

The
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Honored

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Better Data: The First Step in Reducing Disparities in Health Care

Despite considerable advances in technology and pharmaceuticals, the U.S. health system still struggles with issues of quality.

A 2003 study by RAND researcher Beth McGlynn showed that patients in the United States only receive the recommended standard of health care half the time. For racial and ethnic minorities, the quality gap is even worse. The Institute of Medicine issued a landmark report in March 2002 that compiled the evidence from numerous research studies showing that racial and ethnic disparities in treatment exist, even beyond other factors such as socioeconomic status and insurance. Disparities between whites and blacks exist in the treatment received for a wide range of conditions from cardiovascular disease to kidney transplants, diabetes and asthma.

Against this backdrop, RWJF has launched a multi-pronged strategy to reduce racial and ethnic disparities in treatment, and will work with health plans, hospitals and others to implement the strategy. "Clearly, we cannot improve quality for all Americans—and increase the number of people receiving what we know to be appropriate care—if we do not close this gap," says Anne Weiss, M.P.P., an RWJF senior program officer and interim team leader of RWJF's Disparities Team.

"The first problem we confronted was: How can we call for change in this area if the health care systems we are asking to improve do not have information about the race or ethnicity of their patients? So the first challenge we undertook was to promote the collection of better data on race and ethnicity by health plans and health care providers," says Weiss.

Last year, the Foundation commissioned Public Opinion Strategies, Alexandria, Va., to measure how citizens reacted

to the data collection question. The question had special currency at the time the poll was conducted, because the gubernatorial recall ballot in California contained a proposition to ban the collection of racial and ethnic identifiers. Voters chose not to support the proposition, in part due to an active consumer education campaign about the possible implications for research and health care.

When the Public Opinion Strategies survey asked respondents if they would support federal action to allow health providers, insurers and employers to ask people to volunteer information about their racial or ethnic origins, initially just 34 percent of respondents said yes. But when told that such information was necessary to address health care inequities and would be used for that

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Nurses and Hospitals Making Changes Large and Small to Improve Care

At Kaiser Foundation Hospital in Roseville, Calif., nurses and other staff working on a 24-bed medical-surgical unit found that improving staff and patient morale was as simple as putting up a white board in patients' hospital rooms. On the board were photos of the staff to help the patients get to know their caregivers. Before the photos were posted, many of the staff had not known each other's names—a stumbling block to working closely together. The white board also included patients' goals and questions they had for their physician.

"We'd talk to patients about why the doctor wanted lab tests or ultrasounds, and patients began to have much more of a sense of control. They wouldn't feel so passive," says Sandy Sharon, assistant administrator for patient care services at Kaiser.

That change and others also gave nurses a greater sense of power and control over their work, which is critical in having them stay on the job, Sharon says.

Those changes were part of a Robert Wood Johnson Foundation (RWJF) initiative, Transforming Care at the Bedside, a major element in the Foundation's current nursing strategy. The RWJF Nursing Team is collaborating with hospitals and nursing leaders to develop and disseminate ways to improve the hospital work environment—its physical structure, processes and policies, and its culture. (See page 4 to learn more about the Foundation's overall nursing strategy.)

In a six-month prototyping phase for the Transforming Care at the Bedside (TCAB) initiative, nurses and other staff from medical-surgical units in three hospitals brainstormed about the biggest problems they faced and then began testing easy, low-cost solutions at the rate of about one a day. (The other participating hospitals were Seton Northwest Hospital, Austin, Texas, and University of Pittsburgh Medical Center—Shadyside, Pittsburgh.) The idea is that nurses conceive and test small-scale changes quickly, in an effort to eliminate bottlenecks, streamline work processes and improve patient care, says Victoria Weisfeld, M.P.H., an RWJF senior communications officer. The tests often start with one patient and

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purpose, 54 percent said they favored the idea.

Making sure that people understand the connection between collecting race and ethnicity data and reducing unequal treatment is crucial, says John Lumpkin, M.D., M.P.H, an RWJF senior vice president and director of the Health Care Group. "Our involvement with the collection of data isn't just idle curiosity. It's part of measuring and identifying the problems, fixing the problems and then monitoring progress."

Lumpkin recently served on a national panel of experts on the subject. Mandated by Congress and convened by the Committee on National Statistics of the National Academies, the panel advised the Department of Health and Human Services on ways to improve the collection of data at the federal level and then use it to maximum effect. Like most experts who have studied disparities in care, Lumpkin doesn't see malevolent racism at the problem's core. Instead, he sees the workings of biases, which usually operate unconsciously.

"The vast majority of clinicians are trying to give the best care they can," he says. "But no one in this society lives without bias. Bias is a part of how the human brain works. We compartmentalize. We put people into groups. That is how we give order to our world. There is fairly extensive research that shows that when a patient is seen by a clinician, the clinician will tend to stereotype that individual. That stereotyping is based upon race, ethnicity and socioeconomic status. So bias slips into almost every patient encounter."

Bias affects decision-making. For example, a physician might prescribe a simplified but less effective drug regimen for an African-American HIV patient whom he erroneously assumes to have limited social support at home. Another example from the extensive research indicates that African Americans have lower-than-average screening rates for colorectal cancer. However, while the evidence of these disparities in treatment has been firmly established, there is less definitive evidence about what causes the disparities, and the causes

Health Care Disparity

Studies of patients who were appropriate candidates for **coronary angiography** have found race differences in obtaining a referral for this diagnostic procedure.*

Percentage of patients who obtained a referral

Black	58.7%
White	82.4%

A race disparity in **coronary revascularization** was found among patients in the Veteran Affairs health system, where there are no race differences in ability to pay and providers are paid a salary.**

Percentage of patients

Black	27%
White	50%

Among patients in Medicare managed care who had a myocardial infarction (heart attack), African American patients are less likely than white patients to receive **beta blockers**, the established standard of care.***

Percentage of patients receiving a beta blocker prescription

Black	64.1%
White	73.8%

Sources:

* LaVeist TA, Arthur M, Morgan A, Rubinstein M, Kinder J, Kinney LM and Plantholt S. "The Cardiac Access Longitudinal Study. A Study of Access to Invasive Cardiology Among African American and White Patients." *Journal of the American College of Cardiology*, 41(7): 1159-66, 2003.

** Ibrahim SA, Whittle J, Bean-Mayberry B, Kelley ME, Good C and Conigliaro J. "Racial/Ethnic Variations in Physician Recommendations for Cardiac Revascularization." *American Journal of Public Health*, 93(10): 1689-93, 2003.

***Schneider EC, Zaslavsky AM and Epstein AM. "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care." *Journal of the American Medical Association*, 287(10): 1288-94, 2002.

are likely to be multiple and complicated to address. "We know that there could be many underlying factors that contribute to disparities, some that we can try to address and some that are beyond our reach," Weiss says. "Maybe doctors make different assumptions about whether their patients will agree to undergo a test or procedure. Or maybe doctors treat all their patients the same but the patients have different attitudes toward what the doctor is telling them or don't understand what the doctor is telling them in the same way."

Cultural or language differences between patient and provider can adversely affect treatment as well, skewing communication or creating trust issues. Regardless of what causes racial and ethnic disparities in treatment, the team believes that solutions to these disparities start with better data collection. Says Weiss: "We know that we cannot help health care systems deliver better quality care unless we close the gap for minority patients, and we cannot close the gap if we can't keep track of them in the system."

Though such data are widely acknowledged as essential for creating baselines, devising remedies and measuring improvement, few health plans have wanted to collect

race and ethnicity information. Insurers worry about being accused of civil rights violations, malpractice and privacy concerns from members. The Disparities Team was curious about the extent to which health plans were collecting race and ethnicity data, so last year RWJF funded a survey by America's Health Insurance Plans, a trade organization that resulted from the merger of American Association of Health Plans and the Health Insurance Association of America.

The survey showed that about half of the responding companies now collect data on their members' race and ethnicity, and that most are using the information to target minorities at risk for receiving a lower quality of health care.

"Other surveys and anecdotal information indicate that this represents a dramatic increase in the number of health plans that are collecting this data," Lumpkin says. "So I believe we are making progress. We are putting in the infrastructure of data collection. The next step will be to implement pilot programs to test theories for reducing disparities in health care delivery."

—LEE GREEN

For more information on the

one nurse. If the results are promising, nurses gradually expand the test, learning every step of the way.

TCAB is one of several recent RWJF initiatives to address daunting problems facing hospitals today, particularly the high turnover of nurses on medical-surgical units, where most in-patients receive their care, and the well-documented need to improve patient safety. Hospital-acquired infections alone cause more than 80,000 deaths every year.

Other innovations tested by the prototype hospitals were: streamlining 13 different physician order forms into one standardized form; making dispensable drug machines and other equipment more accessible; and including nurses in doctor's rounds so that they could ask on-the-spot questions about the patient's condition and physician orders.

TCAB now has been expanded to include 13 pilot test hospitals through May 2006. They will

build on the most successful tests from the prototyping phase and develop best practices that can be disseminated widely.

To improve patient safety and the quality of care requires a multipronged approach, Weisfeld says. Processes of care, such as those just described, need to be revamped. The organizational culture must respect the staff and encourage innovation, and the physical structure must be conducive to patient healing as well as providing efficient, hazard-free, pleasant surroundings. Hospitals create stress for patients, families and staff alike through noisy conditions, glaring lights and lack of privacy. All these elements combine to create a work environment for nurses that the Institute of Medicine says is "characterized by many serious threats to patient safety."

The RWJF Nursing Team also is promoting good hospital design as part of its strategy. In June, RWJF sponsored a conference, "Designing the 21st-Century Hospital," bringing together archi-

itects, interior designers, hospital executives and government officials to review the growing research on evidence-based hospital design, as well as the need for process changes and healthy corporate culture.

An overview paper by Roger Ulrich, Ph.D., of Texas A&M University and Craig Zimring, Ph.D., of Georgia Tech University, reviewed more than 600 studies documenting how good design improves both patient outcomes and staff performance. Among their examples: patient falls declined 75 percent when a cardiac critical care unit placed nursing stations closer to patients' rooms; hospital-acquired infections decreased 11 percent in a hospital that added private rooms and more conveniently located sinks; and medical errors decreased 30 percent at a cancer unit that allocated more space for medication rooms, reorganized medical supplies and installed acoustical panels to decrease noise.

The researchers recommended ways to construct hospitals to be

more attuned to patient and staff needs. One of them was to provide patients with single rooms. Patients are less likely to acquire infection and they recover more quickly when their rooms are quieter and they can see the outdoors, including views of nature and gardens. While the up-front costs might be higher, another research report presented at the conference demonstrated that hospitals will recoup those costs within a year or two, through savings from fewer adverse events, fewer patient transfers, shorter hospital stays and an increased market share.

The current hospital building boom, the severe nursing shortage and the need to improve quality make this a "once-in-a-lifetime" opportunity to dramatically improve the hospital environment, Weisfeld says.

—SUSAN G. PARKER

For more information on the Foundation's nursing initiatives, including the paper on evidence-based design, see www.rwjf.org/nursing.

2004 Robert Wood Johnson Community Health Leaders Announced

Each year The Robert Wood Johnson Foundation honors 10 outstanding individuals who have overcome numerous obstacles to expand access to health care and social services to underserved and isolated populations in communities across the United States. Each recipient receives \$120,000 to use in his or her own community. For complete information on the awards, see www.communityhealthleaders.org. The 2004 Community Health Leaders are pictured below.



Seated, left to right:

Carole Morison, executive director, DelMarVa Poultry Justice Alliance, Pocomoke City, Md., organized a coalition of farmers, religious leaders, workers and others to advocate for better working conditions. The 17-group alliance addresses health issues, unfair labor practices and environmental pollution stemming from chicken production methods.

Rabbi Elimelech Goldberg, founder and national director, Kids Kicking Cancer, Birmingham, Mich., and a black belt in karate, created a program that uses martial arts therapy to empower young cancer patients and help them manage pain.

Gwendolyn Mastin, CEO, New Phoenix Assistance Center, Chicago, founded the city's first scattered-site housing program for homeless women infected with HIV or AIDS and their children. She also developed a pregnancy

prevention initiative for teens that embraces cultural traditions and encourages the creation of family support networks.

Standing, left to right:

Judy Bentley, president and CEO, Community Health-in-Partnership Services, St. Louis, runs a free health care clinic that serves predominantly uninsured residents of the Northside area. Among its services is an outreach program that offers health screening and education in nontraditional community settings, such as banks and barbershops.

Carol Carothers, executive director, National Alliance for the Mentally Ill—Maine (Augusta), spearheaded a state initiative that has become a national source of best practices for criminal justice, to improve the treatment of mentally ill prison inmates and prevent their inappropriate incarceration.

Lon Newman, executive director, Family Planning Health Services, Wausau, Wis., champions the cause of accessible, affordable family planning for poor

and young women. The agency, which serves about 5,000 women a year, offers reproductive health care, contraceptive services and education at seven clinics and through his innovation, the "contraceptive kiosk" at colleges and local businesses.

Zara Marselian, CEO of La Maestra Family Clinic, San Diego, founded a community center that offers multicultural health care and social services to immigrants and refugees in the inner city. The clinic provides medical and dental care, health education, job training, child-care referrals and translation services in 19 languages to nearly 50,000 residents.

Francois Leconte, president and CEO, Minority Development and Empowerment, Ft. Lauderdale, Fla., launched an organization to provide health services and improve the quality of life for the local Haitian community by offering prevention, education and intervention programs.

Susan Reyna, executive director, Mujeres Unidas en Justicia, Educacion y Reforma, Homestead, Fla., founded a one-stop program to aid victims of domestic violence and sexual abuse in Dade County's farmworker community. Her program, serving primarily Latina women and children, promotes healthy lifestyles, emotional wellness and stability in migrant worker families.

Raymond Figueroa, executive director, Turning Point/Discipleship Outreach Ministries, Brooklyn, N.Y., heads an organization that provides housing, substance abuse treatment and AIDS programs to Brooklyn's most troubled neighborhoods. The program serves more than 2,000 people a year and reaches another 20,000 through outreach initiatives.

—HEDDA COLOSSI

Q&A

with

Susan B. Hassmiller,
Ph.D., R.N.



The past several years have seen a nursing shortage that appears quantitatively and qualitatively different than the more cyclical shortages of the past. A

report produced by The Robert Wood Johnson Foundation in 2002, *Health Care's Human Crisis: The American Nursing Shortage*, concludes that the current shortage is systemic in nature, and will not be fixed by the typical solutions used in the past such as wage and benefit adjustments, sign-on bonuses, foreign recruitment, etc. With that as a background, RWJF launched its latest nursing initiative, which is aimed not at the recruiting pipeline, but at the hospital environment and culture that affects retention of nurses. Susan B. Hassmiller, Ph.D., R.N., leader of the Foundation's Nursing Team, discusses the approach the team plans to take to help ease this significant issue.

What do you see as the overall theme of the Foundation's hospital nursing initiative?

HASSMILLER—As we explored the issues involved in the hospital nursing shortage, it became evident that RWJF should focus on the 800-pound gorilla—the hospital work environment. While nurses are coming into the profession, they are going out just as fast—and the work environment, broadly defined, is a big part of the reason.

Also, although we recognize that training more nurses is important, especially more minority and male nurses, a host of other funders around the country are addressing this “pipeline” issue. As an aside, the shortage of nursing school faculty, particularly faculty with recent work experience out in the hospitals of today, is really serious.

The Foundation's interest in the nursing shortage stems from our interest in the bigger problem of quality of health care in the country. As a nurse, I know that nurses are essential to quality, and now the

Nursing Crisis Impacts Inpatient Quality of Care

Institute of Medicine has said so, too. If hospitals cannot find ways to create better work environments so that they can recruit and retain good nurses, then we are not going to get to the quality agenda. So, as it turns out, the nursing initiative is really working on inpatient quality of care.

How does the current nursing situation affect quality?

HASSMILLER—When the nursing department is short-staffed, managers have just a couple of options. They can assign more patients to each nurse. They can ask—or require—those nurses they do have to work longer hours. Or they can hire “agency” nurses—people who come in much like temporary office help. All of these strategies diminish quality.

A nurse trying to care for too many patients can't answer the call bell quickly, can't counsel the patient about medications, can't take time to go on rounds with the doctors, can't do a lot of things. If they work too long—and shifts longer than 12 hours are common—the number of errors goes up. When you are tired, you make mistakes. And, finally, agency nurses can't be expected to know who's who and what's what like a regular employee would.

Nurses leaving the profession tend to be the more recent graduates. This explains why the average age of hospital nurses is in the mid-40s. It's a problem for older workers to be doing such physically demanding work. And it creates extra stresses and burdens on those older workers—and then they want to leave the hospital workforce, too.

Can you describe the framework of the initiative?

HASSMILLER—We're taking a comprehensive approach to the problems in the hospital work environment that has three components—mind, body and spirit.

The “spirit” component is essentially the organizational culture. Without a positive work culture, people are not going to want to put up with the everyday stresses. The culture cannot be great unless there is strong leadership at the top that fosters respect and provides support for all employees.

By “mind,” we mean the way day-to-day work processes are designed. What makes a process efficient and effective? We know nurses spend a lot of time looking for equipment, looking for medications, chasing down a lab report or a doctor, charting. Are there better ways of doing those activities to eliminate waste, to make things more efficient and with better results for patients? The goal is to set up systems so nurses can spend as much time as possible on activities directly related to improving the quality of care. Often that means spending more time at the bedside.

The third component is the “body,” or the physical design of the hospital. The amount of daylight, the noise control, the organization of storage space, the way the patient rooms are laid out—all of these affect stress levels, healing, injury reduction and staff effectiveness.

What is the Foundation doing for the spirit component?

HASSMILLER—The spirit component is really first and foremost, because having a great work culture is the basis for everything else. We are beginning to identify best practices for work culture in hospitals. We supported a project that has conducted focus groups with hospitals participating in the Magnet certification program run by the American Nurses Credentialing Center. What are these hospitals doing that works well? What is having a positive effect on staff retention?

We also are pulling together information on some of the strategies hospitals across the nation are using to address the work culture. We hope this information will stimulate ideas for potential future programs. And we are piloting a tool that rates the culture of an organization.

Finally, we have a small research project on best practices with respect to human resources policies. What policies make the most difference in retaining staff?

What kinds of projects are planned for the mind component?

HASSMILLER—The mind component relates to work processes; and that is where the nursing team is spending the most time and money at this point. This initiative is called Transforming Care at the Bedside (TCAB). It is managed by the Institute for Healthcare Improvement (IHI) in Boston.

We have invited 13 leading hospitals to participate in the two-year pilot phase of TCAB, which started in June. Our grant monies go for developing technical assistance, and designing and implementing an evaluation of the pilot phase, not to the hospitals themselves. So participation in TCAB demonstrates a real commitment on their part to make positive change.

Can you give some examples of the changes that may help transform care at the bedside?

HASSMILLER—Last year we invited three hospitals to participate in a six-month prototyping phase for TCAB, before we began the pilot phase. Hospitals in Sacramento, Austin and Pittsburgh worked with IHI on possible changes at the medical-surgical unit level. The TCAB model encourages small, quick tests of changes, initiated by frontline staff. In the first test of an

See *Nursing*—page 12

To search our database of Foundation-funded research and to read author interviews and feature articles, visit the RWJF Research Center at www.rwjf.org/research

Collaborating at the State Level to Improve Diabetes Care

Nearly a decade ago, the Boston-based Institute for Healthcare Improvement developed its Breakthrough Series Collaborative to improve systems of care in the United States. Teams of health care providers working within a single hospital, clinic or primary care practice, or working jointly with other health care delivery systems across the nation, “systematically test and measure practice innovations.” Teams focus on a particular clinical condition, such as heart failure or diabetes, or a service function, such as office wait times. Over the course of the collaborative, they share their experiences and results formally with one another through a series of planned conferences, and informally through an e-mail listserv, conference calls and a Web site. The teams’ goal is “to create systems [of care] that are more evidence-based, patient-centered, efficient and effective.”

Beginning in October 1999, for the first time, a Breakthrough Series Collaborative for Diabetes—the Diabetes Collaborative I—operated at the state level; a second statewide collaborative—the Diabetes Collaborative II—followed in February 2001. Teams of health care providers from primary care practices across Washington state partnered with health insurance plans to redesign and align their diabetes care delivery systems with the “Chronic Care Model.” The chronic care model emphasizes patient-centered care and patient self-management support—“helping patients understand their disease and supporting their efforts to manage it.” The Washington State Department of Health Diabetes Prevention and Control Program, Qualis Health (a nonprofit quality improvement organization), and the *Improving Chronic Illness Care* program, a national program of The Robert Wood Johnson Foundation, jointly sponsored both collaboratives. This report chronicled the results of the collaboratives.

According to the report, the 17 primary care practice teams in Diabetes Collaborative I and the 30 teams in Collaborative II included government or public health delivery systems, community care clinics, large clinics, hospital systems and private practices. Each team designated a core leadership group composed of a senior administrator, a clinical champion and an operational or “day-to-day” leader. Eight health plans partnered with the clinical teams in Collaborative I and six health plans served as partners in Collaborative II. The 13-month track of the diabetes collaboratives included four conferences: three learning sessions and a final outcomes congress. Between each learning session, teams developed, tested, implemented and revised changes to their diabetes care delivery system using the “Model for Improvement,” which “test[s] innovations quickly and easily on a small scale but over a wide range of conditions.” Teams

tracked their progress by collecting data on key process and outcome measures for their pilot population of approximately 100 to 200 patients with diabetes. They compared process and outcome changes to a collaborative baseline measure to report absolute changes in diabetes care. Each team maintained a registry for their pilot patient population using an existing electronic system or the public-domain diabetes registry, Diabetes Electronic Management System, developed by the Washington State Department of Health Diabetes Prevention and Control Program.

The results for Collaboratives I and II were significant:

- All 47 teams participated for the full 13 months, although teams with the strongest senior, clinical and operational support saw the greatest improvements in care and outcomes.
- Teams with greater information system support and those using the Diabetes Electronic Management System registry encountered fewer barriers to tracking and reporting their results.
- Across both collaboratives, teams made more significant overall improvements in process measures than in outcome measures. More patients within the pilot population routinely received foot examinations, cholesterol testing, referrals for retinal examinations and documented self-management goals, compared to the baseline of care as usual.

Collaborative I teams made the greatest absolute improvement in LDL cholesterol levels among their outcome measures; Collaborative II teams saw the most absolute improvement in blood-sugar and blood-pressure levels in their outcome measures.

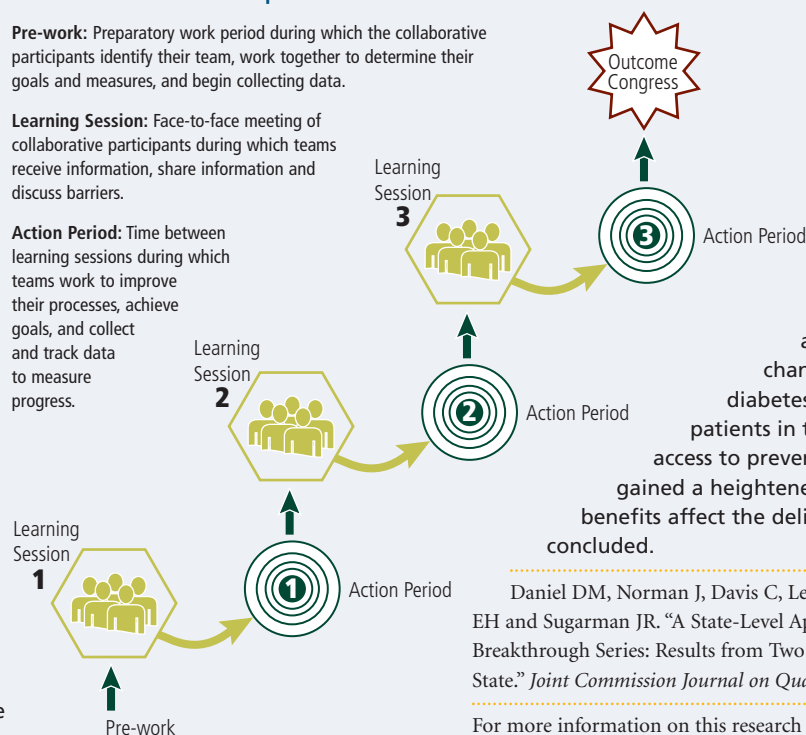
The primary benefits of holding collaboratives on a more local level, rather than a national level, the report’s authors contend, are reduced costs, which drive greater participation, and an ability to provide more technical support for teams’ efforts. The diabetes collaborative teams were “substantially engaged” and “reported substantial improvements.” The end result was “wider implementation of prevention-focused, patient-centered care.” The partnership between clinical teams and health plans added a new dimension to the collaboratives, and “was fruitful,” the authors report. In fact, health plans operationally supported the quality improvement efforts of the primary care practices and implemented a number of policy changes—from expanded benefits for diabetes education to zero copayments for patients in the pilot population—to improved access to preventive care. “Participating health plans gained a heightened awareness of how policies and benefits affect the delivery of chronic care,” the authors concluded.

Collaborative Model Institute for Healthcare Improvement

Pre-work: Preparatory work period during which the collaborative participants identify their team, work together to determine their goals and measures, and begin collecting data.

Learning Session: Face-to-face meeting of collaborative participants during which teams receive information, share information and discuss barriers.

Action Period: Time between learning sessions during which teams work to improve their processes, achieve goals, and collect and track data to measure progress.



Daniel DM, Norman J, Davis C, Lee H, Hindmarsh MF, McCulloch DK, Wagner EH and Sugarman JR. “A State-Level Application of the Chronic Illness Breakthrough Series: Results from Two Collaboratives on Diabetes in Washington State.” *Joint Commission Journal on Quality and Safety*, 30(2): 69–79, 2004.

For more information on this research and two case studies by the investigators, visit www.rwjf.org/news/special/improveDiabetes.jhtml.

Better State-Level Data Needed on Uninsured

There is no dearth of national surveys that measure health insurance coverage in the United States. In fact, there are six major surveys run by the federal government, and two designed and managed by private nonprofit research firms. (Funding for the latter two has been discontinued.) But these instruments fall short in accurately capturing coverage rates and characteristics of the uninsured at the state level. This poses a major problem for states, which, as primary stewards of public health insurance programs, depend on reliable data to judge how well their programs are working and where best to target scarce state resources.

This study is the first to rate how useful the eight national surveys are to state-level policy-makers, and to take a close look at the challenges faced by states that run their own household surveys to get more reliable data on health insurance coverage rates.

Researchers at the State Health Access Data Assistance Center identified five factors that make a national survey useful to state analysts: a valid survey design; a sample large enough to produce state-level estimates; timely release of data; public use files that include state identifiers; and samples large enough to estimate state-level coverage for subgroups such as children, racial minorities or by geographic area.

Only one of the national surveys, the U.S. Census Bureau's Current Population Survey, met all of the state-level criteria to some degree. With the exception of two, all lacked an adequate sample for state estimates, or lacked the sample needed to estimate health coverage in subpopulations.

These shortcomings have real effects. In Minnesota, for example, if state legislators had relied on coverage estimates provided by the Current Population Survey, which remained stable after MinnesotaCare implementation, they would have thought that their state insurance program, MinnesotaCare, was not making a difference. But Minnesota's own household survey, which relied upon a larger sample of state residents, was able to offer a more descriptive picture. While overall

coverage rates had not changed much, MinnesotaCare was indeed reaching its target population; over five years rates of coverage for children increased by 31 percent, and by more than 20 percent for low-income residents.

Meanwhile, at the time of this study, 36 states were conducting their own household surveys, largely funded by the State Planning Grants program administered by the Health Resources and Services Administration (HRSA). Compared with the national surveys, state surveys can increase sample size to better measure coverage rates and across different subgroups, tailor the survey to answer a specific set of policy questions, and control when the results are released.

But the study found a number of challenges to state-level surveys. States vary in their analytic capacity; those that partner with survey experts at local universities are more successful. Also, surveys are expensive (averaging \$250,000 to \$500,000), and it appears unlikely that the HRSA grants will be funded in the future.

The study authors suggest that it is time to coordinate surveys and resources to find creative ways to meet the state needs for better data on health coverage, use and trends. Such an undertaking could be centralized or done through a federal-state partnership where states collect their own information based on uniform standards that all states would use. At the very least, researchers say, the federal government should offer its survey expertise to states to help them improve the usefulness and accuracy of state-level surveys.

Blewett LA, Good MB, Call KT and Davern M. "Monitoring the Uninsured: A State Policy Perspective." *Journal of Health Politics, Policy and Law*, 29(1): 107–145, 2004.

For more information on this research, visit www.rwjf.org/special/monitor or the State Health Access Data Assistance Center Web site at www.rwjf.org/news/special/uninsuredData.jhtml.

Knee Arthroplasty: Gender, Ethnicity and Geography Matter

Knee arthroplasty (replacement of a joint with artificial components) is an increasingly popular surgical option to treat the chronic pain and loss of mobility caused by osteoarthritis. However, among Medicare enrollees—that sector of the population most likely to undergo the procedure—the use of knee arthroplasty varies by gender, race and geography: the knee arthroplasty rate is higher for women than for men, lower among blacks and Hispanics, and varies substantially from hospital region to hospital region across the country. In this study, the investigators looked specifically at the origins of ethnic disparities in arthroplasty. Are the differences attributable to geographic variations in care? In other words, do blacks and Hispanics have lower rates of knee arthroplasty because they live in regions where the overall arthroplasty rate is lower? Or do "lower income levels or residential segregation" among minorities underlie these racial differences?

To answer these questions, the investigators examined demographic and claims data on all Medicare enrollees in fee-for-service programs who received a knee arthroplasty 1998–2000. They categorized Medicare enrollees in three racial/ethnic groups—black, Hispanic and white—and used the *Dartmouth Atlas of Health Care's* Hospital Referral Regions to define their geographic locations. If patients migrated out of their respective referral regions for arthroplasty, the investigators assigned the procedure to the region in which patients resided. They used 2000 U.S. Census Bureau data to determine the median household income of Medicare enrollees in the hospital referral regions.

Overall, across all ethnic groups and geographic locations, the arthroplasty rate was highest for women. Nationally, among both women and men, rates were highest for white Medicare enrollees and lowest for black enrollees. The racial gap was "more pronounced" for men: the rate of 4.82 procedures per 1,000 men for white men was more than double the rate of 1.84 procedures per 1,000 men for black men.

The investigators estimate that "roughly 35 percent of the national difference in arthroplasty rates for black women and 95 percent of national difference for Hispanic women are explained by the fact that black and Hispanic women are more likely to live in regions with lower rates for all races and ethnic groups."

The same finding did not hold true for black men. In almost every hospital referral region, the knee arthroplasty rate was lower for black men than it was for white men. Because arthroplasty rates among black women did not always differ significantly from those for white women living in the same neighborhoods, the authors contend that "one cannot explain these persistent differences on the basis of financial or geographic barriers alone."

These findings, they conclude, "suggest that patterns of differences in the use of knee arthroplasty differ fundamentally according to sex, race or ethnic group, and region." To begin to address these disparities, the authors recommend a two-pronged strategy: 1) physicians should fully inform patients about the benefits and costs of the procedure; and 2) patients must be able to make their choices "free of economic or geographic barriers to care."

Skinner J, Weinstein JN, Sporer SM and Wennberg JE. "Racial, Ethnic, and Geographic Disparities in Rates of Knee Arthroplasty Among Medicare Patients." *New England Journal of Medicine*, 349(14): 1350–1359, 2003.

For more information on this research, visit www.rwjf.org/news/special/kneeArthro.jhtml.

School Disorder Contributes to Kids Not Feeling Safe

A disorderly school climate is one of the most important factors determining whether a student feels safe at school, even when neighborhood and family characteristics are taken into account. This was the major finding of a study of 2,768 students (ages 10–18) living in five economically distressed cities and their suburban rings. This finding was remarkably consistent for students from different neighborhoods, family types (single- and two-parent), income levels and school types (both public and private).

The study's authors note that it's important to understand what causes students to feel unsafe in school, because students who feel unsafe have a lower sense of competence and control, and the lack of a sense of safety in school has been shown to be linked to poor school performance, depression, and other psychological and behavioral problems.

Students in the study were asked two safety-related questions: whether they felt safe everywhere they were the day before being interviewed, and whether they felt safe at school. Overall, 8 percent of respondents reported feeling unsafe on the day prior to the interview and 15 percent reported feeling unsafe at school.

Students who reported that their schoolmates could get away with anything (a proxy definition

for a disorderly school environment) had a 55 percent higher chance of feeling unsafe the day before the interview than those who felt their school was less disorderly. Place of residence and parents' views about fighting also were important factors. Youths living in suburbs were 36 percent less likely to feel unsafe than urban youths.

A major risk factor for children feeling unsafe at school was their perception that students could get away with anything. Youths who reported that they attended highly disordered schools were 120 percent more likely to report feeling unsafe in school than those who had more orderly school environments. Interestingly, the proportion of students reporting school disorder was the same across neighborhoods, races and income levels.

Researchers note that their findings may be good news for policy-makers, since "it may be easier to promote a healthy school climate . . . than it is to address the multiple sources of objective threats to children's safety both in and out of school."

Mijanovich T and Weitzman BC. "Which 'Broken Windows' Matter? School, Neighborhood, and Family Characteristics Associated with Youths' Feelings of Unsafety." *Journal of Urban Health*, 80(3): 400–415, 2003.

For more information on this research, visit www.rwjf.org/news/special/schoolDisorder.jhtml.

Work Conditions, Nurse Burnout and Patient Satisfaction

Amid a national nurse shortage, hospital nurse burnout and its effect on patient safety are rising as national concerns. More than 40 percent of hospital-based nurses report high job-related burnout, and more than 20 percent say they plan to leave their jobs within a year.

This study examined the effect of working conditions on nurse burnout, and the ways in which nurse working conditions and burnout affect patient satisfaction. Data were taken from surveys of 820 nurses in 20 urban hospitals across the United States, along with interviews from 621 AIDS patients who were in their care.

The study found that nurse burnout increases the likelihood of patient dissatisfaction, and that nurses' work conditions affect both nurse burnout and patients' views of their care.

Work environments were measured in terms of staffing adequacy, administrative support for nurses' decisions and the quality of nurse-physician relationships. Nurse burnout was measured by rates of emotional exhaustion, depersonalization and feelings of personal accomplishment. Nurses working in good environments were two to three times less likely to be highly emotionally exhausted and to depersonalize interactions with patients than

those working in poor environments. But environment seemed to have no impact on nurses' feelings of personal accomplishment.

Patients on units where nurses reported higher-than-average levels of emotional exhaustion were only half as likely to be highly satisfied with their care as those cared for by nurses with lower-than-average exhaustion. Personal accomplishment also had an impact. Patients cared for by nurses with higher-than-average feelings of personal accomplishment were more than twice as likely to be highly satisfied as those patients treated by nurses with lower-than-average levels. But nurses' feelings of depersonalization did not affect patient satisfaction.

The paper's findings suggest that improved work environments for nurses will improve outcomes for both nurses and physicians.

Vahey DC, Aiken LH, Sloane DM, Clarke SP and Vargas D. "Nurse Burnout and Patient Satisfaction." *Medical Care*, 42(2): 57-66, 2004.

Linda Aiken, Ph.D., R.N., is a Robert Wood Johnson Investigator Awards in Health Policy Research Fellow.

For more information on this research, visit www.rwjf.org/news/special/nurseBurnout.jhtml.

Racial/Ethnic Differences in Asthma Care Among Medicaid-Enrolled Children

Since the National Institutes of Health issued its first clinical guidelines for asthma more than a decade ago, health care providers have striven to improve asthma care, with limited success. The number of asthma-related hospitalizations for children has continued to increase—particularly among ethnic minorities. Using 1993 and 1994 claims and demographic data from the primary care case manager plan and fee-for-service program of the Massachusetts Medicaid program, this study examined differences in care for 5,773 white, black and Hispanic children with a primary diagnosis of asthma.

The researchers looked specifically at four domains of care addressed by the National Heart, Lung and Blood Institute's 1991 asthma care guidelines: regular primary care visits for asthma, appropriate use of medications, access to specialists and timely follow-up care after an asthma-related hospitalization or emergency department (ED) visit.

The investigators found no significant differences in the number of asthma-related primary care visits across the three racial/ethnic groups, although children in all three groups had far fewer than the minimum number of primary care visits recommended to manage childhood asthma. Less than 28 percent of children saw a primary care physician for their asthma at least twice during the yearlong study period.

Nor were there significant differences in asthma pharmacology across study groups. While black and Hispanic children had fewer prescriptions for anti-inflammatory medications (such as inhaled steroids that are used to prevent acute asthma attacks) relative to white children, these differences were not significant.

There were, however, significant racial/ethnic disparities in two important dimensions of care: access to asthma specialists and timely follow-up care after an asthma ED visit. Specifically, Hispanic children with persistent asthma were 39 percent less likely than white children to see an asthma specialist during the year.

With respect to asthma ED use, black and Hispanic children were not only more likely to be seen in the ED for asthma, but also received less timely follow-up care after asthma-related ED encounters. "Black children were 75 percent more likely and Hispanic children were 56 percent more likely than white children to have had one or more asthma ED visits during the year," researchers wrote. The hospitalization rate for asthma was similar among white and Hispanic children, but 50 percent higher for black children. With respect to timely follow-up care after an asthma ED visit, Hispanics were 41 percent less likely and black children 64 percent less likely than white children to receive a follow-up visit within five days of an ED visit.

"For the aspects of asthma care measured in this analysis, children across all study groups received less than optimal care," the authors contend. Black and Hispanic children, however, were more likely to use the ED for asthma care and less likely to receive timely follow-up care after doing so. Hispanic children also had reduced access to asthma specialists. Because all children in the study had similar socioeconomic backgrounds and used the same statewide network of providers, the researchers conclude that "access alone is not sufficient to eradicate racial disparities in asthma care." Future asthma improvement efforts should target specific areas where suboptimal care is being provided—which may be different for different communities—to meet the needs of specific pediatric populations. The authors also suggest that future racial health disparities research focus on the "different values and experiences of low-income families" as they interact with the health care system, to maximize the effectiveness of future quality improvement interventions.

Shields AE, Comstock C and Weiss KB. "Variations in Asthma Care by Race/Ethnicity Among Children Enrolled in a State Medicaid Program." *Pediatrics*, 113(3): 496-504, 2004.

For more information on this research, visit www.rwjf.org/news/special/childAsthma.jhtml.

Measuring Quality of Care in Twelve Communities

Measuring health care quality should be done at the local level, where findings can be addressed more directly. This was the theory behind a study that provided concrete estimates of the quality of care in 12 metropolitan areas across the United States, and found much room for improvement.

Findings were based on data from the RWJF-funded Community Quality Index Study (conducted by RAND), a collateral study of the Community Tracking Study, which uses periodic surveys and site visits to track health care system changes in 60 metropolitan areas. Researchers used the Quality Assessment Tools system to evaluate the proportion of indicated care that was provided to 6,712 adults for preventive care and for 30 acute and chronic conditions. These conditions represent the leading causes of death, disability and utilization of health care services.

Variations in Quality Among 12 Community Quality Index Study Communities, by Chronic Condition

	HYPERTENSION	DIABETES	PULMONARY	CARDIAC CARE	DEPRESSION
Boston	65.4	55.0	51.4	57.4	55.7
Cleveland	68.9	43.8	60.2	69.8	48.9
Greenville, SC	62.8	41.4	55.9	62.6	59.8
Indianapolis	62.5	54.3	50.2	52.0	60.0
Lansing, MI	63.7	45.3	51.3	53.2	59.0
Little Rock, AR	54.1	38.9	52.2	57.0	58.6
Miami	62.1	58.8	63.5	60.8	51.0
Newark, NJ	68.6	44.8	47.9	61.2	47.0
Orange Co., CA	63.4	41.0	44.6	52.0	56.3
Phoenix	68.3	49.6	51.9	59.1	62.4
Seattle	67.5	53.6	54.8	60.6	62.8
Syracuse, NY	67.6	44.3	50.9	70.4	55.1

Quality Index
 <40-45 46-50 51-55 56-60 61-65 66-70+
 Percentage of recommended care received

The study found that the overall quality of preventive, acute and chronic care was similarly lacking across the 12 communities. Overall quality ranged from 51 percent of recommended care received in Little Rock, Ark., to 59 percent in Seattle.

When it came to preventive care, all areas did a better job of preventing chronic conditions through screening and vaccinations than through other means, such as HIV prevention and substance-abuse counseling.

Researchers found more variability in the quality of chronic care, both across conditions and across communities. Localities scored highest on treating hypertension. Cleveland ranked highest, with 70 percent of hypertension patients receiving recommended care. The quality of care for pulmonary problems, and communities rated the worst on quality of care for diabetes. "The lack of variation in overall quality should serve as a wake-up call to all communities to examine their own quality of care and determine how they might be able to approach local quality improvement initiatives," the study states.

Kerr EA, McGlynn EA, Adams J, Keesey J and Asch SM. "Profiling the Quality of Care in Twelve Communities: Results from the CQI Study." *Health Affairs*, 23(3): 247-256, 2004.

For more information on this research, visit www.rwjf.org/news/special/measureCare.jhtml.

Taking a Community Approach to Help Youth Break The Cycle of Substance Abuse and Crime

The juvenile justice system faces a major public health crisis. About 2 million young people enter the justice system each year, and as many as four out of five of them have a substance abuse problem. Yet fewer than 40 percent of juvenile corrections facilities offer any type of care or treatment for alcohol or drug addiction.

One reason for the lack of treatment is the not-uncommon view that individuals convicted of crimes are in the system to be punished, not to be provided with services. The Robert Wood Johnson Foundation's national program, *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime*[®], offers a different approach that encourages community involvement to find alternative methods to address the issue of substance-abusing young people in the juvenile justice system.

"We are working against a framework in which providing substance abuse treatment to people who have committed an offense is viewed as being soft on crime," says Laura Burney Nissen, Ph.D., director of *Reclaiming Futures*, which is based at Portland State University.

"In fact, we strongly believe that kids need to be held accountable for their actions. They also need an opportunity to grow and thrive, and that's what we are trying to provide," she says.

Reclaiming Futures is a five-year, \$21-million initiative aimed at promoting new opportunities and standards of care in juvenile justice. The program made grants of \$1.5 million each to 10 pilot projects across the nation (Anchorage, Alaska; Chicago; Dayton, Ohio; Marquette, Mich.; Portland, Ore.; Rosebud, S.D.; Santa Cruz, Calif.; Seattle; Southeastern Kentucky and the state of New Hampshire). The program also provides technical assistance to two dozen other communities and sponsors a national leadership program.

Investing in treatment for young people makes economic sense. The

state of California found that it saves seven dollars for every dollar it invests in substance-abuse treatment.

Now in its third year, one of the program's initial accomplishments has been to help the 10 pilot project communities set up comprehensive programs to evaluate for substance abuse problems all the children and teenagers who enter the juvenile justice system.

"At each of the sites, we've developed routine screening and assessment programs so we know which kids have what kind of problems," says Katherine Kraft, Ph.D., an RWJF senior program officer. "That may not sound like a big deal. But in many communities there is no screening whatsoever, so kids who need help are never even identified."

Each of the pilot project sites focuses on reforming systems, improving drug and alcohol treatment and establishing youth development programs—such as courses in culinary arts, horticulture and other skills—taught by people from the community.

"The idea is to demonstrate to the community that these kids can be productive and contribute—and

to show the kids that the community supports them," says Kraft.

Studies support the notion that involving multiple components of a community is crucial to helping youth break the cycle of drugs, alcohol and crime. *Reclaiming Futures* brings together judges, prosecutors, public defenders, probation officers, treatment providers, social workers, police, businesses, civic groups and schools.

"We are trying to help communities understand what an expensive and inhumane way the juvenile justice system is to raise troubled children," Nissen says. "The public does not have a good understanding that most kids in the system are not violent criminals. Yes, children who commit crimes need to be accountable. But they should not be punished for having a health problem—and that is what addiction is.

"Only when we work within and outside the system can we build a bridge for these kids that will take them out of the system for good," says Nissen.

Bringing together such disparate groups can be a challenge, according to Kraft.

"We are seeing a gradual culture shift toward a strength-based philosophy, where many of those involved are starting to look at youths and their families from an asset perspective, trying to build on what they have, rather than seeing what they don't have," says Kraft.

Involving children's families in their substance-abuse treatment is a critical element of success, according to Nissen.

Pilot community Multnomah County, Ore., for example, is developing adolescent treatment protocols that build on family involvement and make it a key part of treatment. When families participate in treatment with teens, the youths have a better chance of successful treatment and are less likely to commit crimes in the future.

"There are literally hundreds of people in formal and informal leadership roles [across the country] who are everyday heroes for doing the work in the trenches to reclaim kids," says Nissen.

—LAURIE JONES

For more information on this program, visit www.reclaimingfutures.org. For more on the Foundation's work with addiction prevention and treatment, see www.rwjf.org/addiction.

What's New on the RWJF Web Site

Even though the Foundation-sponsored TIME/ABC News Summit on Obesity is over—it was held June 2–4 in Williamsburg, Va.—the event lives on in webcast form. You can view highlights from the three-day conference at www.rwjf.org/obesity.

In an important webcast stemming from the summit, Joe Thompson, M.D., M.P.H., director of the Arkansas Center for Health Improvement, presented initial results of a statewide effort to assess the body mass of schoolchildren. Arkansas is the first state to require annual body-mass index (BMI) screening of every public school student. You can view the press conference at the address above as well.

RWJF's popular Television Health Series produced three segments focusing on research findings presented in Williamsburg:

- A survey to gauge public support for childhood obesity interventions.
- A study focusing on barriers to routine BMI screening and monitoring in children.
- Research probing access to community fitness facilities among members of various racial, ethnic and socioeconomic groups.

You can view all Television Health series pieces at www.rwjf.org/news/tvhealth. For direct access to all of the Web site's Active Living interactive tools, including walkability, bikeability and sprawl checklists, an active communities photo essay, and more, go to www.rwjf.org/programs/activityinteractives.jhtml.

Another Television Health Series segment explores new research demonstrating a link between lengthy and erratic work hours by nurses and patient safety.

In an effort to improve the quality of our webcasts, www.rwjf.org has created a customized "skin," allowing the simultaneous showing of webcast video in conjunction with presenters' slides. The webcast skin made its debut with the presentation of video and slides from an invitation-only national conference, "Designing the 21st-Century Hospital: Serving Patients and Staff." See the webcast at www.rwjf.org/news/hospitaldesign.

Future webcasts will be offered in this new, uncluttered format.

In our Research Center, we added a number of new abstracts, many including links to full text. Two recent additions to the Research Center direct readers to these Synthesis Project reports:

- "Public Program Crowd-Out of Private Coverage: What Are the Issues?"
- "Geographic Variation in Medicare Per-Capita Spending: Should Policy-Makers Be Concerned?"

To see all abstracts, visit the Research Center at www.rwjf.org/research.

The Foundation Web site continues to offer an e-mail service that allows you to be alerted to new funding opportunities and the posting of new articles, research reports, news releases and other content in various interest areas. To register for RWJF e-mails or to change your profile, visit subscribe.rwjf.org.

—JEFFREY MEADE

A Personal Disability Inspires a Research Passion

On most days, Lisa Iezzoni, M.D., M.Sc., is patient with people who talk to her husband Reed and ignore her as she sits in her motorized wheelchair. “I try to be polite about it, although it depends on how my day has been,” says Iezzoni, smiling. “If they are asking my husband a question about me, I will tell the person it might be more helpful to ask me the question instead.”

Iezzoni, 50, a professor of medicine at Harvard Medical School, Beth Israel Deaconess Medical Center, was diagnosed with multiple sclerosis (MS) nearly 24 years ago, during her first year as a medical student. Because she was discouraged from becoming a practicing physician, she went straight into research after earning her degree, building a reputation as one of the world’s leading experts in risk adjustment (methods for quantifying health-related risks across populations).

A few years ago, however, Iezzoni drastically switched course. In 1996, she received The Robert Wood Johnson Foundation’s *Investigator Award in Health Policy Research*. She used the grant to interview 119 people—56 of whom had mobility issues due to chronic, progressive diseases or disorders—and wrote a book, *When Walking Fails* (University of California Press, 2003). The interviews and Iezzoni’s comments describe how impaired mobility affects daily life, relationships with friends and family, and the ability to work, as well as experiences with insurance and health care providers.

“I hoped from the very start, given her personal understanding of disability, that she would some day turn her attention to that field,” says Thomas Delbanco, M.D., Koplrow-Tullis Professor of General Medicine and Primary Care, Harvard Medical School, who hired Iezzoni to work at Harvard. “I felt that anything Lisa touched would emerge as a new and mushrooming field of inquiry, and that is exactly what has happened.”

Iezzoni never expected a future without walking. Growing up on the East Coast, she used long walks to meditate on important decisions. As an undergraduate at Duke University, she started jogging daily, and before entering medical school, she took a walking vacation through northern Scotland and the Outer Hebrides islands. But it was while she was studying for a graduate degree in public health at Harvard in the mid-1970s that Iezzoni first noticed something was wrong. She felt as if she didn’t know where her legs were during a run.

At age 26 the symptoms worsened and her then boyfriend, Reed, also a medical student, urged her to see a doctor. Iezzoni was diagnosed with MS, a chronic neurologic disease, in January 1981.

This was in the days prior to the Americans with Disabilities Act, and she was advised by medical school faculty not to pursue medical practice. In her third year of medical school, for example, Iezzoni asked a leader of a Harvard teaching hospital for advice on accommodations that might be needed for her residency (she wouldn’t be able to stay up all night and thought sharing a position could work).

“Frankly, there are too many doctors in the country right now for us to worry about training handicapped physicians,” he replied. “If that means certain people get left by the wayside, that’s too bad.” It was a rebuke that gnawed at her self-confidence and taught her not to discuss MS.

After graduation, her career in research blossomed. Despite having to walk with one cane, then two, and later using a motorized scooter to get around, she rarely discussed her illness and being mobility impaired—until she started work on *When Walking Fails*.

“Over time, I came to realize that silence carries consequences,” Iezzoni writes in her book, offering one reason why she took on this project. “Silence reinforces the stigmatization of disabling condi-

tions, the sense that becoming less able to walk is something to hide—although, of course, we can’t.”

She also wrote the book because of constant questions she got from strangers about walking problems—their own, and those of their relatives or friends—while she was out on her scooter. “I started wondering why people were asking me these questions. Why weren’t they talking to their



Lisa Iezzoni, M.D.

doctors or other professionals?” says Iezzoni. “I decided to reverse the tables, to go out and ask people about how walking problems affect their daily lives and about the barriers they confront to getting information and restoring their mobility. I wrote it to help people like the strangers who talk to me understand their options and learn from the experiences of others facing similar situations.”

Like breaking the silence about her disease, getting a scooter in her mid-30s was a huge step. “Nobody wants to admit they can no longer walk,” explains Iezzoni. “But it [the scooter] is so liberating. You no longer think about falling or injuring yourself, you are no longer extraordinarily tired and you have energy to do other things.”

In addition to her work at Harvard, she now travels the

country lecturing on improving quality of care for people with disabilities and tours health care facilities pointing out “where things just won’t work for those with disabilities.”

“I try to make two basic points when I lecture [to health care providers],” says Iezzoni. “First, never assume anything about a person with a disability. Second, ask them how you can help. If you want to help them up onto an examining table, help them undress or you are not sure how to position them, just ask.”

Iezzoni has been married for 22 years to Reed, an academic hematologist and oncologist who also works at Beth Israel Deaconess Medical Center. He does the shopping, laundry, gardening and other physical chores around the house, while Lisa spends much of her time reading, writing and researching. She’s no longer able to enjoy the hobbies she once did, such as knitting, gardening and, of course, walking.

But, she says, “I view my cup as half full rather than half empty. Yes, things aren’t exactly what I hoped they would be, but they are not bad. I have a career I enjoy. It is an amazing thing to be a researcher and be able to help people. I have a very supportive husband, and I don’t have the pressures on me that so many people with disabilities have, like poverty, low levels of education and other health problems. I have been very lucky.”

Iezzoni describes MS as “the landscape” she lives in. “It would be paralyzing if every minute of every day I thought about what my future would be. That would make it impossible to move forward. Denial is a fairly useful defense mechanism when used selectively,” she says, laughingly. “I am grateful for what I have.”

—ANNE E. STEIN

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, organized by topic area, detail the results of the Foundation's work, including the products produced. Since April 2004, two new National Program Reports and 34 new Grants Results Reports have been posted on the RWJF Web site, www.rwjf.org. You can search the entire database of reports at www.rwjf.org/grantresults. Among those posted are reports on projects with specific products that may be of interest to others. Recent reports on such projects include the following:

Online Measures of Health Care Quality Based on Consumers' Assessment of Their Own Health Care

During 2002 and 2003, researchers at the nonprofit advocacy organization, FACCT (Foundation for Accountability) tested the feasibility of using data from online patient surveys to create a valid assessment of physicians' performance. The project was part of a five-phase research project designed to test, refine and validate this Internet-based information strategy. The CompareYourCare™ online survey tool provides consumers with information and performance indicators about the physician's technical and interpersonal skills and offers tips on how to get good care. The survey measured:

- *Service and Support*—including quality of physician-patient interactions, access and continuity of care, and integration of care.
- *Appropriate Care*, based on national treatment guidelines.
- *Education and Teamwork*, the support provided to the patient by the physician.

The CompareYourCare physician assessment tool is available at www.facct.org. See the Grant Results Brief at www.rwjf.org/reports/grr/045269.htm.

Action Against Crime and Violence Education Fund
Fight Crime: Invest in Kids, a national, nonprofit child advocacy organization, conducted an educational campaign to increase policy-makers' awareness of the value of publicly funded programs to strengthen youth and fragile families. To educate policy-makers, project staff synthesized existing research in three areas: child abuse prevention, early child care and after-school programs. More than 10 research briefs and five research reports were developed and disseminated to policy-makers, the media and others. The research reports included:

- *New York's After-School Choice* at www.fightcrime.org/ny/afterschool.php.
- *When the School Bell Rings... Juvenile Crime or Constructive Time?* at www.fightcrime.org/reports/ILASReportWendnotes.pdf.
- *Cutting Pre-Kindergarten Will Increase Crime in New York* at www.winningbeginningny.org/FCIK_report.pdf.
- *New Hope for Preventing Child Abuse and Neglect* at www.fightcrime.org/reports/CANreport.pdf.
- *Pennsylvania's Pre-Kindergarten Crisis* at www.fightcrime.org/pa/reports/PAPre-k.pdf.

See the Grant Results Brief at www.rwjf.org/reports/grr/042818.htm.

Physician Orders for Life-Sustaining Treatment in Nursing Homes

Researchers at the Center for Ethics in Health Care at the Oregon Health and Science University disseminated the results of a study on the effectiveness of Physician Orders for Life-Sustaining Treatment (POLST). The researchers specifically looked at the ability of POLST to help prevent unwanted aggressive medical treatment for nursing home residents at the end of life. They developed and distributed a monograph, *The Oregon Report Card: Improving Care of the Dying*, to 15,000 health care providers and others, developed a brochure for a general audience describing POLST, and expanded their Web site to include information on

POLST and its development. For more information about POLST, go to www.ohsu.edu/ethics/polst/index.htm. See the Grant Results Brief at www.rwjf.org/reports/grr/033903.htm.

Consensus Reports from the National Quality Forum

The National Forum for Health Care Quality Measurement and Reporting, now known as the National Quality Forum (NQF), seeks to change how health care quality information is collected and used in the United States. NQF has developed six consensus reports:

- *Serious Reportable Events in Healthcare* identifies 27 adverse events that are largely preventable and of concern to both the public and health care providers. Information on ordering the report, which costs \$8 for NQF members and \$12 for nonmembers, can be downloaded at www.qualityforum.org/neverteaser.pdf.
- *A National Framework for Healthcare Quality Measurement and Reporting* identifies longer-term strategic areas that the NQF will pursue. Information for ordering the report, which costs \$8 for members and \$12 for nonmembers, can be downloaded at www.qualityforum.org/txframepublic.pdf.
- *National Voluntary Consensus Standards for Adult Diabetes Care* categorizes consensus standards by area and includes both external and internal quality measures. Information for ordering the report, which costs \$9.50 for members and \$14 for nonmembers, can be downloaded at www.qualityforum.org/txdiabetes-orderformonly.pdf.
- *A Comprehensive Framework for Hospital Care Performance Evaluation* provides principles for hospital measurement and reporting that can be uniformly adopted and applied by hospitals, regulators and other stakeholders to standardize these activities. The document can be downloaded for free at www.qualityforum.org/hosp_framework_report.html.
- *Safe Practices for Better Healthcare* details 30 health care practices that should be used in

clinical care settings to reduce the risk of harm to patients. Information for ordering the report, which costs \$25.50 for members and \$38.50 for nonmembers, can be downloaded at www.qualityforum.org/txsafeexecsumm+order6-8-03PUBLIC.pdf.

- *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measurement Set* provides the first set of nationally standardized measures to assess the quality of care provided by the more than 6,000 acute care U.S. hospitals. The measures are intended to promote both public accountability and internal quality improvement. The document can be downloaded from the NQF Web site at www.qualityforum.org. See the Grant Results Brief at www.rwjf.org/reports/grr/039645.htm.

Longitudinal Effects of Housing Policies on Health Indicators and Outcomes

Between 1994 and 1998, the U.S. Department of Housing and Urban Development (HUD) conducted and evaluated a controlled, random-assignment housing relocation experiment called Moving to Opportunity. The purpose of the program was to determine the long-term impact of moving families from high-poverty to low-poverty communities. Findings include:

- There was a large and significant reduction in the prevalence of obesity in adults among both experimental and comparison families.
- There were improvements in mental health among adults in the experimental group families: a reduction in psychological distress, a reduction in depression, and an increase in feelings of calm and peacefulness.
- Among children, the significant effects of Moving to Opportunity on health were confined to mental health measures.

A report on the interim findings is available at www.huduser.org/publications/fairhsg/mtofinal.html. See the Grant Results Brief at www.rwjf.org/reports/grr/040075.htm.

— HEDDA COLOSSI

Search all active RWJF grants at

www.rwjf.org/grants

RWJF national programs are denoted by italics.

Active Living, Obesity and Nutrition

- > *Active Living Research*. For studying the contributions of trails and walking paths to adults' physical activity, one renewal award of \$149,991 to Harvard University School of Public Health, Boston.
- > *Active Living Resource Center*. An award of \$277,500 to the Bicycle Federation, Washington.

Alcohol and Drug Addiction Prevention and Treatment

- > *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime*. Renewal awards to 10 sites, totaling \$1 million.
- > *Substance Abuse Policy Research Program*. Awards to five sites, totaling \$616,393.

Building Human Capital

- > *Generalist Physician Faculty Scholars Program*. Support for 15 scholars, totaling \$4.5 million.
- > *The Harold Amos Medical Faculty Development Program*. Support for four fellows, totaling \$1.5 million.
- > *Health Policy Fellowships Program*. Support for seven fellows, totaling \$1.1 million.
- > *Innovators Combating Substance Abuse*. For increasing access to methadone treatment through the criminal justice system, \$300,000 to the American Association for the Treatment of Opioid Dependence, New York.
- > *Investigator Awards in Health Policy Research Program*. Awards to two sites, totaling \$545,451.
- > *The Robert Wood Johnson Clinical Scholars Program*. Renewal awards for seven sites, totaling \$4.6 million.

Health Insurance Coverage

- > *Covering Kids and Families*. Awards to four sites for liaison projects, totaling \$199,595.

Pioneer

- > For developing universal symbols for health care facilities, \$375,000 to the Tomas Rivera Policy Institute, Los Angeles.

Public Health

- > For increasing the effectiveness of disease prevention and health promotion policies, \$350,000 to the Partnership for Prevention, Washington.
- > *Public Health Informatics Institute—Phase II*. For a new paradigm for developing public health information infrastructure, a renewal award of \$3.2 million to the Task Force for Child Survival, Decatur, Ga.

Quality Health Care

- > *Advancing Diabetes Self-Management*. Renewal awards to six sites, totaling \$2.6 million.
- > *Pursuing Perfection: Raising the Bar for Health Care Performance*. Renewal awards to seven sites, totaling \$2.1 million.
- > For investigating legal barriers to using quality and disparities data, \$156,648 to George Washington University Center for Health Services Research and Policy, Washington.

Reducing Racial and Ethnic Disparities in Chronic Care

- > For developing a federation on disparities in health care, \$199,471 to the American Medical Association, Chicago.
- > For reducing racial and ethnic disparities in health care: A best clinical and administrative practices initiative, \$381,789 to the Center for Healthcare Strategies, Princeton, N.J.
- > For research on the impact of different service providers on racial and ethnic disparities and outcomes, \$395,926 to the New York Academy of Medicine, New York.
- > *Building Community Supports for Diabetes Care*. Renewal awards to eight sites, totaling \$3 million.
- > *Southern Rural Access Program*. Awards to eight sites, totaling \$5.8 million.

Tobacco Use

- > *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy*.
 - Awards to three sites, totaling \$151,407.
 - For the National Program Dissemination Office, a renewal award of \$504,952 to the University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
- > *SmokeLess States®: National Tobacco Policy Initiative*. Award of five special opportunity grants, totaling \$1.1 million.
- > *Tobacco Policy Change: A Collaborative for Healthier Communities and States*. Four awards, totaling \$487,074.

Vulnerable Populations

- > *Taking Health Care Home: National Initiative to Reduce Chronic Homelessness Through the Creation of Supportive Housing*. An award of \$6 million to the Corporation for Supportive Housing, Oakland, Calif.
- > For the National Partnership to Build Healthier Communities, \$3 million to Living Cities: The National Community Development Initiative, New York, N.Y.
- > *Faith in Action*. Awards to 14 sites, totaling \$490,000.
- > *Local Initiative Funding Partners Program*. Awards to 11 sites, totaling \$4.1 million.
- > *New Jersey Health Initiatives*.
 - Awards to two sites, totaling \$120,494.
 - For implementing the Phase II pilot of a management capacity-building program for the managers of small- to medium-sized health agencies in New Jersey, \$207,320 to the University of Pennsylvania School of Arts and Sciences, Philadelphia.

Other

- > For promoting philanthropy in professional sports to improve community health, \$964,619 to Third Sector New England, Boston.
- > For building advocacy expertise among RWJF grantees, \$126,508 to the Alliance for Justice, Washington.
- > For the National Nonprofit Data System: Building for the Future, \$100,000 to the Urban Institute, Washington.
- > *Changes in Health Care Financing and Organization*. Awards to seven sites, totaling \$1.85 million.
- > For improving disaster response preparedness and education in Central New Jersey, a renewal award of \$266,516 to the American National Red Cross, Central New Jersey Chapter, Princeton, N.J.
- > For a neighborhood family support services program, a renewal award of \$559,001 to Renaissance Community Development Corp., Somerset, N.J.
- > For a camping program for health-impaired children, a renewal award of \$394,000 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, a renewal award of \$450,000 to New Brunswick Tomorrow, New Brunswick, N.J.
- > Support for the 2004–2005 campaign, a renewal award of \$307,125 to the United Way of Greater Mercer County, Lawrenceville, N.J.

PEOPLE

ELAINE CASSIDY, Ph.D., M.S.Ed., joined RWJF in July as a program officer in the Research and



Evaluation Unit. Previously, she was with the unit as a postdoctoral fellow. Before coming to the Foundation, Cassidy held research, administrative and teaching positions at the University of Pennsylvania. She earned her Ph.D. in school, community and child clinical psychology and an M.S.Ed. in psychological services from the University of Pennsylvania.

CATHERINE MALONE, M.B.A.,

joined RWJF and the Nursing Team in the Health Care Group in June as a program associate. Most recently Malone was the activities director for transitional care at St. Peter's Hospital, New Brunswick, N.J. She received her



M.B.A. from Georgian Court University, Lakewood, N.J.

MARJORIE PALOMA, M.P.H.,

joined the Foundation in July as a program associate with the Tobacco Team and Health Group. Most



recently, she managed the Wisconsin Tobacco Quit Line in Madison. Paloma

received her M.P.H. from Columbia University, New York.

PROMOTIONS

MARY CASTRIA, M.B.A., C.P.A., was promoted to

controller in July after serving as

assistant controller since 2001. Prior to coming to RWJF, she was the associate vice president for financial affairs and controller for the Juilliard School in New York City.

FAREWELL

KIM LOCHNER, program officer, Health Group, left the Foundation in June to become a senior fellow at the National Center for Health Statistics in Hyattsville, Md.

ENNISE WILLIAMS, Web production associate, left the Foundation in June to move to Arizona.

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idea, maybe only one nurse and one or two patients are involved; if the idea seems promising, it is refined until it's ready to be tested with more patients and staff.

In one case, the staff realized that a lot of time was being wasted because different departments were not communicating efficiently with each other. A nurse on the medical-surgical floor waiting for X-rays would call the radiology technician, but if no one was at the desk, the nurse couldn't get the information needed. The staff decided to buy several cell phones to keep in touch with the other departments when people were away from their desks. It sounds like such a small change, but it saved an enormous amount of time.

Another example involved pain medications. For safety and security reasons, there usually is just one set of keys for the cabinet where narcotics are stored on the hospital floor. You can imagine that on a floor of 60 patients, if even only half of them are in pain at any one time, nurses are always searching for that one set of keys.

Patients in pain have to wait too long for medication. The staff at one prototyping hospital decided to give all the nurses a set of keys and developed a system to account for every key at the end of each shift.

There are countless small changes such as these that can make a difference in the work culture, and, added together, can help improve quality.

And what about the body component?

HASSMILLER—We have commissioned the Center for Health Design (Concord, Calif.) to prepare a research paper summarizing the scientific literature on different aspects of the built environment—access to nature, light, noise, materials used, infection control. One reason we are interested in this is that a huge hospital construction boom is going on now—a projected \$200 billion in new construction and major renovation will take place in the next decade. Why not use the best design features, based on the latest science for those new and renovated hospitals? The data are accumulating about the

benefits of good design for both patients and hospital workers, and on the cost-effectiveness of using evidence-based design.

Will improving quality through the nursing initiative save money?

HASSMILLER—We see the need to assess the financial implications of TCAB innovations and our other nursing work as a central mandate. We have to be vigilant as to what these interventions cost, what the return on investment will be. We believe many of these changes will increase efficiency and improve patient outcomes and staff satisfaction—and ultimately, nurse recruitment and retention. Whether this will translate into overall savings for the health sector is an open question, because at the same time the U.S. population is aging, and there are many other forces at work.

I'm amazed that hospitals are contracting with international consulting firms to go into other countries and bring nurses to the United States. Hospitals are paying huge signing bonuses and higher and higher rates for agency nurses. But all of these are just

quick fixes and wasted money if the hospitals do not retain the nurses. I firmly believe that it would be far better to invest in keeping the nurses they have, especially with just one nurse turnover costing an average of \$50,000.

Nurses are leaving the hospital setting in large part because they feel they can no longer provide good care for their patients. Trying to take care of people in a high-stress atmosphere, with a high probability of errors, is just too much for many people. We really do have to get back to creating environments that put patients first. When you put patients first, you automatically help nurses do their best work—efficiently, effectively, and with great pride and satisfaction.

—INTERVIEW BY

LAURIE JONES

For more information on the Foundation's nursing initiatives, see www.rwjf.org/nursing.