at the community level—programs like *Faith in Action*. In 2002, the project expanded its focus to include grantees and programs that seek policy and systemwide change.

One of those programs is *Turning Point: Collaborating for a New Century in Public Health,* which seeks to improve the public health system. Neil Hann, M.P.H., a *Turning Point* grantee and chief of the Community Development Service for the Oklahoma State Department of Health, was among a group who met with their representatives. He asked his congressional delegation to help him develop relationships with business leaders for a *Turning Point* project.

"Many of us in public health have been afraid even to talk to our congressional delegation," Hann says. "There has been this misconception that any time you speak to a policy-maker you're lobbying. But the best way to have an impact on the broad population is through policy changes. We need to start looking at our congressional delegations as partners in making broad sweeping changes that will affect the entire population."

—Susan G. Parker

For more information on the Connect Project, visit www.rwjf.org/grantee/connect/index.jhtml.

In June, actress, singer and minister Della Reese was named national spokesperson for *Faith in Action*, a national interfaith volunteer caregiving initiative supported by a grant from The Robert Wood Johnson Foundation. Della Reese is pictured at far right with Risa Lavizzo-Mourey, M.D., M.B.A., RWJF president and CEO.

Back-to-School Campaign Seeks to Enroll Families In SCHIP and Medicaid

The fourth annual *Covering Kids and Families*® "Back-to-School" campaign—a nationwide effort to enroll uninsured children in the State Children's Health Insurance Program (SCHIP) and Medicaid—was launched on Capitol Hill on July 31. U.S. Surgeon General Richard Carmona took part in the event as did Senators Patty Murray (D-Wash.) and Kit Bond (R-Mo.) and former Health and Human Services Secretary Louis Sullivan, among others. Urban Institute research released at the event found that 7.8 million kids are uninsured, and at least 4 million are eligible for coverage but are not enrolled. Hispanic children are the most likely to be uninsured.

A new partnership with Capital One, a consumer-lending group, was announced at the launch. Capitol One will use monthly billing statements and its staff to promote the national toll-free hotline 877-KIDS-NOW to families whose children are likely to be eligible. This year, more than 1,700 community enrollment events will take place in all 50 states and the District of Columbia, and special emphasis is being placed on outreach to Hispanic families. The campaign brings together hundreds of community coalitions and dozens of corporate sponsors to let working parents know that their kids are likely eligible for health coverage.

Covering Kids and Families is a $55-million, four-year national program of The Robert Wood Johnson Foundation to help states cover children and their parents who work in jobs that do not provide health insurance.
For more information on the "Back to School" campaign see www.*coveringkidsandfamilies.org*.

What's New on the RWJF Web Site

The Foundation has launched a major new tool, the Walkability Checklist, built in conjunction with the Pedestrian and Bicycle Information Center. View it at *www.rwjf.org/news/video/walkabilityTV.jhtml.*

The checklist is designed to help Americans identify and address impediments to pedestrian- and activity-friendly neighborhoods. Created as part of an RWJF Television Health Series segment, the Walkability Checklist also is integrated into the RWJF Web site's Active Living Resource Center as well as *The Shape We're In*, the Foundation-supported nationally syndicated newspaper series on physical activity and obesity.

Also on the Web:

- Several new additions to the Television Health Series, including a piece about RWJF-funded CeaseFire Chicago. View all Television Health Series installments at *www.rwjf.org/news/videos.jsp.*
- A number of new profiles highlighting members of the Foundation's extended family, including an interview with Carla Pope, program manager of the Foundation-supported Iowa *Coming Home Program*; and an in-depth story about Jeanne Armitage, visiting nurse with the Berrien County Health Department, Benton Harbor, Mich., Nurse-Family Partnership program. View all RWJF profiles at *www.rwjf.org/news/profiles.jsp.*
- Several new webcasts are available, including a press briefing sponsored by the Alliance for Health Reform. The topic: health spending in the fiscal year 2004 federal budget. See all RWJF webcasts at *www.rwjf.org/news/eventcastsUpcoming.jsp.*

—Jeffrey Meade