ADVANCES®

The Robert Wood Johnson Foundation Quarterly Newsletter

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Environmental Changes Can Reduce College Binge Drinking

In the dozen years that researchers at the Harvard School of Public Health have been studying college binge drinking, the news, for the most part, has not been positive.

Despite increased attention among university administrators and numerous attempts at intervention, the rate of binge drinking has remained steady at most colleges in the United States since 1993. In short, many students continued to drink dangerous amounts of alcohol in a short time on a regular basis. So far in the 2004–05 academic year, seven college students have died from alcohol poisoning. A recent study sponsored by the National Institute of Alcohol Abuse and Alcoholism conservatively estimates that some 1,400 college students' deaths can be attributed to alcohol use each year.

Now comes a ray of hope. For the first time, there is empirical evidence that efforts to change key environmental influences around campuses can lead to reductions in alcohol consumption and in the harm associated with binge drinking.

"We can't point to any one magic bullet, but we can say a comprehensive approach focused on environmental prevention policies does make a difference," says Elissa Weitzman, Sc.D., lead author and co-principal investigator of the preliminary evaluation of The Robert Wood Johnson Foundation national program, *A Matter of Degree: Reducing High-Risk Drinking Among College Students.*

The program, launched in 1997 at 10 colleges and universities, is aimed at changing the environments on and around campuses that promote heavy alcohol consumption by fostering collaboration among college administrators, local community leaders, landlords, business owners, campus and local law enforcement officials, and parents.

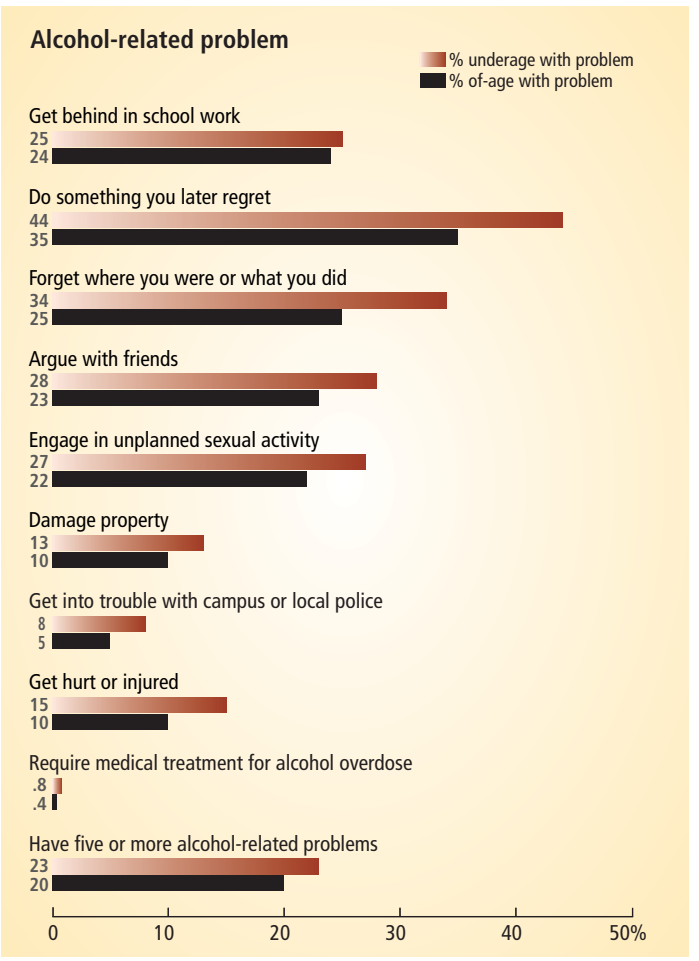
For the preliminary evaluation, Weitzman and colleagues monitored the program from 1997 through 2001. The results were published in the October issue of the *American Journal of Preventive Medicine.*

"Though the change is modest and the results preliminary, I think it is still very exciting to see what may be the beginning of change in the national picture," says Henry Wechsler, Ph.D., a study co-author and co-principal investigator. Wechsler is director of the national College Alcohol Study, and a lecturer in the department of society, human development and health at the Harvard School of Public Health.

"For years we have looked at numerous approaches and found no change at schools that try these

See **Binge Drinking**—page 2

Of students who drank, underage college students were more likely than their of-age peers to suffer the following alcohol-related problems:



Source: Wechsler H et al. "Environmental Correlates of Underage Alcohol Use and Related Problems of College Students." *American Journal of Preventive Medicine,* (19)1: 24–29, 2000.

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From **Binge Drinking**—page 1

approaches," says Wechsler. "So it is very heartening to see a change at last."

Part of the problem with many past approaches was their limited scope, according to Wechsler.

"For a long time, many colleges took the approach of just offering students alcohol education programs and attitude-change programs," says Wechsler. "They concentrated solely on the students. But the reality is students are not the only contributors to this problem."

Urging students to avoid drinking heavily easily can fall on deaf ears, for example, if nearby bars regularly offer half-price beers and liquor stores offer reduced-price kegs every weekend.

"The idea is to use an approach focused on controlling the surrounding environment so it's not cheaper for students to get drunk than to go to the movies or to have a beer than buy a bottle of water," says Wechsler.

The preliminary evaluation of *A Matter of Degree* found that the most important factor in determining effectiveness was the extent to which each participating college implemented the program.

Researchers studied drinking and harm patterns from the 10 *A Matter of Degree* schools and compared them to patterns at 32 matched colleges from the national College Alcohol Study. They also divided the *A Matter of Degree* program colleges into two groups, based on how fully they implemented the program.

The result? Reductions in drinking and related harms were found at the five *A Matter of Degree* program schools that fully implemented the environmental policies. No reductions were found at the five program schools that implemented fewer changes or at the 32 comparison colleges.

"The key difference is the degree to which the schools and the communities were able to change the environmental features on and around campus," says Weitzman.

Among the *A Matter of Degree* environmental initiative policies are changes in pricing and promotion of alcohol near campus, such as eliminating high-volume, low-cost specials at bars; limiting availability of alcohol to young people; mandatory training of those who serve alcohol; required registration for purchasers of kegs; expansion of substance-free residence halls; and promotion of alcohol-free activities on campus.

The program, when fully implemented, also develops and strengthens links and cooperation among supervising adults at the university and in the surrounding communities, as well as with students' parents.

Among the schools that fully implemented the *A Matter of Degree* program, the study found between 5 and 11 percent reductions in rates of binge drinking, frequent intoxication, taking up binge drinking in college and in "usually binging when drinking." Also at these schools, there was an 18 percent reduction in alcohol-related problems among students who drank alcohol, including fewer missed classes, less trouble with police and fewer injuries. In addition, these schools reported 10 percent fewer secondhand effects from other students' heavy alcohol use, such as vandalism and interrupted sleep or study time.

Alcohol consumption and harm patterns did not decrease at the five schools that implemented fewer of the *A Matter of Degree* policies.

Researchers acknowledge that fully implementing the program policies requires considerable effort by college administrators and community leaders.

"It's definitely an investment," says Wechsler. "It requires strong commitment because there will be some opposition to some of the policies. But given the number of deaths and injuries and ensuing litigations associated with heavy alcohol use by students, I believe schools will recognize the need to take action."

The results of the preliminary evaluation show that, as with other public health issues, a focus solely on individual behavior change often falls short in bringing about significant health improvements.

As an analogy, Weitzman cites the fluoridation of water. "Health officials for many years urged individuals to brush their teeth as a way to prevent cavities. But the fluoridation of water was the real transformative moment, because it shifted the approach from relying only on individual behavior to also relying on changes in the environment."

It was this comprehensive approach that brought about significant health improvements, says Weitzman.

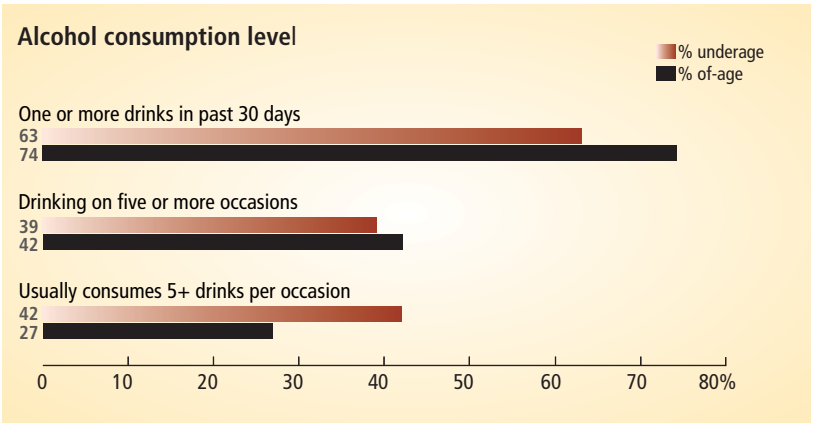
In a similar way, changing environmental factors is essential in any effort to reduce the incidence of binge drinking and associated risks.

"Studies have shown that college students drink more alcohol than their peers who do not go to college," says Wechsler. "There is something about the college environment that helps to increase the drinking levels among students, and that includes marketing, targeting of college students by the alcohol industry, heavy advertising of alcohol around college sports, and low-price specials in bars and liquor stores. We now have evidence that changing that environment can make a difference."

—LAURIE JONES

For more on *A Matter of Degree* visit *www.alcoholpolicysolutions.net.* For more on the evaluation of the program see *www.hsph.harvard.edu/amod.*

Percentages of Underage and Of-Age Students Who Drank:



Source: Wechsler H et al. "Environmental Correlates of Underage Alcohol Use and Related Problems of College Students." *American Journal of Preventive Medicine,* (19)1: 24–29, 2000.

Fostering Continued Change in Tobacco Policy

After more than a decade of continuous effort in the national campaign to reduce tobacco use, The Robert Wood Johnson Foundation's aggregate investment of nearly $450 million has helped alter social dynamics and change the tobacco policy landscape. Smoking's hip image has been eroded. Smoking rates have declined across all age groups. Thirty-one states and the District of Columbia have created effective disincentives to smoking by increasing taxes on tobacco products. Seven states—California, Connecticut, Delaware, Maine, Massachusetts, New York and Rhode Island—now have comprehensive clean-indoor-air laws. Yet more work needs to be done; every year the lives of more than 440,000 people are cut short by tobacco-related disease.

To sustain momentum, build on hard-won gains and capitalize on accumulated expertise, the Foundation recently issued the first round of grants comprising a new RWJF national initiative. *Tobacco Policy Change: A Collaborative for Healthier Communities and States* is a three-year, $12-million program that represents an evolution of the Foundation's previous efforts in tobacco control. It focuses on providing funding and technical assistance for established, credible advocacy organizations—local, regional, national and tribal groups—with a track record in forging strategic partnerships and advocating for government and private-sector policy changes. Grants under this program will be aimed at further reducing tobacco use through policy advocacy, though grantees need not have worked previously in tobacco control to receive funding.

"This is really about tapping into organizations that we haven't worked with before, groups that have a lot of experience in community organizing and policy advocacy for social change, whether or not that experience is tobacco-related," says Michelle Larkin, R.N., M.S., an RWJF senior program officer. "It's exciting because this is the first time we've done a large initiative that is focused across the nation, at the local and state levels. We hope to expand the tobacco-control infrastructure and build a more sustainable movement."

By requiring recipients to guarantee matching funds for any grant exceeding $50,000, the *Tobacco Policy Change* initiative plans to attract not just new partners but a commitment of new capital. "We want organizations to put up real dollars and demonstrate that they're going to be in this for the long haul, that this is going to be part of their institutional efforts, part of their culture as they move forward," says Joe Marx, an RWJF senior communications officer.

To maintain traction against a tobacco industry that spends more than $30 million per day to market its products (Federal Trade Commission, *Cigarette Report for 2001*), the Foundation must work with efficiency and strategic precision. This initiative will concentrate on populations most affected by tobacco use—minority communities, for example, and low-income regions of the country. Organizations currently funded by RWJF that work on tobacco policy advocacy will offer the new grantees their technical know-how.

"Essentially, what we're doing is taking advantage of the wealth of talent and expertise out there," Marx explains. "We're in a unique position with tobacco prevention and cessation where we have more than a decade of experience, so we've built up a knowledge base. Now we're going to put it to use in a highly integrated, coordinated way.

"We know how to achieve policy change. That's been our niche, and our grantees and staff understand these issues really well. Now we want to capitalize even more on what we've built."

—LEE GREEN

For more on the Foundation's tobacco initiatives see *www.rwjf.org/tobacco.*

Getting the "Truth" to Youths About Perils of Smoking

One of the most effective national, youth-focused anti-tobacco ad campaigns ever conducted may soon disappear for lack of funding. The truth® campaign, launched by the American Legacy Foundation in 2000 and targeted to at-risk teens, spreads sobering revelations about smoking's health impacts primarily through hard-hitting television spots, but also via radio, print and Internet ads. Funding for the campaign came from the tobacco industry under the 1998 Master Settlement Agreement.

The newly formed Citizens' Commission to Protect the Truth, a coalition of many of the top federal health officials over the past 40 years, hopes to salvage the ads by convincing the major tobacco companies—Philip Morris (Altria), R.J. Reynolds and Lorillard—to continue funding them. The commission is seeking to bolster its clout by collecting at least one million signatures from individuals who agree that the industry should finance public education about its products' perils. Anyone wishing to read and sign the petition can do so online at *www.protectthetruth.org.*

The tobacco companies are not enthusiastic about providing more money. "They say they're against youth smoking, but they think the ads are too tough," says commission Chairman Joseph Califano, Secretary of Health, Education and Welfare in the 1970s under the Carter administration, and currently chairman and president of the National Center on Addiction and Substance Abuse at Columbia University. "The fact that the cigarette companies are so determined to end the campaign is an indication of how effective it has been."

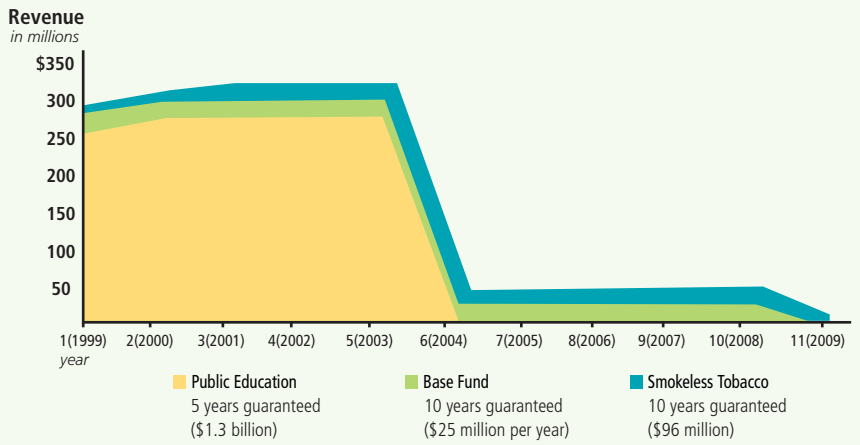
Smoking among American youth aged 12 to 17 dropped substantially from 2000 to 2003, the campaign's initial years. Three-quarters of surveyed children in that age range could accurately describe one or more of the truth ads, and 90 percent said the ads were convincing.

"The reason the tobacco companies are so opposed to this is because these are their replacement smokers," Califano says. "Most adult smokers were hooked in their early teens. We have to get the word out to these kids."

—LEE GREEN

Principal funding for the Citizens' Commission to Protect the Truth comes from the National Association of Attorneys General through a $1.5 million pass-through grant from the American Legacy Foundation.

Funding From the Tobacco Master Settlement Agreement



Source: *www.protectthetruth.org/truthcampaign.htm.*

Q&A with Victor Capoccia, Ph.D., M.A.

Foundation Focuses Attention on Quality And Availability of Addiction Treatment

The Robert Wood Johnson Foundation has made substantial investments over the years in the area of addiction. Much of the work has focused on reducing underage drinking, mobilizing communities and increasing public understanding about the harmful effects of drug use. While the prevention work is ongoing, the Foundation is now turning its attention toward improving the quality and availability of addiction treatment services. Victor Capoccia, Ph.D., M.A., leader of the Foundation's Addiction Prevention and Treatment Team, spoke recently about the strategy behind the team's new focus.

The Foundation is shifting away from using the term substance abuse. Why?

CAPOCCIA—We have consciously changed the name to addiction prevention and treatment, to reflect our perspective that addiction is a treatable *health* issue. There are other legitimate perspectives that view addiction as a justice system issue or as an issue of supply and demand. As a health foundation, we do not want our language and our programs to marginalize or stigmatize people.

Can you discuss the history of the Foundation's work in this area?

CAPOCCIA—Much of the work has focused on two major themes: how do we discourage underage alcohol use and increase the understanding of its harmful effects? And how do we mobilize communities and increase public understanding about the harmful effects of drug use? The Foundation has made substantial investments—about $380 million—in these two areas over the past 20 years.

One of our signature programs has been *Reducing Underage Drinking Through Coalitions*, an effort to create coalitions at the state level that promote policies that limit underage access to alcohol. Another national program, *A Matter of Degree: Reducing High-Risk Drinking Among College Students*, uses the same strategy through coalitions on college campuses to create environments around academic centers that discourage underage alcohol use.

One high-profile effort to increase public understanding of addiction issues was the creation of the Partnership for a Drug-Free America, which has leveraged millions of dollars of volunteer advertising in media-based public awareness campaigns about the harmful effects of misusing drugs. The Partnership entered into a relationship with the federal government to expand exponentially its presence and impact.

Another program, *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol,* helped local communities create coalitions of concerned citizens, including political, public safety, religious and educational leaders, to develop ways to reduce the demand for underage alcohol and drug use in their community. When *Fighting Back* was created in the late 1980s and early 1990s, urban neighborhoods were subject to violence in the streets and immense loss of human potential because of the drug trade. *Fighting Back* gave communities specific tools and programs to increase treatment availability, report criminal activity, and educate families about the harmful effects of underage alcohol and drug use.

What is the Foundation's current approach to drug and alcohol addiction programs?

CAPOCCIA—We are going to continue to support and learn from the programs designed to prevent underage alcohol use and the misuse of drugs. One of the observations we have heard from people working in alcohol and drug prevention and treatment is that while we have done a considerable amount of work in prevention, as of 2003 there are still 22.2 million Americans who need treatment for alcohol and/or drug use problems and addiction. These are the people the prevention programs are not reaching, for one reason or another. When we looked at the system of treatment that was available, we found it was not adequate to the task, either in terms of quantity or quality. So our focus, along with prevention programs, is to improve the treatment of alcohol and drug addiction. Over the course of the next three years, we will be making investments toward measuring the quality of treatment, overcoming the barriers to achieving quality care in local treatment settings, and working with states on how they can use their significant roles to support quality care.

What does the Foundation's shift in focus mean for prevention?

CAPOCCIA—Addiction to alcohol and drugs is a condition like any other chronic medical condition, and therefore requires a continuum of intervention that includes prevention, education, self-management, community support and proven clinical interventions in medical settings. We want a holistic approach to this issue.

Let's think for a minute about other health and public health issues, for example, diabetes or injury from car crashes. In neither instance would a dichotomous approach that forces choices between prevention or treatment be accepted. It would be unthinkable to assume we didn't need emergency department medical services, because we have seat belts, air bags and speed limits. It would also be unthinkable to not make full medical care available to people with diabetes who failed to follow the dietary guidelines that controlled their condition. It is equally unacceptable to have an addiction treatment system that lacks the size and capability to deliver treatments proven to work. Prevention and treatment are integral components of a continuum of care needed to manage chronic illness, and we plan to continue supporting both.

Can you discuss the evidence-based approach to addiction treatment?

CAPOCCIA—Great strides have been made in the past 15 years to develop and test treatment interventions. We now understand that treatment for addiction to alcohol and/or drugs must be individually tailored to meet the unique biological, psychological, social and use history of each patient. This is different from the one-size-fits-all "program" that dominated treatment for many years. We also understand that the treatment plan for a given individual, like that of other chronic medical conditions, is derived from a combination of four categories of interventions: (1) pharmaceutical therapies; (2) specific behavioral clinical interventions; (3) community and environmental supports; and (4) time connected to treatment and recovery supports.

The first category has seen the development and limited use of several medications, including methadone, buprenorphrine and naltrexone, that either block or neutralize the effects of alcohol or a particular drug. Ignorance, lack of reimbursement and limited connections to medical systems unfortunately limit the use of these interventions.

The second category is represented by interventions such as motivational interviewing and contingency management. These are essentially therapeutic approaches that are highly regimented and targeted, eliciting an understanding of a person's readiness to change and his or her understanding of the consequences of behavior change.

The third category recognizes that community and environmental supports are needed by

See **Addiction Treatment**—page 8

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**

Health Care Costs Increasing at Slower Rate Since 2002

While health care costs rose by 7.4 percent in 2003, the increase was smaller than that in 2002, and marks a trend of slowing growth rates that began in 2002. Still, increases in health care spending outpaced economic growth by 3.6 percentage points.

In this study, the researchers examined spending for services covered by private insurance and found that a 2.1 percentage point drop in the growth of health care spending since 2002 reflected slower growth in hospital spending, physician care and especially, prescription drugs.

Growth in physician care spending dropped by 1.4 percentage points. The researchers say this decrease occurred in part because consumers and practitioners have completed their adjustment to reduced restrictions of more loosely managed care health plans.

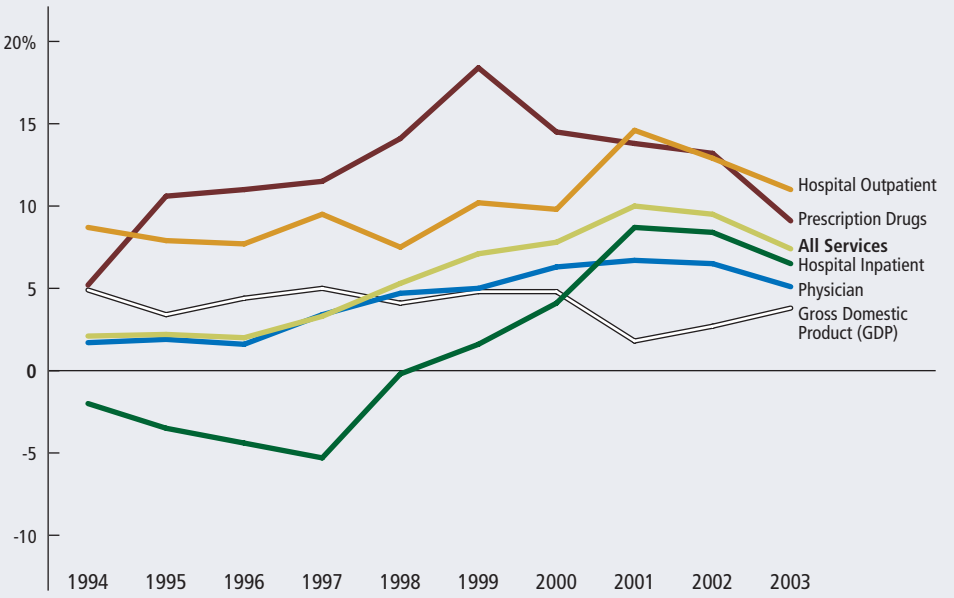
Growth in inpatient and outpatient hospital spending decreased by 1.9 percentage points each between 2002 and 2003. While hospital prices continued their upward trend, hospital spending growth declined because growth in hospital use declined, in part for the same reason that physician care declined. The study notes that hospital worker shortages, especially among nurses, have driven up wage rates, and hospitals have passed along these costs by raising prices.

Meanwhile, prescription drug spending growth dropped by more than 4 percentage points. The authors say spending has slowed in part because consumers are facing higher copayments and stronger incentives to choose generic brands.

Still, cost increases are being felt by those who buy private health insurance. While increases in premium rates slowed from 15 percent in 2003 to a still high 12 percent in 2004, patient cost sharing grew considerably.

The researchers state that higher patient cost sharing may reduce health care spending by inducing patients to use less care, but its potential to slow cost trends further is limited. Over time, the key driver of health costs is the adoption of new medical technologies. Until patients and health care financers scrutinize their use of and coverage for these technologies, health care costs "will likely continue to outstrip growth in the overall U.S. economy," the researchers say.

Annual percentage change per capita in health care spending and gross domestic product, 1994–2003



Source: Health care spending data are the Milliman USA Health Cost Index ($0 deductible). Gross Domestic Product is from the U.S. Department of Commerce, Bureau of Economic Analysis.

Notes: GDP is in nominal dollars. Estimates may differ from past reports due to data revisions by Milliman USA and the Bureau of Economic Analysis.

Strunk BC and Ginsburg PB. "Tracking Health Care Costs: Trends Turn Downward in 2003." *Health Affairs* (Web Exclusive), June 9, 2004, W4 354–362.

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

Medicaid Fees Rise, But Physician Participation Still Low

Bolstered by strong economic growth, states increased their Medicaid physician fees by an average of 27 percent between 1998 and 2003. Still, Medicaid pays considerably less for patient care than other types of insurance, and doctors are "much less likely to accept new Medicaid patients than other insured patients," a recent study concludes.

The researchers collected fee data from a state-by-state survey conducted by the Urban Institute and the Center for Studying Health System Change. The study examined changes from 1998 to 2003 in fee-for-service Medicaid rates, how Medicaid rates compared with Medicare fees, and analyzed changes in the proportion of doctors accepting new Medicaid patients. Data on doctors accepting new Medicaid patients were drawn from the Community Tracking Study physician survey.

Overall, 36 states raised their physician fees, seven states did not change them and the District of Columbia lowered its fees. Interestingly, the ranking of state fees relative to each other remained virtually unchanged. Most of the increases in physician fees were fueled by large rate increases for primary care services. Their raises were four times as high as those received for obstetrical care and other services. The researchers suggest states raised rates to increase patients' access to primary care.

But these increases only slightly narrowed the gap between Medicaid and Medicare physician fees. Between 1998 and 2003, Medicaid fees increased from 62 percent to 69 percent of Medicare fees. Arizona was the only state to increase Medicaid fees enough to surpass Medicare fees.

The study found that Medicaid fee hikes had only a modest impact on the proportion of doctors accepting new Medicaid patients between 1997 and 2001 (the time frame for which they have provider participation data). The rate rose from 61 percent to 62 percent. But states that offered the largest pay increases for primary care services were able to increase the participation of primary care physicians by more, in comparison.

Taking a longer view, the study's authors note that despite a very prosperous time between 1998 and 2003, states over the past decade have not increased Medicaid fees by much more than the rate of inflation. Access to care may be at "increasing risk" due to the recent downturn in state economies.

Zuckerman S, McFeeters J, Cunningham P and Nichols L. "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation." *Health Affairs* (Web Exclusive), June 23, 2004, W4 374–384.

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

One Perspective on Improving the Medicare Prescription Drug Coverage: Price Controls Could Help Eliminate the Coverage Gap

Americans pay more for prescription drugs than do citizens of other industrialized nations. This creates a significant financial burden for seniors with multiple chronic conditions who fill multiple prescriptions each month. The Medicare Prescription Drug, Improvement and Modernization Act, signed into law in December 2003, sought to eliminate this burden. It provided seniors with outpatient prescription drug coverage for the first time in the program's history. Unfortunately, there are gaps in coverage. Seniors who spend up to $2,250 on outpatient prescription drugs are covered for 75 percent of that expense. At the opposite end of the spending continuum, Medicare covers 95 percent of prescription drug expenses above $5,100. But there is a big coverage gap, commonly known as the "doughnut hole," for prescription drug spending that falls somewhere in the middle: Medicare provides absolutely no coverage for prescription drug expenses that range from $2,250 to $5,100 annually.

This doughnut hole was purposely crafted into the legislation to limit Medicare drug spending to $400 billion over a 10-year period, and simultaneously attract seniors with smaller drug bills and protect those with larger bills. Could the Medicare program redesign the prescription drug coverage and eliminate the doughnut hole if it "paid the same prices for pharmaceuticals as other countries pay?"

To answer this question, this study's authors compared average wholesale prices for a market basket of 30 drugs with the highest total spending in the United States during January through September 2003 with prices for the same market basket of drugs in Canada, France and Great Britain during the same time period. Assuming a 20 percent discount in prices in the United States—because large purchasers typically pay less than the wholesale price—drug prices were significantly lower in all three countries: 34 percent lower in Great Britain, 40 percent lower in Canada and 48 percent lower in France.

Modeling an alternative prescription drug benefit that eliminated the doughnut hole and discounted the costs of prescription drugs by 45 percent, the investigators compared projected spending by beneficiaries and Medicare's portion of that expense with estimates for the Medicare prescription coverage scheduled to go into effect. Under the current legislation, total drug spending for beneficiaries in 2006 was projected at $101.9 billion, with Medicare covering $44.5 billion of the bill. Under the alternative benefit, total spending in 2006 would be only $73.6 billion, with the same $44.5 billion financed by Medicare. Both out-of-pocket costs for beneficiaries and costs to third-party payers dropped significantly under the alternative benefit.

"It is possible to eliminate the doughnut hole if Medicare pays drug prices that are similar to the prices of Canada, the United Kingdom, and France," the authors conclude. However, they caution, "the trade-off is less pharmaceutical R&D."

Anderson GF, Shea DG, Hussey PS, Keyhani S and Zephyrin L. "Doughnut Holes and Price Controls." *Health Affairs* (Web Exclusive), July 21, 2004, W4 396–404.

Laurie Zephyrin. M.D., and Salomeh Keyhani, M.D., were Robert Wood Johnson Clinical Scholars at the time of this research.

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

Spending on Medicare Prescription Drug Benefits In 2006

	Model Assumptions		Drug Spending by Medicare Beneficiaries in 2006 (billions of dollars)			
Model Version	Stop-Loss Level	Price Discount	Total Drug Spending	Medicare	Out-of-Pocket	Third-Party Payers
Current legislation	$5,100	20%	101.9	44.5	31.0	26.4
Alternative benefit	$2,250	45%	73.6	44.5	19.1	9.9

Source: Authors' simulation using Medicare Current Beneficiary Survey Data.

Assessing Emergency Preparedness at the Community Level

Localities have progressed in preparing for public health emergencies since the terrorist attacks of 2001, but considerable gaps remain. Researchers in this study assessed the readiness of 12 communities more than a year after the attacks, and after the federal government gave states $1.1 billion to develop anti-bioterrorism plans.

The Center for Studying Health System Change interviewed local officials in public health departments, hospitals, emergency management agencies and various government offices on six topics: emergency planning, disease surveillance, lab capacity, informing the public about health risks, information technology and workforce training.

The researchers reported that communities were furthest along in developing emergency plans in which numerous agencies knew their response roles. Only two of the 12 localities had the surveillance capacity to detect unusual clusters of disease, although systems were being planned in another six sites. Lab capacity varied. In several sites the local public health agency did not have its own lab and had to send samples to the state lab, which sometimes took up to two weeks to report results.

The ability to respond to public queries about certain health risks, as well as disseminate information, also varied. One community reported relying on the state and federal government to educate the public. Communications among agencies and information technology were among the weakest areas of preparedness, although some progress is being made. In Seattle, for example, the city developed a system to link police, fire, hospitals and the local public health agency.

Finally, localities differed in their sophistication in training the public health workforce for emergencies. Researchers reported that this variation can be explained in part by the presence or absence of several factors that contribute to better preparedness: strong leadership, experience with other public health threats, successful collaborations and adequate funding.

Funding remains a huge barrier to improvements. Researchers note that state budget deficits have weakened public health departments, improving and maintaining bioterrorism preparedness is expensive, and a number of states had not yet distributed their federal grants to localities. They recommend that policy-makers help communities by funding information technology systems, providing technical assistance and training to public health staff and bolstering the public health worker supply through recruitment programs.

McHugh M, Staiti AB and Felland LE. "How Prepared Are Americans for Public Health Emergencies? Twelve Communities Weigh In." *Health Affairs*, 23(3): 201–209, 2004.

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

Are Income Inequality and Population Health Linked?

In the 1970s, the United States, the United Kingdom and other wealthy nations saw marked increases in income inequality within their populations. This gap between the rich and the poor—the uneven distribution of wealth within and among countries—had a detrimental effect on population health, the income inequality hypothesis theorized. In other words, on the flip side: "the more equally wealth is distributed, the better the health of that society."

In two large investigations, researchers looked at the effect of income inequality on population health within the United States and internationally. In their earlier review of 98 studies on this theme, the investigators found "little support for the idea that income inequality is a major, generalizable determinant of population health differences within or between rich countries." The United States, they discovered, was somewhat of an anomaly: "It is the country where income inequality is the most consistently linked to population health." This link, however, appeared to be weak and contextual, meaning that "in some contexts, income inequality contributes to some health outcomes." To better understand the strength and scope of the link in the United States, the investigators subsequently examined trends in U.S. income inequality and mortality. In this second study, they looked specifically at income inequality in relation to national trends in mortality rates for heart disease, cerebrovascular disease, suicide and homicide, and among infants during the 20th century; and regional trends in these and other causes of death over the 30-year period 1968 to 1998.

By examining longer-term trends, the investigators found little evidence of a national or regional income inequality–population health link: heart disease was more closely linked with changes in its major risk factors than with changes in income inequality; infant mortality and stroke fell continuously while income inequality fluctuated; and suicide and homicide were only "partly consistent with the trends in income inequality." The authors conclude: "Theories concerning the determinants of population health [in regard to income inequality] fail to generate as much support when examined over longer periods of time."

Instead, they suggest, it is important to understand how "broad social and economic conditions in the population" are linked to specific risk factors that ultimately affect particular health outcomes. And, according to the authors, "such linkages change over time and place."

Lynch J, Smith GD, Harper S, Hillemeier M, Ross N, Kaplan GA and Wolfson M. "Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review." *Milbank Quarterly*, 82(1): 5–99, 2004.

Lynch J, Smith GD, Harper S and Hillemeier M. "Is Income Inequality a Determinant of Population Health? Part 2. U.S. National and Regional Trends in Income Inequality and Age- and Cause-Specific Mortality." *Milbank Quarterly*, 82(2): 355–400, 2004.

John Lynch, Ph.D., M.P.H., M.Ed., and George Davey Smith, M.D., Ph.D., were Robert Wood Johnson Investigator Awards in Health Policy Research fellows at the time of this research.

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

As Hospital Nurses Work Longer Hours, Is Patient Safety Jeopardized?

A combustible mixture of sicker patients, abbreviated lengths of stay and a shortage of nurses already threatens the safety of hospital patients. On top of this, anecdotal reports indicate that hospital staff nurses are working longer shifts—sometimes 16 and even 24 hours at a stretch. Currently, no state or federal restrictions limit the number of hours nurses may voluntarily work in a 24-hour or seven-day period. Are longer hours among staff nurses becoming the norm? And do extended shifts increase the potential for human error and compromise nursing care? Because "systematic national data" on trends in working hours among hospital nurses and the consequences of those trends are lacking, these investigators examined work patterns and the frequency of errors and near errors among a random sample of hospital nurses across the country.

The researchers recruited full-time hospital staff nurses from the rolls of the American Nurses Association; 393 nurses completed and returned logbooks covering a four-week period that detailed the following: scheduled and actual hours worked; time of day worked; overtime worked; days off; sleep and wake patterns; moods; caffeine intake; and any errors or near errors that occurred during their work periods.

In all, participating nurses worked 5,317 shifts. During nearly 40 percent of these shifts, nurses worked 12.5 or more consecutive hours. Longer shifts were not uncommon: 14 percent of nurses worked 16 or more consecutive hours at least once during the four-week study period. In general, "hospital staff nurses worked longer than scheduled daily." In fact, "nurses reported leaving work at the end of their scheduled shift less than 20 percent of the time." Fully one-third of the nurses worked overtime each day they worked.

Did the investigators find a relationship between these longer hours and nursing errors? Nurses' logbooks provided evidence of this. The nurses reported a total of 199 errors and 213 near errors during the study period. The likelihood of making an error increased as the number of hours worked increased: nurses working shifts of 12.5 hours or more were three times more likely than their colleagues working shorter shifts to report an error. "Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled."

The authors conclude that "hospital staff nurses' long hours may have adverse effects on patient care." They suggest that hospitals curtail the routine use of 12-hour shifts and eliminate lengthy overtime.

Rogers AE, Hwang W, Scott LD, Aiken LH and Dinges DF. "The Working Hours of Hospital Staff Nurses and Patient Safety." *Health Affairs*, 23(4): 202–212, 2004.

Linda Aiken, R.N., Ph.D., was a Robert Wood Johnson Investigator Awards in Health Policy Research fellow at the time of this research.

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

Social and Economic Disparities Create a Two-Tiered Nursing Home Care System

The quality of nursing home care in the United States has been a concern for decades, with most believing that care is uniformly poor. However, a recently released study contends that many quality problems are concentrated in a minority of nursing homes. Using primarily data from the Centers for Medicare & Medicaid Services, the investigators examined the characteristics of 14,130 nonhospital-based U.S. nursing homes, the residents they serve and the quality of care they provide, and found evidence of a "two-tiered system differentiated by quality." The lower tier—defined as the 13 percent of facilities that care for a resident population that is at least 85 percent Medicaid—has the fewest resources, both financial and human.

Lower-tier nursing homes are located in poorer communities; employ significantly fewer registered nurses, nurse practitioners and physician assistants; and have significantly more quality deficiencies than non-lower-tier facilities. In addition, lower-tier nursing homes are almost twice as likely to care for residents with psychiatric conditions. There also are racial differences by tier: Only 9 percent of white nursing home residents are in lower-tier facilities, while 40 percent of African-American residents are in these facilities.

"A dependence on Medicaid affects [a] nursing home's staffing, case mix, occupancy, and risk of termination from public reimbursement programs," the authors conclude. The largest purchaser of nursing home services in the United States, Medicaid, reimburses nursing homes at rates that are often "below the actual cost of providing care."

With fewer opportunities to subsidize inadequately reimbursed care—because of Medicare's fixed-price system, competition from assisted-living facilities for profitable private-pay patients and managed care organizations' reluctance to cover these costs—the authors suggest that new public policies are needed that "promote the natural evolution of nursing home care."

They recommend the following four policy alternatives to support lower-tier nursing homes: (1) selectively increase Medicaid reimbursement rates only in those states where rates are insufficient to cover the cost of care, and then only for nursing homes that are willing to make quality improvements; (2) increase lower-tier nursing homes' access to managerial talent by offering educational loan repayment or other incentives to encourage top managers to seek and remain at positions in these facilities; (3) rescue chronically failing facilities—under the direction of state and municipal governments—and provide short-term leadership through a "SWAT" team approach using retired health care executives; and (4) provide risk pools for residents forced to relocate because of lower-tier nursing home closures. Policies could provide incentives for high-tier nursing homes to assume some of these residents through a higher Medicaid payment rate or mandate them to accept displaced residents as a condition for Medicare participation. Additionally, the government should mandate that a substantial portion of the resources now being devoted to nursing home quality improvement be focused on lower-tier facilities in order to target improvement efforts where they could do the most good.

Mor V, Zinn J, Angelelli J, Teno JM and Miller SC. "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care." *Milbank Quarterly*, 82(2): 227–256, 2004.

Vincent Mor, Ph.D., and Jacqueline Zinn, Ph.D., were Robert Wood Johnson Investigator Awards in Health Policy Research fellows at the time of this research.

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

Which Anti-Smoking TV Ads Work Best with Teens?

Anti-tobacco ads that generate fear or sadness by showing the diseases caused by smoking are more effective in reaching youths, compared to ads that are funny and entertaining or focus on what is or isn't cool, according to a study of a television campaign that ran in Massachusetts in 1993.

The study contradicts previous findings that anti-tobacco ads are more effective in reaching youths when the ads identify smoking as being socially unacceptable because it can cause bad breath, tainted teeth and the disapproval of peers.

Some of the ads in the study relied on humor to mock tobacco companies or teenagers who smoke, others were meant to show that being smoke-free was attractive while smoking was not, and still others portrayed the serious illnesses caused by smoking. A panel of 104 youth judges rated the ads on the amount of emotion they aroused in the viewer, whether the emotion was positive (funny, happy, entertaining) or negative (frightening, sad, disturbing), and whether the ad was thought-provoking and believable. It turned out that ads arousing negative feeling (those featuring the serious consequences of smoking) were also the ones rated as highly emotional and thought provoking. Those arousing positive feelings were rated as less emotional and less thought-provoking by the judges.

The researchers put the information from these ratings together with results from a survey of 618 youths across Massachusetts. The survey asked respondents if they recalled having seen the ads on television and if so, how effective they were as anti-smoking messages. The ads that survey respondents recalled as being most effective against smoking were those that the panel of judges said evoked highly powerful and negative emotions. Ads that relied on humor, those that portrayed poor social acceptability of smoking, or ads that featured youth celebrities, such as female soccer players, did not score as highly among survey respondents on either recall or effectiveness. Females had higher recall than males across all ad categories.

"Girls tended to perceive ads as more effective than boys, and minority youths perceived the ads as significantly more effective than whites," the researchers write. "Teenagers who did not own a tobacco promotional item saw the ads as significantly more effective than those who did."

In addition, researchers found that airing ads repeatedly had a two-sided effect. The more an ad was aired, the more it was likely to be remembered. But the more frequently respondents viewed the ad, the less effective it was perceived, a phenomenon the researchers call "wear-out."

Biener L, Ming J, Gilpin EA and Albers AB. "The Impact of Emotional Tone, Message, and Broadcast Parameters in Youth Anti-smoking Advertisements," *Journal of Health Communication*, 9: 259–274, 2004.

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

Grant Results Reports

The Robert Wood Johnson Foundation generates a Grant Results Report on almost all its independent grants after they are closed, as well as regular reports on its national programs. These reports detail the results of the Foundation's work, including the products produced. Since July 2004, four new National Program Reports and 90 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:

- **What You Should Know About Prescription Drugs**
  California Health Decisions developed a statewide pilot education initiative called *Healthcare 101: Choosing and Using Prescription Medicines*. As part of the initiative, they conducted telephone surveys and developed fact sheets, brochures and educational tools. The coalition partner, California Public Employees' Retirement System (CalPERS), developed a seven-minute video, *Healthcare 101: What You Should Know about Prescription Drugs*, based on the California Health Decisions education tools. The fact sheets were collected into a brochure, "What Every Consumer Should Know," which can be downloaded for free at *www.cahd.org/consumerservice.html*. The video is free to all CalPERS members from their Web site at *www. calpers.ca.gov*. See the Grant Results Report at *www.rwjf.org/reports/grr/041745.htm.*

- **Web-Based Database for Tobacco-Dependence Treatment**
  In 2001, the Society for Nicotine and Tobacco, working in partnership with the World Health Organization (WHO), unveiled a Web-based database on tobacco dependence treatment. The site serves as an evidence-based Internet resource for researchers, policy-makers and practitioners working in the field of tobacco-dependence treatment. The site provides key findings and recommendations, areas for further study and a downloadable PowerPoint slide kit. Information can be downloaded at *www.treatobacco.net*. See the Grant Results Report at *www.rwjf.org/reports/grr/042510.htm*.

- **Forum on Affordable Assisted Living**
  Volunteers of America held a roundtable on affordable assisted living in 2002 in Washington. The group convened 37 people with expertise in housing, health services and assisted living to discuss key issues. As a result, a 112-page paper, *Affordable Assisted Living: Surveying the Possibilities,* was issued by the Joint Center for Housing Studies at Harvard University. The paper reviews demographics, examines lessons from market-rate assisted living, presents various funding mechanisms for affordable facilities, profiles successful projects, and offers policy options and recommended strategies. The paper can be downloaded at *www.jchs.harvard.edu/publications/seniors/03-1_schuetz.pdf*. See the Grant Results Report at *www.rwjf.org/reports/grr/046283.htm.*

- **Handbook on Improving the Public Health System**
  In 2002, the Center for Public Health Practice of the Rollins School of Public Health at Emory University published *The Public Health Competency Handbook: Optimizing Individual and Organizational Performance for the Public's Health*, which outlines the crucial competencies needed by public health agencies to put newly defined performance standards into practice. The handbook also assists health departments in tailoring these competencies to their local situation. It provides an overview of the nation's public health system in transition, an examination of the seven organizational competency areas by organizational level and practice setting, strategies and tools for institutionalizing organizational competencies and a section on competency-based performance management. The 276-page handbook can be purchased for $85 at the Public Health Foundation Web site, *http://bookstore.phf.org/prod284.htm*. A Web site that supports the handbook, including related topics, resources and training material, can be found at *www.populationhealthfutures.com*. See the Grant Results Report at *www.rwjf.org/reports/grr/044484.htm*.

See **Grant Results Reports**—page 12

From **Addiction Treatment**—page 4

people to go to treatment and stay in it. For example, a mother who is addicted to alcohol and has a 3-year-old child cannot go into a day program without appropriate child care. Access to and retention in treatment are more remote for this mother if the treatment site is not available by public transportation or she does not have a car. Her ability to maintain a successful connection to aftercare would be threatened by returning to a living environment in which her spouse or social network are steeped in excessive alcohol use. These "wraparound" services have been demonstrated to be essential ingredients in successful treatment for many people.

The fourth category of intervention recognizes that the amount of time that one is connected to treatment or aftercare supports is the strongest single predictor of effective treatment. This is consistent with the patient self-management and monitoring function found with diabetes, asthma and heart diseases.

Can you discuss the Foundation's current programs to strengthen addiction treatment?

Capoccia—*Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime* is a program aimed at making sure that when young people with addiction problems come in contact with the juvenile justice system, they get connected with treatment that is developmentally appropriate and of good quality. There is a focus on reinforcing family involvement because often, with the frustration of dealing with the youth's behaviors, the family connection is broken.

Paths to Recovery: Changing the Process of Care for Substance Abuse program has taken the quality-improvement principles perfected by the Japanese auto industry and applied them to the addiction field. The focus is on improving the process of getting people into treatment and keeping them there. The program looks at such questions as what is the phone system like? What is the paperwork process? How are you moving people through? What happens when a client does not show up? The goal is to reduce the delay between the first request for service and the first appointment for treatment, reduce no-shows, increase admissions and improve retention. The Foundation funded 12 sites in the first round, 12 sites in the second round and another 12 through a partnership RWJF has formed with the U.S. Department of Health and Human Services Center for Substance Abuse Treatment.

Looking ahead, we have a broad blueprint of programs in early stages looking at a number of issues. How does the state support improvement in quality? How do we continue to help provider organizations improve quality? How do we help consumers understand what quality is? Our journey continues, and we welcome partners to join in this effort to view and respond to addiction to alcohol and drugs with the same compassion and skill that we expect when other circumstances threaten our health.

—Interview by Laurie Jones

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

Arkansas Provides Startling Evidence of Childhood Obesity Epidemic

Arkansas is leading the country in its comprehensive approach to fighting childhood obesity, including measuring every public school student's body mass index (BMI) and reporting the confidential results to parents. BMI is a formula used to assess whether a person may be at risk for weight problems. For kids, results are broken down into one of four categories: underweight, normal weight, at risk for becoming overweight, or overweight.

In 2003 and 2004, researchers at the Arkansas Center for Health Improvement compiled data on nearly 346,000 schoolchildren and adolescents and disseminated reports to parents and schools. The results are alarming. Thirty-eight percent of schoolchildren in Arkansas are either overweight or at risk for becoming overweight—a figure more than 25 percent higher than national estimates. Among the findings:

- Approximately one-third of children entering kindergarten are already either overweight or at risk of becoming overweight.
- The problem worsens as children grow older. Between fifth and seventh grades, 42 percent of children are in one of these two risk categories.
- The problem affects children in all Arkansas school districts, spanning all income levels and demographic characteristics. While children of all ethnicities are affected, Hispanic boys and African-American girls suffer disproportionately high rates of overweight and obesity. This mirrors nationwide trends, which indicate prevalence is higher among racial and ethnic minorities and lower-income populations.

Mandatory BMI screening is just one requirement of Act 1220, a wide-ranging law passed by the Arkansas legislature in 2003 that is designed to combat childhood obesity through changes in school policies. But it's the one that has gotten the most attention. BMI is calculated based on a child's height, weight, age and gender. Parents receive a letter that details their child's BMI, explains the health risks of being underweight or overweight, includes nutrition and physical activity advice, and directs parents to resources in their community that can help them address their child's weight issues.

"Many parents don't recognize that their children are at risk for obesity," says Joseph Thompson, M.D., M.P.H., director of the Arkansas Center for Health Improvement, who is overseeing the BMI analysis. "As a society, we've watched our kids become heavier, and we haven't recognized it."

The state law has several other provisions designed to address childhood obesity, among them: (1) eliminating vending machines from elementary schools; (2) requiring school districts to publicly disclose revenue from competitive food and beverage contracts; (3) mandating that each school district assess its physical activity and health and nutrition programs and set goals for improvement; and (4) establishing a statewide Child Health Advisory Committee that will make recommendations to the state Board of Education on nutrition and physical activity standards.

The Robert Wood Johnson Foundation is funding a comprehensive evaluation of efforts to implement Act 1220 and its effectiveness, as well as a confidential database that will be used to track changes in students' BMI. These projects are expected to inform efforts to reduce childhood obesity—not just in Arkansas, but in states across the nation.

Evaluators are surveying parents, local superintendents, principals and policy-makers to learn about the process of implementing the law, including changes in school policy. Evaluators also hope to learn how parents respond if a BMI report indicates that their child is overweight or at risk for becoming overweight. For example, do parents modify a child's diet or encourage them to become more physically active? In addition, the evaluators want to explore whether the focus on obesity has negative consequences, such as an overweight child being teased or parents trying to implement a weight-loss program without medical supervision. Schools also are incurring costs in collecting the BMI data and removing vending machines. It is important to learn whether these efforts are yielding results, says James Raczynski, Ph.D., principal evaluator and dean of the College of Public Health at the University of Arkansas for Medical Sciences.

"Obesity is a national epidemic and we hope that our evaluation will better inform other states in taking action such as Act 1220," Raczynski says. "We think this is a good policy. We think it's going to be good for our state and children but we don't know that. We need to have some data to find out whether this works or not."

—Susan G. Parker

2004 Lienhard Award Recipient

Kenneth W. Kizer, M.D., M.P.H., president and chief executive officer of the National Quality Forum, Washington, is the recipient of the Institute of Medicine of the National Academies 2004 Gustav O. Lienhard Award. The award recognizes outstanding national achievement in improving personal health care services in the United States. Kizer is being honored for his commitment to military personnel, as demonstrated by his transformation of the veterans' health care system to a model of patient safety innovation and performance-based quality care.

As former undersecretary for health of the U.S. Department of Veterans Affairs and chief executive officer of the veterans' health care system, Kizer is credited with the greatest transformation of veterans' health care since the system was created in 1946. During his tenure, Kizer took actions to enhance and standardize the quality of care, optimize patients' ability to function and facilitate their access to care. He also worked to decentralize operational decision-making, reduce operating costs, allocate resources equitably and improve information technology management. Kizer was responsible for several patient care achievements, including exceeding the Healthy People 2000 target to immunize 61 percent of those under VA care for pneumococcal disease and influenza. He also greatly improved screening for breast cancer and cervical cancer for women in the armed forces. Additionally, his leadership efforts include establishing the VA National Center for Patient Safety, instituting a policy in 1997 that requires employees to report medical errors and adverse events, and establishing a medication bar-code system that greatly reduced medication errors. He founded the National Patient Safety Partnership to promote safety collaboration.

In his current position at the National Quality Forum, Kizer is one of the leaders of the national effort to improve the quality of the nation's health care through a unique public–private partnership.

Kizer is the 19th recipient of the Lienhard Award, which includes a medal and a $25,000 prize. The award is funded by an endowment from The Robert Wood Johnson Foundation. Lienhard was chair of the Foundation's Board of Trustees from the organization's establishment in 1971 to his retirement in 1986.

—Hedda Colossi

Improving Patient Flow and Overcrowding in EDs

Throughout the United States, from small towns to the largest cities, many hospital emergency departments (EDs) are in deep trouble. From 1992 to 2002, according to the Centers for Disease Control and Prevention, the number of EDs decreased by 15 percent while annual visits jumped 23 percent. Add a nationwide nursing shortage, downsizing in hospital personnel and hospitals shutting down, and the result is crowded EDs where patients may wait anywhere from a few hours to a few days for treatment— if they aren't diverted elsewhere or just leave without being seen.

Two years ago, in search of solutions to the ED crisis, The Robert Wood Johnson Foundation initiated *Urgent Matters*, a national program focused on developing and spreading patient-flow best practices to America's hospitals. A report released in September, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, details the results of this program, including selected success stories. (For a copy of the report, go to *www.urgentmatters.org.)*

All public or nonprofit hospitals with Level I or Level II trauma centers—440 hospitals—were initially invited to apply to *Urgent Matters*. Nearly two-thirds did and 10 hospitals were selected to participate in a yearlong Learning Network.

"We wanted hospitals that were ready to engage in this issue, improve the situation and make changes," explains Bruce Siegel, M.D., M.P.H., director of the *Urgent Matters* program, which is located at the Center for Health Services Research and Policy at George Washington University Medical Center's School of Public Health and Health Services in Washington.

All of the participating hospitals demonstrated improvement in patient flow and developed practical tools—some surprisingly simple—to address issues related to ED overcrowding. One hospital, for example, moved a supply of tetanus shots from the hospital pharmacy to the emergency department, cutting out a two- to three-hour delivery time from pharmacy to ED patient.

At the Regional Medical Center at Memphis, a discharge lounge off the lobby was created to open up inpatient beds. "Early discharge was a major theme across a lot of the hospitals," says Siegel. Patients would stay in this monitored environment while waiting for transportation, rather than occupy a needed hospital bed for four or five hours.

At Fairfax Inova Hospital, Fairfax County, Va., the ED started stationing doctors and nurses in triage so that care could begin at the triage desk. "They just positioned staff differently and started care earlier," says Siegel, to speed up patient flow.

Each Learning Network participant was provided with on-site visits and regular phone consultations by the *Urgent Matters* team and its advisers. Hospital representatives attended three face-to-face meetings during the year, and during monthly conference calls each hospital gave updates, with one giving a feature presentation on a particular topic. This collaboration allowed everyone to share (and borrow) ideas and learn from one another's successes and challenges.

Learning Network participants also posted action plans, monthly project reports and other data on the *Urgent Matters* Web site, which fostered collaboration. Each hospital turned in 17 data points, such as throughput time, time to be seen by a doctor and bed turnaround time, all critical to finding where hospital bottlenecks were occurring.

"You can't improve what you don't measure," says Leon L. Haley Jr., M.D., chief of emergency medicine and deputy senior vice president for medical affairs at Atlanta's Grady Health System, one of the *Urgent Matters* hospitals.

Some hospitals, says Siegel, were stunned by the measurements. Before the study began, "hospitals couldn't begin to tell you where the bottlenecks were and how to fix them."

"We found multiple areas where we could improve internal flow," says Ted Chan, M.D., associate professor of clinical medicine and emergency medicine at University of California, San Diego (UCSD) Medical Center, where some 40,000 patients are seen each year. "There were multiple steps and waiting at different points from the ED to a bed. We worked with the software folks to integrate our registration and hospital computer systems with ED electronic records, then added bar-coding on a patient's arrival that is automated and recognized by various computer systems."

Now patients at UCSD are assigned a bar-code associated with their medical records. Lab tests and X-rays can be ordered whether they're registered or not. As a result, says Chan, as soon as they're triaged, they're put into any empty bed in the ED, instead of going back out to the waiting room. "A triage nurse would contact a physician and initiate tests when no bed was available. When the patient got a bed and saw a physician, many studies were already done."

Because of this and other changes, average length of stay (from arriving at ED to getting a hospital bed or going home) went from seven hours to four-and-a-half. Wait time (from ED arrival to getting an ED bed) went from 45 minutes to less than 15. One of the hospital's biggest successes: Their "left without being seen" rate dropped from nearly 9 percent to 3 percent.

Atlanta's Grady Health System, which serves a largely indigent population and has about 240,000 visits to its five ED/urgent care units each year, made a number of changes, including the way Fast Track (lower acuity) patients were processed in the ED. These changes were instituted after they were found to be successful during a two-week pilot project.

Fast Track changes, says Grady's Haley, included creating an in-patient team and an ED team. The patient chart in-basket was relocated from the information desk to the Fast Track unit and three boxes were created to indicate patient status, giving Fast Track staff ownership of patients waiting to be seen, and creating a highly visible system showing what services each patient needed. They altered the role of midlevel provider or nurse responsible for patient assessment to change the screening process, giving that provider a more active role in making sure the patient received needed ancillary tests.

With these and other changes, the average time from arrival to bed placement for Fast Track patients decreased from 219 minutes to 94 minutes. The average time of bed placement to initial exam decreased from 43 to 35 minutes. From May 2003 to April 2004, average total ED throughput went from almost 7 hours to approximately 5.25 hours.

And Grady's ED is a place where most of the statistics are tallied by humans, not by a computer system. "This is not an issue of spending millions of dollars," concludes Siegel. "It is about planning, teamwork and people throughout the hospital paying attention to ED overcrowding and patient flow."

—Anne E. Stein

For more on *Urgent Matters*, visit *www.urgentmatters.org.* For more on RWJF's quality initiatives, visit *www.rwjf.org/quality.*

The *Urgent Matters* experience, according to the September 2004 report, "shows that hospitals can dramatically improve patient flow and decompress their Emergency Department (ED) without investing significant resources, but it takes commitment and several important ingredients." These include:

- Recognizing that ED crowding is a hospital-wide problem, not an ED problem.
- Building multidisciplinary, hospital-wide teams to oversee and implement change.
- Determining the presence of a "champion" to sell patient-flow improvement to medical staff and executive management.
- Guaranteeing management's support.
- Using formal improvement methods, such as Rapid Cycle Change, to improve patient flow.
- Committing to rigorous metrics.
- Sharing outcomes and results with all involved staff.
- Finding the right balance between collaboration and competition.

Selected Grants

Search all active RWJF grants at

www.rwjf.org/grants

RWJF national programs are denoted by italics.

Addiction Prevention and Treatment

- For an evaluation of *A Matter of Degree: Reducing High-Risk Drinking Among College Students—Phase IV,* $811,049 to Harvard University School of Public Health, Boston.
- For strategic planning for the PRISM Awards, $250,000 to Entertainment Industries Council, Reston, Va.
- For providing technical assistance to state legislators on the issue of substance abuse, $301,034 to the National Conference of State Legislatures, Washington.
- *A Matter of Degree: Reducing High-Risk Drinking Among College Students.* Awards to two sites, totaling $936,000.
- *Pilot Program of Research to Integrate Substance Abuse Issues into Mainstream Medicine.* Awards to five sites, totaling $439,842.
- *Substance Abuse Policy Research Program.* Awards to 14 sites, totaling $2.8 million.

Building Human Capital

- *Investigator Awards in Health Policy Research Program.* Awards to four sites, totaling $1 million.

Childhood Obesity

- For developing a valid survey and assessment of food marketing in schools, $123,795 to Arizona State University College of Education, Tempe.
- For developing a school- and community-based intervention to prevent and reduce obesity among fourth- through eighth-grade students, $117,400 to the Food Trust, Philadelphia.
- *Active Living Leadership*. For developing local government leaders for active living, one renewal award of $131,582 to the International City/County Management Association, Washington.
- *Active Living Research.* Awards to six sites, totaling $394,708.

End-of-Life Care

- For the Circle of Life Awards: Celebrating Innovation in End-of-Life Care, $238,000 to the Health Research and Educational Trust, Chicago.
- For building on *Last Acts* and *Rallying Points* activities, $2.4 million to the National Hospice and Palliative Care Organization, Alexandria, Va.

Health Insurance Coverage

- For disseminating lessons learned from community-based coverage programs, $289,563 to the National Center for Primary Care at the Morehouse School of Medicine, Atlanta.
- *Covering Kids and Families*, one renewal award of $492,336 to the State of Alabama Department of Public Health, Montgomery.

Nursing

- For evaluation of the program *Transforming Care at the Bedside—Phase II*, $550,000 to the University of California, Los Angeles, School of Public Health.

Pioneer

- For designing a reliable system of medical justice, $715,710 to the Common Good Institute, New York; and $760,540 to Harvard University School of Public Health, Boston.
- For shortening the lag time between published research and medical practice, $221,500 to Institute for Healthcare Improvement, Boston.

Quality Health Care

- For building consumer demand for health care transparency and accountability in outpatient care, $405,594 to the National Partnership for Women and Families, Washington.
- For standardizing hospital and physician quality measures, $280,350 to the National Partnership for Women and Families, Washington.
- *Depression in Primary Care: Linking Clinical and System Strategies,* awards to 10 sites, totaling $1.8 million.
- *Diabetes Initiative—Phase II*. One renewal award of $1.1 million for evaluation of the program to Research Triangle Institute, Research Triangle Park, N.C.
- *Health E-Technologies: Assessing New Tools for Chronic Disease Management and Health Behavior Change.* Awards to five sites, totaling $2 million.

Reducing Racial and Ethnic Disparities in Chronic Care

- For supporting activities for a health plan collaborative to reduce health care disparities, $499,893 to the Center for Healthcare Strategies Supporting Organization, Lawrenceville, N.J.
- For continuation and expansion of analyses for *The Dartmouth Atlas of Health Care,* $900,000 to Dartmouth Medical School, Hanover, N.H.
- For the Dartmouth Atlas Disparities Database, $662,673 to Dartmouth Medical School.
- *Southern Rural Access Program.*
  - For Sound Partners for Community Health Targeting Southern Rural Radio Stations, $125,000 to the Benton Foundation, Washington.
  - For developing policy initiatives to address community health worker program sustainability, award of one Special Opportunity grant of $482,892 to the Arkansas Department of Human Services, Little Rock.

Tobacco Use

- For enhancing and sustaining smoke-free environments, $1.5 million to American Nonsmokers' Rights Foundation, Berkeley, Calif.
- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy.* Awards to 12 sites, totaling $2.3 million.
- For the *Smoke-Free Families* National Dissemination Office, a renewal award of $779,939 to the University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.

Vulnerable Populations

- A grant of $1.6 million to the National Campaign to Prevent Teen Pregnancy, Washington.
- For a neighborhood family support center, $657,706 to the District of Columbia Developing Families Center, Washington.
- For understanding the nexus among prisoner reentry, public health and substance abuse, $296,468 to the Urban Institute, Washington.
- *Faith in Action*. Awards to 12 sites, totaling $420,000.
- *Local Initiative Funding Partners Program.* Awards to seven sites, totaling $3.2 million.
- *New Jersey Health Initiatives.* Awards to nine sites, totaling $2.4 million.
- For evaluating the success of the *New Jersey Health Initiatives* workforce agenda grantees, a renewal award of $323,922 to Rutgers, the State University of New Jersey, Institute for Health, Health Care Policy and Aging Research, New Brunswick.
- *Vote and Vaccinate: A Community-Based Strategy to Promote Adult Immunization.* Awards to 15 sites, totaling $111,942.

Other

- For news collaboration with the Health and Health Policy Unit of *The NewsHour with Jim Lehrer,* $1.6 million to the Greater Washington Educational Telecommunications Association, Arlington, Va.
- Continued support for *Health Affairs,* $850,000 to Project Hope—the People-to-People Health Foundation, Millwood, Va.
- Emergency assistance for the victims of Hurricane Charley, $750,000 to the American National Red Cross, Washington.
- *Changes in Health Care Financing and Organization.* For studying the use of tiered provider networks by employer-sponsored health plans, one award of $367,636 to the University of Southern Maine, Edmund S. Muskie School of Public Service, Portland.
- *Sound Partners for Community Health.* Support for the sites under the program, one renewal award of $1.7 million to the Benton Foundation, Washington.
- For a program for educationally and economically disadvantaged undergraduates who are interested in careers in medicine, $292,869 to Rutgers University Foundation, New Brunswick, N.J.
- For a revitalization program for the city of New Brunswick, N.J., $550,000 to New Brunswick Development Corporation.
- Support for the 2004–2005 annual campaign drive, $713,790 to United Way of Central Jersey, Milltown, N.J.

People

Katherine Hatton, M.S.L., J.D., joined RWJF as vice president, general counsel and secretary in September. Previously, Hatton was vice president and general counsel of Philadelphia Newspapers, publisher of the *Philadelphia Inquirer* and *Philadelphia Daily News*. Prior to that, she was at the Philadelphia law firm of Kohn, Swift & Graf. She

is a former chair of the Philadelphia Bar Association's Professional Responsibility Committee. Hatton received a master of studies in law degree from Yale Law School, New Haven, Conn., and a law degree with honors from Case Western Reserve University, Cleveland.

Adam Coyne joined the RWJF Communications Department in September as director of media relations. Formerly, Coyne was director of media relations for the City of Hope National Medical Center, Los Angeles. Prior to that, he was communications director for the Elizabeth Glaser Pediatric AIDS Foundation, also in Los Angeles. In this newly created

position, Coyne will be responsible for highlighting the Foundation's goals, programs, research and other activities with the media. In addition, he will help create, disseminate and manage materials about the Foundation for a variety of external audiences and work closely with program, communications, and research and evaluation staff to develop and coordinate senior staff members' public presentations.

Debra Perez, M.A., M.P.A., joined the Foundation in October as a program officer in the Research and Evaluation Unit. She will be a member of the Racial and Ethnic Disparities Team and the Public Health Team. Perez, who currently is finishing her Ph.D. degree in health policy at Harvard University, served as deputy director of RWJF's *New Jersey Health Initiatives* program from 1997 to 2000. Perez earned an M.A. in women's studies from the University of Kent in Canterbury, England, and an M.P.A. from Baruch College, New York.

Emily Culbertson joined RWJF in September as a Web editorial associate in the Communications Department. Formerly Culberston was an eHealth strategist and senior account manager at I-SITE, a Philadelphia-based Web strategy firm, where she oversaw development of a Web site for RWJF's *Health & Society Scholars* program.

Promotions

Robert Hughes, Ph.D., became the first chief learning officer for the Foundation. In this capacity Hughes has overall responsibility for coordination and oversight of institutional knowledge that contributes to creating effective programs and achieving strategic objectives. Hughes will continue to oversee the Pioneer portfolio, work closely with the Office of National Program Affairs and coordinate special projects.

Ann Christiano, M.P.A.P., has been promoted to senior communications officer. She joined RWJF in 1995 as a communications assistant and in 1996 was promoted to communications associate. In 1999, Christiano became a communications officer and has since worked with the Connect project and grantee training. She is a member of the Vulnerable Populations portfolio team.

Michelle Larkin, R.N., M.S., has been promoted to senior program officer. She joined RWJF in November 1999 as a program associate and was promoted to a program officer in January 2001. Larkin is a member of the Tobacco Team and is director of the *Tobacco Policy Change* program. She also works with the Nursing Team.

Hope Woodhead was promoted to production director for the Communications Department's Creative and Information Services team. In her new position, Woodhead has responsibility for coordinating production and creative direction across the Foundation's Web and print products. Since joining the Foundation in 1996, Woodhead has worked on a variety of Web and print initiatives including the Annual Report, Calls for Proposals, wall displays and special publications.

Carol Chang, M.P.H., has been promoted to program officer in the Research and Evaluation Unit. Chang has been a program associate since July 2000. Her new responsibilities include overseeing the internal National Program Office for the *Health & Society Scholars* program. She will continue to be a member of the Public Health Team.

Farewell

Karen Davenport, M.P.H., former senior program officer, left RWJF in August to become director of the Medicare Rights Center, Washington.

Maureen Michael, M.G.A., former senior program officer, left the Foundation in August to spend more time with her family. She will continue to work with RWJF on a consulting basis.

From **Grant Results Reports**—page 8

- **Strategic Planning and Infrastructure Development for the California Mentor Foundation** The California Mentor Foundation is a nonprofit organization that provides resources and technical assistance to local mentoring organizations. The organization produced the book *Mentoring Works*, which is a collection of essays on best practices in mentoring by experts in the field. The book can be ordered for $4 from the California Mentor Foundation. Details can be found at *www.calmentor.com/mentoringmovement_promotions.fsp*. See the Grant Results Report at *www.rwjf.org/reports/grr/038663.htm*.

—Hedda Colossi

What's New on the RWJF Web Site

The Institute of Medicine (IOM) recently published an RWJF-sponsored action plan for preventing obesity in children and youth in the United States. RWJF President and CEO Risa Lavizzo-Mourey, M.D., M.B.A., discusses the IOM report *Preventing Childhood Obesity: Health in the Balance,* as well as the Foundation's ongoing work in this area at *www.rwjf.org/news/special/risaObesityInterview.jhtml.*

The Foundation also sponsored a briefing to present findings from the *Dartmouth Atlas of Health Care* project. The Dartmouth studies, published in a special Web-exclusive edition of the journal *Health Affairs*, show that Medicare patients with comparable chronic conditions often receive remarkably different care. RWJF offers an archived webcast of a briefing by Dartmouth Medical School researchers at *www.rwjf.org/news/webcast/webcast.jsp?id=4&bhcp=1.*

The Web site also published an in-depth interview with John E. Wennberg, M.D., professor of Community and Family Medicine (epidemiology) and of Medicine and director of the Center for the Evaluative Clinical Services at Dartmouth Medical School, and principal investigator of the *Dartmouth Atlas of Health Care.* See *www.rwjf.org/news/special/wennbergInterview_1.jhtml.*

The site posted a webcast: a National Association of City and County Health Officials (NACCHO) town hall meeting. The purpose of the meeting was to discuss an "operational definition of a functional local public health agency." See *www.rwjf.org/news/eventDetail.jsp?id=1094657291390&contentGroup=webcast.*

New installments to the Foundation's Television Health Series include the following:

- A report on hospital emergency department overcrowding, focusing on an *Urgent Matters* white paper, "Bursting at the Seams—Improving Patient Flow to Help America's Emergency Departments." *www.rwjf.org/news/video/urgentMattersTV.jhtml.*
- An interview with Allan Formicola, D.D.S., co-director of the RWJF national program *Pipeline, Profession and Practice: Community-Based Dental Education,* about the critical problem of dental decay, the single most common chronic childhood disease. *www.rwjf.org/news/special/dentalDecay.jhtml.*

—Jeff Meade