2009 National Meeting
La Jolla, California | November 3-6

2009 MEETING THEME:
Transformational Change Through Community-Partnered
Research and Public Health
The committee offers special thanks to EMCVenues, particularly Carmelita Marrow, Debbie Odden, and Jennifer Cohen, for its excellent support in attendee management, pre-planning logistics, and on-site support for this meeting.
Dear Scholars, NAC members, Trustees, Faculty, Foundation Staff, Speakers, and Community Partners,

We are delighted to welcome you to the 2009 Robert Wood Johnson Foundation Clinical Scholars Program National Meeting. The meeting will focus on improving community and public health through partnered leadership. Over the next few days, our Scholars and Alumni will present their work with community partners from coast to coast ranging from grass roots community clinics and non-profit organizations to large institutions such as county health departments and school districts. As you will see from the meeting agenda, our invited speakers, and current Scholars are working on important community and policy issues such as the H1N1 (swine flu) epidemic in the US Department of Health and Human Services, plans to improve the delivery of health care and to re-open Martin Luther King Hospital in South Central Los Angeles, and perspectives on National Health Reform efforts. We hope that during the meeting you will have a chance to meet and network with the many leaders in attendance who are truly change agents in our communities.

We also take advantage of the opportunity to celebrate the 40 years since the founding of the program and its shift towards community partnered work to address the mission of improving the health and healthcare for Americans by developing leaders and change agents for communities.

The meeting opens with plenary presentations from alumni who have worked in a variety settings across the country. We will hear from Mitchell Katz, our Anne Lea Schuster Alumni Speaker and Director of Health for the City and County of San Francisco Department of Public Health, on “Achieving Universal Access: Healthy San Francisco.” Also, a roundtable discussion with Stacey Lindau, Eric Whitaker, and Dorian Miller from the University of Chicago, entitled “Health Justice on the South Side of Chicago? Skepticism, System, Service, and Science,” will highlight the challenges of academic and community partnerships to improve the delivery of health services to some of the most underserved members of their community. In addition to presentations by Alumni and current Scholars, we have small group interactive common interest sessions led by our Scholars around a variety of topics such as current issues for their specialty areas, health messages in the media, and best practices and challenges with community engagement. Additionally, our Yale scholars will present a photo exhibit on youth violence prevention showcasing their work with the Street Outreach Workers Program in New Haven, Connecticut.

It is our pleasure to share this program with you and we hope you enjoy the meeting and interacting with our diverse group of Scholars, Faculty, and Community Partners.

Sincerely,

Carol M. Mangione, MD, MSPH
Chair-Committee on Arrangements
Co-Director, UCLA RWJF CSP
Professor of Medicine and Public Health
UCLA

Desmond Runyan, MD, DrPH
National Program Director, RWJF CSP
Professor of Social Medicine & Pediatrics
University of North Carolina

For express mail:
333 S. Columbia Street
MacNider Hall Room 333
Chapel Hill, NC 27599
## Agenda

*Sessions marked with an asterik (*) are available for CME credits. Table assignments are located at end of Agenda as well as a map of the complex.*

### Tuesday, November 3, 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>3:00 PM - 5:00 PM</td>
<td>Speaker Ready Room</td>
<td>Cypress</td>
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<tr>
<td>3:00 PM - 5:00 PM</td>
<td>Registration</td>
<td>Hacienda Uno</td>
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<tr>
<td>6:00 PM - 7:00 PM</td>
<td>Reception</td>
<td>Garden Courtyard</td>
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<tr>
<td>7:00 PM - 8:30 PM</td>
<td>Dinner</td>
<td>Garden Courtyard</td>
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<tr>
<td>8:00 PM - 11:30 PM</td>
<td>Hospitality Suite</td>
<td>Library</td>
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</tbody>
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### Wednesday, November 4, 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00 AM - 8:00 AM</td>
<td>Breakfast</td>
<td>Grande Room</td>
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<tr>
<td>8:00 AM - 12:35 PM</td>
<td>Plenary Session*</td>
<td>La Jolla Abe</td>
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<tr>
<td>8:00 AM - 8:30 AM</td>
<td>Welcome &amp; Introductions</td>
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<tr>
<td></td>
<td>Facilitator: Dr. Herminia Palacio, Clinical Scholars National Advisory Committee, Harris County Public Health &amp; Environmental Services</td>
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<td></td>
<td>Dr. Carol Mangione</td>
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<td></td>
<td>National Meeting Planning Committee Chair, Co-Director, UCLA RWJF Clinical Scholars</td>
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<td></td>
<td>Dr. Desmond Runyan</td>
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<td></td>
<td>RWJF Clinical Scholars National Program Office Director, University of North Carolina at Chapel Hill</td>
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<td></td>
<td>Dr. Risa Lavizzo-Mourey</td>
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<td></td>
<td>President &amp; CEO, Robert Wood Johnson Foundation</td>
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<td>Dr. Richard Krugman</td>
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<td>Chair, RWJF Clinical Scholars National Advisory Committee, University of Colorado</td>
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<tr>
<td></td>
<td>Annie Lea Shuster – Alumni Speaker</td>
<td>Introduced by: Dr. Herminia Palacio, Clinical Scholars National Advisory Committee</td>
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<tr>
<td>9:15 AM - 9:35 AM</td>
<td>Can A Fledgling Community-Based Researcher Survive in Academia?: The Perspective of an Academic Just Starting Out</td>
<td>Arshiya Baig, (UCLA 2005-2008), University of Chicago</td>
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<tr>
<td>9:55 AM - 10:05 AM</td>
<td>Plenary Session* (continued)</td>
<td>LA JOLLA ABE</td>
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<tr>
<td>10:05 AM - 11:25 AM</td>
<td>PANEL ONE</td>
<td>LA JOLLA PRE-FUNCTION A</td>
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<tr>
<td></td>
<td>Health Justice on the South Side of Chicago? Skepticism, System, Service, and Science</td>
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<td></td>
<td>• Loretta Jones, MA, Director, Healthy African American Families, Los Angeles, CA</td>
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<td></td>
<td>• Stacy Lindau, MD, MAPP, former RWJ CSP (Chicago CSP 2000-2002), Assistant Professor of Ob/Gyn and Medicine, University of Chicago, Principal Investigator, South Side Health and Vitality Studies, Chicago, IL</td>
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<tr>
<td></td>
<td>• Doriane Miller, MD, former RWJF VP, Director, University of Chicago, Center for Community Health and Vitality, Chicago, IL</td>
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<td></td>
<td>• Serena Seifer, MD, Founding Executive Director, Community-Campus Partnerships for Health and Research Associate Professor, Dept. of Health Services, University of Washington School of Public Health, Seattle, WA</td>
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<td></td>
<td>• Eric Whitaker, MD, MPH, former RWJ CSP (Chicago CSP 1998-2000, 1997), Exec. VP for Strategic Affiliations, Associate Dean for Community-Based Research, Chicago, IL</td>
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<tr>
<td>11:25 AM - 11:35 AM</td>
<td>BREAK</td>
<td>LA JOLLA PRE-FUNCTION A</td>
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<tr>
<td>11:35 AM - 11:55 PM</td>
<td>The Asthma Epidemic, 1979-2009: The Rise and Fall of a Public Problem Carla Keirns, (Michigan 2006-2009), Stony Brook University School of Medicine</td>
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<tr>
<td>11:55 AM - 12:15 PM</td>
<td>The Shortage of On-Call Surgical Coverage: A National Survey of Emergency Department Directors Mitesh Rao, (Yale 2007-2009), Yale University</td>
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<td>12:15 PM - 1:30 PM</td>
<td>LUNCH</td>
<td>OLIVE LAWN/MUSTANGS &amp; BURROWS</td>
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<tr>
<td>1:30 PM - 3:00 PM</td>
<td>NETWORKING</td>
<td>N/A</td>
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<tr>
<td>1:30 PM - 3:00 PM</td>
<td>NATIONAL ADVISORY COMMITTEE/PROGRAM DIRECTORS/ NATIONAL PROGRAM OFFICE MEETING</td>
<td>PACIFICA A</td>
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<tr>
<td>3:00 PM - 4:00 PM</td>
<td>COMMON INTEREST SESSIONS*</td>
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<tr>
<td></td>
<td>• Community Engagement: Challenges and Successes Adriana Izquierdo (UCLA CSP)</td>
<td>Grande Patio</td>
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<td>• Emergency Medicine: Finding Solutions to ED Overcrowding Outside of the Ambulance Bay Doors Medell Briggs-Malonson (UCLA CSP)</td>
<td>Grande Patio</td>
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<tr>
<td></td>
<td>• Off-site Policy Experiences during the Clinical Scholar program Kate Goodrich (Yale CSP ) Adam Landman (Yale CSP) Zachary Meisel (Penn CSP)</td>
<td>Garden Suite</td>
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### Common Interest Sessions* *(continued)*

<table>
<thead>
<tr>
<th>Session</th>
<th>Location</th>
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<tbody>
<tr>
<td><strong>Pediatrician Interest Group</strong></td>
<td>Cypress</td>
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<tr>
<td>Rebecca Dudovitz, Ray Perry (UCLA CSP)</td>
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<tr>
<td><strong>PSA Screening for Prostate Cancer</strong></td>
<td>La Jolla</td>
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<tr>
<td>Danil Makarov (Yale CSP)</td>
<td>Pre-function A</td>
</tr>
<tr>
<td><strong>Research in a Foreign Language</strong></td>
<td>La Jolla</td>
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<tr>
<td>Lisa DeCamp (Michigan CSP)</td>
<td>Pre-function B</td>
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<tr>
<td><strong>Surgeon Interest Group</strong></td>
<td>La Jolla</td>
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<tr>
<td>Nick Osborne (Michigan CSP)</td>
<td>Garden</td>
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</tbody>
</table>

### POSTER PRESENTATIONS* — 2ND YEAR SCHOLARS

#### HEALTH BELIEFS/BEHAVIORS

<table>
<thead>
<tr>
<th>Time</th>
<th>Title</th>
<th>Presenter &amp; Institution</th>
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<tbody>
<tr>
<td>4:00 PM - 4:20 PM</td>
<td>‘I Stuffed It’: Exploring the Help Seeking Process in African American Women Following Sexual Assault</td>
<td>Glenda Wrenn, CSP (Penn 2008-2010)</td>
</tr>
<tr>
<td>4:40 PM - 5:00 PM</td>
<td>Christian Clergy’s Portrayal of Mental Illness in Televized Sermons</td>
<td>Rhonda Mattox, CSP (UCLA 2008-2010)</td>
</tr>
<tr>
<td>5:00 PM - 5:20 PM</td>
<td>Understanding the Temporal Relationship Between Patient Attributes and Self-Management, and Outcomes in Diabetes</td>
<td>Donna Zulman, CSP (Michigan 2008-2010)</td>
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#### PREVENTION AND SCREENING

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<thead>
<tr>
<th>Time</th>
<th>Title</th>
<th>Presenter &amp; Institution</th>
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<tbody>
<tr>
<td>4:00 PM - 4:20 PM</td>
<td>Cutting Through the Uncertainty of Prostate Cancer for Black Men Using Barbershop Outreach</td>
<td>Stanley Frencher Jr., CSP (UCLA 2008-2010)</td>
</tr>
<tr>
<td>4:20 PM - 4:40 PM</td>
<td>The Role of School Based Health Centers in Teen Pregnancy Prevention: Experiences of New Haven Public School Students</td>
<td>Lara Johnson, CSP (Yale 2008-2010)</td>
</tr>
<tr>
<td>4:40 PM - 5:00 PM</td>
<td>A Tiered Approach to Developmental and Behavioral Services in Preschool: Stakeholder Perceptions and Referral Outcomes</td>
<td>Bergen Nelson, CSP (UCLA 2008-2010)</td>
</tr>
<tr>
<td>5:00 PM - 5:20 PM</td>
<td>Who Should Use Aspirin to Prevent Cardiovascular Disease?</td>
<td>Jeremy Sussman, CSP (Michigan 2008-2010)</td>
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<tr>
<td>Time</td>
<td>Presentation</td>
<td>Location</td>
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</table>
| 4:00 PM - 4:20 PM  | • Care Transitions and Patient Readmission: Where Does Literacy Fit In?  
Katherine Goodrich, CSP (Yale 2008-2010)                                                                          | LA JOLLA C    |
| 4:20 PM - 4:40 PM  | • Oversuse and Underuse of Imaging to Stage Newly Diagnosed Cancer Patients in the Medicare Population  
Danil Makarov, CSP (Yale 2008-2010)                                                                         | LA JOLLA C    |
| 4:40 PM - 5:00 PM  | • Opening of Ambulatory Surgery Centers and Procedure Use in the Elderly  
John Hollingsworth, CSP (Michigan 2008-2010)                                                                    | LA JOLLA C    |
| 5:00 PM - 5:20 PM  | • The Impact of Resident Duty Hour Reform on Hospital Readmission Rates  
Matthew Press, CSP (Penn 2008-2010)                                                                           | LA JOLLA C    |
| 4:00 PM - 4:20 PM  | • Airing Our Dirty Laundry: Community Based Participatory Methods to Explore Occupational Hazards and Coping Mechanisms Among Latina Household Workers  
Adam Richards, CSP (UCLA 2008-2010)                                                                             | LA JOLLA D    |
| 4:20 PM - 4:40 PM  | • Family- and Provider-Level Predictors of Health Care Utilization in Medicaid-Eligible Infants in Philadelphia  
Anje Van Berckelaer, CSP (Penn 2008-2010)                                                                      | LA JOLLA D    |
| 4:40 PM - 5:00 PM  | • Medical Students in the Community: Are Students Participating in Community Partnerships that Promote Reciprocal Knowledge Transfer?  
Caroline Bonham, CSP (Michigan 2008-2010)                                                                        | LA JOLLA D    |
| 5:00 PM - 5:20 PM  | • Non-Operative Care for Hip Fracture in the Elderly: The Influence of Race, Income, and Comorbidities  
Mark D. Neuman, CSP (Penn 2008-2010)                                                                            | LA JOLLA D    |
| 6:00 PM - 6:30 PM  | RECEPTION                                                                                                                                    | LA JOLLA FOYER|
| 6:30 PM - 8:00 PM  | DINNER  
Dinner Speaker: Reflections on Public Health in the Community & Looking Forward  
Dr. Regina Benjamin  
Surgeon General Elect  
RWJF Board of Trustees                                                                                         | LA JOLLA BALLROOM|
| 8:00 PM - 11:30 PM | HOSPITALITY SUITE LIBRARY                                                                                                                  |               |
# Thursday, November 5, 2009

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tr>
<td>7:30 AM - 8:30 AM</td>
<td>BREAKFAST</td>
<td>GRANDE ROOM</td>
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<tr>
<td>8:50 AM - 12:30 PM</td>
<td>CONCURRENT SESSIONS*</td>
<td>LEARNING THEATER</td>
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<tr>
<td>Facilitator: Dr. Karen Hein, Clinical Scholars National Advisory Committee, Albert Einstein College of Medicine</td>
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<tr>
<td>8:50 AM - 9:10 AM</td>
<td>• OB Cares: The Obstetric Clinics and Resources Study: Provider Views on Delivering Perinatal Depression Care Christie Lancaster, 3rd Year, CSP (Michigan 2007-2010)</td>
<td>LEARNING THEATER</td>
</tr>
<tr>
<td>9:10 AM - 9:30 AM</td>
<td>• Impact of Care for Depression on HIV Outcomes Among Medicaid Beneficiaries in California Rhondee Benjamin-Johnson, 3rd Year, CSP (UCLA 2007-2010)</td>
<td>LEARNING THEATER</td>
</tr>
<tr>
<td>9:30 AM - 9:50 AM</td>
<td>• Groovi Care: A Community Coalition to Engage with Veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) About Their Health Patrick Link, 3rd Year, CSP (UCLA 2007-2010)</td>
<td>LEARNING THEATER</td>
</tr>
<tr>
<td>9:50 AM - 10:10 AM</td>
<td>• Mental Health Education Consultation in Cambodia: The Effects of Psychological Trauma in Post-Conflict Countries James Boehnlein, Abstract Alumni, (Penn 1985-1987) Oregon Health and Science University, Department of Psychiatry, Intercultural Psychiatric Program</td>
<td>LEARNING THEATER</td>
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<tr>
<td>10:10 AM - 10:30 AM</td>
<td>BREAK</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
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<tr>
<td>10:30 AM - 10:50 AM</td>
<td>• Cognitive Health Among Older Adults in the United States and in England Kenneth Langa, Abstract Alumni, (Michigan 1997-1999) University of Michigan</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
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<tr>
<td>10:50 AM - 11:10 AM</td>
<td>• A New Social Capital Scale: Geographic Stability Compared to Income, Personal Support and Depressive Symptoms John Pascoe, Abstract Alumni, (UNC 1977-1979) Wright State University, Boonshoft School of Medicine</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
</tr>
<tr>
<td>11:10 AM - 11:30 AM</td>
<td>• An Assessment of Child and Adolescent Mental Health Care Needs in the United States by Insurance Status Jill Barron, Abstract Alumni, (Yale 2007-2009) Yale University School of Medicine</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
</tr>
<tr>
<td>11:30 AM - 11:50 AM</td>
<td>• Socioeconomic and Racial Variations in Evaluation For and Diagnosis of Abuse in Infants with Traumatic Brain Injury Joanne Wood, 3rd Year, CSP (Penn 2007-2010)</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
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<tr>
<td>Time</td>
<td>Concurrent Session* A (continued)</td>
<td>Location</td>
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<tr>
<td>12:10 PM - 12:30 AM</td>
<td>Changing Health Behavior by Influencing Knowledge, Attitudes, and Practice: A Partnership Between a Clinical Scholar and New Haven Healthy Start</td>
<td>LEARNING THEATER</td>
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<td>Peggy Chen, 3rd Year, CSP (Yale 2007-2010)</td>
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<tr>
<td>8:50 AM - 9:10 AM</td>
<td>Through Our Eyes: Perspectives of Young Black Men on Factors Affecting Transition to Manhood</td>
<td>PACIFICA B</td>
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<td>University of California, Los Angeles, David Geffen School of Medicine</td>
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<tr>
<td>9:10 AM - 9:30 AM</td>
<td>Opportunities to Improve Quality of Care, Self-Care Behaviors, and Interpersonal Care for Patients with Diabetes in a Migrant Health Center</td>
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<td>Gerardo Moreno, 3rd Year, CSP (UCLA 2007-2010)</td>
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<td>9:30 AM - 9:50 AM</td>
<td>Puentes De Salud: A Model for Improving Community Health</td>
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<td>Matt O’Brien, 3rd Year, CSP (Penn 2007-2010)</td>
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<td>9:50 AM - 10:10 AM</td>
<td>Linguistic Access Services in the United States: Do They Measure Up to the National Culturally and Linguistically Accessible Services Standards?</td>
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<td>Lisa Diamond, Abstract Alumni, (Yale 2006-2008)</td>
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<td>Palo Alto Medical Foundation Research Institute</td>
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<tr>
<td>10:10 AM - 10:30 AM</td>
<td>Understanding Delays in Care and Unmet Need in South Los Angeles: Age-Related Variation</td>
<td>PACIFICA/LEARNING THEATER PREFUNCTION</td>
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<td>Kara Odom Walker, 3rd Year, CSP (UCLA 2007-2010)</td>
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<tr>
<td>10:30 AM - 10:50 AM</td>
<td>Racial Disparities in Survival After Out-of-Hospital Cardiac Arrest</td>
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<td>Raina Merchant, 3rd Year, CSP (Penn 2007-2010)</td>
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<td>11:00 AM - 11:30 AM</td>
<td>Small Area Variations in Bystander CPR: Do Neighborhoods Matter?</td>
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<td>Comilla Sasson, 3rd Year, CSP (Michigan 2007-2010)</td>
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<td>11:30 AM - 11:50 AM</td>
<td>Patient Flow at Children’s Hospitals: Assessment, Research, Improvement</td>
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<td>Evan Fieldston, 3rd Year, CSP (Penn 2007-2010)</td>
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<td>10:50 AM - 12:10 PM</td>
<td>Early Readmission Following Gastric Cancer Resection in California</td>
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<td>Joan Ryoo, 3rd Year, CSP (UCLA 2007-2010)</td>
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<tr>
<td>12:10 PM - 12:30 AM</td>
<td>Disparate Disparities? Dental Care and Insurance in U.S. Adults</td>
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<td></td>
<td>University of Washington</td>
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<tr>
<td>Time</td>
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<tr>
<td>12:30 PM - 1:30 PM</td>
<td>LUNCH</td>
<td>MUSTANGS &amp; BURROWS/CARETAKERS LAW</td>
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<td></td>
<td>Lunch For VA Scholars</td>
<td>Magnolia</td>
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<td>1:30 PM - 1:40 PM</td>
<td>GROUP PHOTO</td>
<td>STEPS TO GARDEN COURTYARD</td>
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<tr>
<td>1:40 PM - 3:00 PM</td>
<td>NETWORKING</td>
<td>N/A</td>
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<tr>
<td>3:00 PM - 4:00 PM</td>
<td>COMMON INTEREST SESSIONS*</td>
<td>Grande</td>
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<td></td>
<td>• Carving Out a Dual Appointment Academic Position</td>
<td>Grande Patio</td>
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<td></td>
<td>Aasim Padela (Michigan CSP)</td>
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<td></td>
<td>• Clinical and Public Health Methods to Prevent Violence</td>
<td>Grande Patio</td>
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<td>Vijay Singh (Michigan CSP)</td>
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<td></td>
<td>• Institutional Leadership Garden</td>
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<td>Rhondée Benjamin Johnson (UCLA CSP)</td>
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<td>• Integrating Quality of Care into Medical Training</td>
<td>La Jolla Garden</td>
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<td>Ryan Greysen (Yale CSP)</td>
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<td>• Nutrition and Obesity: Community and Policy Approaches to Encouraging Health Lifestyles</td>
<td>La Jolla Pre-function A</td>
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<td>Jeff Kullgren (Penn CSP)</td>
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<td></td>
<td>Lenard Lesser (UCLA CSP)</td>
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<td></td>
<td>• Patient-Provider Interventions to Increase Screening Adherence</td>
<td>La Jolla Pre-function B</td>
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<td>Alejandra Casillas (UCLA CSP)</td>
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<td>Demetria Malloy (UCLA CSP)</td>
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<td>• The Safety Net in a Changing Health System</td>
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<td>Anje Van Berckelaer (Penn CSP)</td>
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<td>• Working with Hollywood Television Writers to Increase Accuracy of Health Messages in Television Storylines</td>
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<td>Rhonda Mattox (UCLA CSP)</td>
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<td>4:00 PM - 5:20 PM</td>
<td>POSTER PRESENTATIONS* — 2ND YEAR SCHOLARS</td>
<td>LA JOLLA A</td>
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<td>4:00 PM - 4:20 PM</td>
<td>ACCESS TO CARE – HEALTH DISPARITIES</td>
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<td>• Operation Access: A Proven Model for Providing Volunteer Surgical Services to the Uninsured in the United States</td>
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<td>Sierra Matula, CSP (UCLA 2008-2010)</td>
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<td>4:20 PM - 4:40 PM</td>
<td>• A Comprehensive Effectiveness Study Piloting Rapid HIV Testing Algorithm in the Los Angeles County Jail</td>
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<td>Sonali Kulkarni, CSP (UCLA 2008-2010)</td>
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<td>4:40 PM - 5:00 PM</td>
<td>• A Community-Partnered Approach to Evaluating Access to Care for Patients with Neurological Disorders in a Los Angeles Safety-Net System</td>
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<td>Christine Bower Baca, CSP (UCLA 2008-2010)</td>
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<td>5:00 PM - 5:20 PM</td>
<td>• Prehospital Care for Chest Pain Patients Differs by Gender But Not by Race</td>
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<td>Zachary Meisel, CSP (Penn 2008-2010)</td>
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</table>
### Poster Presentations* (continued)

#### PATIENT LEVEL FACTORS AND HEALTH OUTCOMES  
**LA JOLLA B**

- **4:00 PM - 4:20 PM**
  - Voces Para Niños Saludables: An Assessment of Pediatric Primary Care by Latina Mothers with Limited English Proficiency  
    Lisa DeCamp, CSP (Michigan 2008-2010)

- **4:20 PM - 4:40 PM**
  - Higher Education and Weight Gain  
    J. Jane S. Jue, CSP (Penn 2008-2010)

- **4:40 PM - 5:00 PM**
  - Epidemiology and Outcomes of Elevated Temperature Among Patients with Acute Ischemic Stroke  
    Michael Phipps, CSP (Yale 2008-2010)

- **5:00 PM - 5:20 PM**
  - Characteristics of 98 Low-Income Woman in a Philadelphia Postpartum Weight Retention Study  
    Charmaine Wright, CSP (Penn 2008-2010)

#### SYSTEM LEVEL FACTORS, QUALITY OF CARE, OTHER  
**LA JOLLA C**

- **4:00 PM - 4:20 PM**
    Erica Spatz, CSP (Yale 2008-2010)

- **4:20 PM - 4:40 PM**
  - Emergency Department Information System Adoption in the United States  
    Adam Landman, CSP (Yale 2008-2010)

- **4:40 PM - 5:00 PM**
  - Evaluating Popular Media and Internet-Based Hospital Quality Ratings for High-Risk Surgery  
    Nicholas Osborne, CSP (Michigan 2008-2010)

- **5:00 PM - 5:20 PM**
  - Family and Gender Impact Career Goals: Results of a National Survey of 4,586 Surgery Residents  
    Kate Viola, CSP (Yale 2008-2010)

#### PANEL TWO*  
**PACIFICA BALLROOM**

**Topic: Current and Former Robert Wood Foundation Clinical Scholars Collaborate on 2009-H1N1 Influenza**

- **Nicole Lurie, MD**, former RWJCSP (UCLACSP 1982-1984), Assistant Secretary for Preparedness and Response, Department of Health and Human Services, Washington, DC

  Director of Health, Rhode Island Department of Health, Providence, RI

- **Adam Landman, MD**, RWJF Clinical Scholars Program, Yale University, New Haven, CT

- **Arthur Kellermann, MD**, former RWJCSP, (Washington CSP 1983-1985), Professor and Associate Dean for Health Policy, Emory School of Medicine, Atlanta, GA

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**Thursday, November 5, 2009  continued**

**Location**
### Thursday, November 5, 2009  
#### Location

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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| 7:30 PM - 9:00 PM | DINNER  
Recognition: Dr. Gerald Levey  
Dean, David Geffen School of Medicine  
University of California, at Los Angeles  
Remarks by: Dr. Robert Brook, UCLA Clinical Scholars and others |
| 8:00 PM - 11:30 PM | HOSPITALITY SUITE LIBRARY |

### FRIDAY, NOVEMBER 6, 2009  
#### Location

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>7:00 AM - 8:00 AM</td>
<td>BREAKFAST</td>
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</tbody>
</table>
| 8:00 AM - 10:30 AM | PLENARY SESSION*  
Facilitator: Dr. Somnath Saha  
Clinical Scholars National Advisory Committee, Oregon Health & Science University, Portland VA Medical Center |
| 8:00 AM - 8:20 AM | • Emergency Preparedness – National Initiatives  
Nicole Lurie, former RWJCSP, (UCLACSP 1982-1984),  
Assistant Secretary for Preparedness and Response,  
Department of Health and Human Services, Washington, DC |
| 8:20 AM - 8:40 AM | • Understanding Black-White Differences in Colorectal Cancer Treatment: A Mixed-Method Study  
Arden Morris, (Washington 2000-2002), University of Michigan |
| 8:40 AM - 9:10 AM | • Understanding Youth Violence in New Haven:  
A Photovoice Project with New Haven Youth  
Luke Hansen, (Yale 2007-2009), Northwestern University,  
Feinberg School of Medicine  
• Participatory Evaluation of a Community Youth Violence Prevention Initiative  
Rachel Skeete, (Yale 2006-2009), The National Institute of Health |
| 9:10 AM - 9:25 AM | BREAK |
| 9:25 AM - 9:45 AM | • Challenges to Impending Dementia Collaborative Care in Community Practices  
Barbara Vickrey, (UCLA 1988-1990), University of California,  
Los Angeles/VA Greater Los Angeles Healthcare System |
| 9:45 AM - 10:25 AM | • Reforming the U.S. Health Care System:  
What Have We Learned from Evaluating the Options?  
Elizabeth McGlynn  
Associate Director, RAND Health; Distinguished Chair in Health Quality; Senior Principal Researcher  
Introduced by: Dr. Robert Brook, Co-Director UCLA Clinical Scholars |
| 10:30 AM | ADJOURN  
OUTSIDE LA JOLLA |
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<th>Day</th>
<th>Table Assignments by Registration Type</th>
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<td>Tuesday</td>
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<tr>
<td>Dinner</td>
<td>Reserved Tables: NPO, Alumni Panelists &amp; Speakers, NAC, and RWJF Trustees &amp; Staff</td>
<td>Garden Courtyard</td>
<td>Reserved</td>
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<td>Wednesday</td>
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<tr>
<td>Breakfast</td>
<td>Reserved Tables: Current Scholars, NAC, and RWJF Trustees &amp; Staff</td>
<td>Grande</td>
<td>Reserved</td>
<td>10 (8-10)</td>
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<tr>
<td>Lunch</td>
<td>Reserved Tables A: Current Scholars and Alumni Panelists &amp; Speakers</td>
<td>Olive Lawn/</td>
<td>Reserved A</td>
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<td>Dinner</td>
<td>Reserved Tables B: Community Partners &amp; CBPR Special Issue Faculty Editors</td>
<td>Olive Lawn/</td>
<td>Reserved B</td>
<td>2 (8-10)</td>
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<td>Reserved Tables: NAC, NPO, RWJF Trustees &amp; Staff, Program Directors &amp; Faculty, and Community Partners</td>
<td>La Jolla</td>
<td>Reserved</td>
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<td>Ballroom</td>
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<tr>
<td>Breakfast</td>
<td>Reserved Tables: Current Scholars &amp; NAC Mentors</td>
<td>Grande</td>
<td>Reserved</td>
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<tr>
<td>Lunch</td>
<td>Reserved Tables: Current VA Scholars with Drs. Cox &amp; Gilman</td>
<td>Magnolia</td>
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<td>Dinner</td>
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<td>Breakfast</td>
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Mitchell Katz, M.D.  
San Francisco Department of Health | Annie Lea Shuster Alumni Speaker

Mitchell Katz, MD has been the Director of Health for the City and County of San Francisco for twelve years. Prior to becoming Director, he served the Department in a number of positions, including Director of the AIDS Office and Director of the Emergency Medical Services Agency. He is also Professor of Medicine, Epidemiology, and Biostatistics at the University of California, San Francisco. He practices medicine as a primary care doctor at San Francisco General Hospital.

He was a Clinical Scholars at University of California, San Francisco from 1989-1991.

Regina M. Benjamin, MD.  
RWJF Trustee, U.S. Surgeon General-Elect

Regina M. Benjamin, MD, MBA, is Founder and CEO of the Bayou La Batre Rural Health Clinic in Bayou La Batre, Alabama. She is the Immediate Past-Chair of the Federation of State Medical Boards of the United States, and previously served as Associate Dean for Rural Health at the University of South Alabama College of Medicine. In 2002, she became President of the Medical Association of the State of Alabama, making her the first African American woman to be president of a State Medical Society in the United States. Dr. Benjamin holds a BS in Chemistry from Xavier University, New Orleans. She was in the 2nd class at Morehouse School of Medicine and received her MD degree from the University of Alabama, Birmingham, as well as an MBA from Tulane University. She completed her residency in family medicine at the Medical Center of Central Georgia. Dr. Benjamin received the Nelson Mandela Award for Health and Human Rights in 1998, and was elected to the American Medical Association Board of Trustees in 1995, making her the first physician under age 40 and the first African-American woman to be elected. Dr. Benjamin was previously named by Time Magazine as one of the “Nation’s 50 Future Leaders Age 40 and Under.” She was also featured in a New York Times article, “Angel in a White Coat”, as “Person of the Week” on ABC’s World News Tonight with Peter Jennings, and as “Woman of the Year” by CBS This Morning. She received the 2000 National Caring Award which was inspired by Mother Teresa, as well as the papal honor Pro Ecclesia et Pontifice from Pope Benedict XVI. She is also a recent recipient of the MacArthur Genius Award.

Elizabeth A. McGlynn

Associate Director, RAND Health; Distinguished Chair in Health Quality; Senior Principal Researcher

Elizabeth A. McGlynn is Associate Director, RAND Health; Distinguished Chair in Health Quality; Senior Principal Researcher. McGlynn oversees strategic development, external dissemination, and communications of the results of the RAND Health research portfolio. She is an internationally known expert on methods for assessing and reporting on the quality and efficiency of health care delivery at the physician, medical group, hospital, health plan, regional, and national level. She is coleading RAND Health’s COMPARE initiative, which has developed a comprehensive framework and methods for evaluating a wide range of health policy proposals being considered at the federal and state level as well as by the private sector. She is a member of the Institute of Medicine and serves on a variety of national advisory committees. She is the vice chair of the board of AcademyHealth, the professional association for health services researchers. She is the vice chair of the board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for Health Services Research and Milbank Quarterly and is a reviewer for many leading journals.
Panel One

To Improve Health and Health Care for Communities: Systems, Service, Science and Skepticism

Wednesday, November 4, 2009
La Jolla ABE  |  10:05 AM - 11:25 AM

Sarena Seifer, MD, Founding Executive Director, Community-Campus Partnerships for Health and Research, Dept. of Health Services, University of Washington School of Public Health, Seattle, WA

Eric Whitaker, MD, MPH, former RWJ CSP (Chicago CSP ‘98-‘00, 1997), Exec. VP for Strategic Affiliations, Associate Dean for Community-Based Research, Chicago, IL

Stacy Lindau, MD, MAPP, former RWJ CSP (Chicago CSP ‘00-‘02), Assistant Professor of Ob/Gyn and Medicine, University of Chicago, Principal Investigator, South Side Health and Vitality Studies, Chicago, IL

Doriane Miller, MD, former RWJF VP, Director, University of Chicago, Center for Community Health and Vitality, Chicago, IL

Loretta Jones, MA, Director, Healthy African American Families, Los Angeles, CA

“The outstanding problem before the medical profession today is that involved in the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life.” This statement summarizes the findings from a meeting of the Committee on the Costs of Medical Care convened at the University of Chicago in 1932 as a national health care advisory to the federal government.

Seventy five years later, despite a rich cultural and political history, the health of many people living in the communities surrounding the University of Chicago and its world-premier medical center is dismal. Population health indicators, using Healthy People 2010 benchmarks, epitomize the failure of the medical profession and the United States government to deliver “adequate medical service to all the people.” Comparing the South Side to the rest of Chicago, the US,
and to much of the developed world, disproportionately more babies are born prematurely and die. Preventable and treatable chronic illnesses take younger lives. Painful dental problems go untreated, interfering with nutrition, social engagement and employment. Depression, anxiety, and stress are more prevalent with earlier onset. Basic, quality medical services necessary for a life of dignity are either not available or not accessible to far too many people living on Chicago’s South Side. There is no system of care.

Many physicians working at the University of Chicago Medical Center, like South Side residents, feel ashamed of the poor state of health in our communities. Some individuals from both groups, along with the media, blame the medical center for the poor health of the community. How can a community that houses hundreds of the world’s leading scientists and the world’s most advanced biomedical technology suffer such poor health?

This panel will describe the politics and policy of University of Chicago’s Urban Health Initiative, led by former Clinical Scholar Eric Whitaker, and its endeavor for health justice on the South Side of Chicago through: 1) creation of a quality, sustainable health system linking the academic medical center with community health centers, hospitals and other service providers; 2) direct service to the community to improve health and build capacity in areas of greatest need (led by Doriane Miller); and 3) scientific evaluation of health and health-related policies using a prospective, longitudinal Community Health and Nutrition Examination Survey model (led by Stacy Lindau, former Clinical Scholar). Ms. Loretta Jones, Executive Director of Healthy African American Families and longtime partner of the UCLA RWJCSP, will add her expertise on community-university partnership and how communities can hold academic institutions accountable for community engagement and benefit.

The roundtable session will share the Chicago process and model for community engagement, including partnership with government agencies, the conceptual framework for the research, and the politics of the Urban Health Initiative. This initiative is embraced by some as a bold and necessary move to form a sustainable and exemplary system of care. Others regard the initiative as an immoral strategy to profit by abdicating care for poor and uninsured individuals. Is health justice a realizable goal in the U.S.? Can partnerships like those in LA or the South Side of Chicago become the model? Sarena Seifer, MD, Executive Director of the Community-Campus Partnerships for Health, will place the Chicago and LA work in an historical context, and will moderate a provocative discussion of the obligation of academic medical centers and clinician scholars in civic society.
As of August 22, 2009, over 8,000 hospitalizations and 556 deaths have been reported in the United States (US) from 2009-H1N1 influenza (H1N1). While the future impact of H1N1 in the US is difficult to predict, the US government is preparing for a severe fall resurgence based on the experience of Southern Hemisphere countries during their winter season and the continued presence of the virus in the US this summer. In this forum, four current or former Clinical Scholars from government, academia, state public health, and the private sector will share how they joined forces to help the nation become better prepared for this public health emergency. Each speaker will share how their respective roles led them to collaborate to enhance surveillance, vaccine safety monitoring, medical care capacity, vaccine distribution, communications, and overall coordination for 2009-H1N1 influenza.
An Assessment of Child And Adolescent Mental Health Care Needs in The United States by Insurance Status

 CONTEXT: Although 11 million American children suffer from mental illness, only 20% report receiving needed services (despite the availability of evidence based treatments). Mental health service delivery system fragmentation, insurance inequities, and limited access to child psychiatry specialists have been identified as contributing to the problem of unmet need. Children with mental illness who are privately insured may have increased unmet need due to barriers inherent in private insurance.

 PURPOSE: To assess the unmet mental health needs of children and adolescents in the United States, to evaluate the correlates of unmet need including whether private or public insurance coverage is associated with greater unmet need, and to compare whether children’s unmet need for mental health care is similar to children’s unmet need for physical health care.

 METHODS: We analyzed data on 40,723 children with special health care needs aged 1 to 18 years included in the 2005 National Survey of Children with Special Health Care Needs. We conducted multivariate analyses to assess the independent association of insurance status (public or private) on unmet need for mental health services, need for specialty (general health) services, and need for routine physical care.

 RESULTS: An estimated 25% of children with special health care needs have an Emotional, Developmental or Behavioral (EDB) condition. Of those with EDB conditions, 65% were privately insured, 35% were publicly insured. Insurance status was an independent predictor of unmet mental health care needs with privately insured children having greater unmet need than publicly insured children (OR 1.34; 95%CI 1.00-1.79). Privately insured children with special health care needs without EDB did not have significantly greater need for specialist (general health) care or for routine care than publicly insured children.

 CONCLUSIONS: Privately insured children with mental illness had significantly greater unmet need for mental health services than publicly insured children with mental illness. This finding points to an important gap in care.

 KEY WORDS: Unmet Need, CSHCN (Children with Special Health Care Needs), EDB (Emotional, Developmental, Behavioral) Conditions

 AUTHORS: Jill Barron, MD MHS, Yale University; Corey Pil- 

ner, PhD, Yale University; Rani Desai, PhD, Yale University; 

Susan Busch, PhD, Yale University
Impact Of Care For Depression On Hiv Outcomes Among Medicaid Beneficiaries In California

Depression and anxiety disorders are prevalent among persons living with HIV/AIDS and are associated with worse survival. Often mental health care is not provided to those who need it, including racial and ethnic minorities. Yet what is also not known is the extent to which care for these disorders is associated with better HIV outcomes.

WE INVESTIGATED THE FOLLOWING: a) whether providing care for depression or anxiety is associated with improved HIV outcomes; b) if racial and ethnic disparities in care for depression or anxiety partly account for racial disparity in HIV outcomes; and c) if care for depression or anxiety is associated with receipt of recommended HIV care. Care for depression was defined as anti-depressant use and mental health specialty visits. Recommended HIV care processes included influenza vaccination, annual STD screening, receipt of HAART, cervical cancer screening, TB screening, and regular HIV disease monitoring. The design was a prospective cohort study of Medicaid beneficiaries diagnosed with AIDS in the state of California. We selected beneficiaries aged 18 and older, with 12 months of continuous coverage prior to January 1, 2003 from Medicaid eligibility files. Subjects included in the analysis were those with an AIDS diagnosis as of January 1, 2002, as documented in the California State HIV/AIDS Registry and/or if they were hospitalized primarily for an AIDS-defining condition prior to January 2002. We used medical and mental health claims data to identify socio-demographic characteristics, co-morbid medical and psychiatric illnesses, and mental illness severity in the baseline year (2003). Claims data also provided use of anti-depressant medication and mental health specialist care in the year following baseline (2004) and receipt of recommended HIV care in the follow-up year (2005). Claims data, the state death file, and statewide hospitalization database were merged and used to examine selected outcomes in the follow-up year (2005). Main independent variables are months of anti-depressant therapy and use of mental health specialist care. Main outcome variables are emergency department visits, hospitalizations, new AIDS-defining illness, and death.

WE USE LOGISTIC REGRESSION MODELS TO COMPARE OUTCOMES AMONG THREE GROUPS OF SUBJECTS: AIDS without depression/anxiety, AIDS and depression/anxiety without evidence of treatment, AIDS and depression/anxiety with evidence of treatment. Sensitivity analyses explore the impact of ‘guideline’ consistent depression treatment on HIV outcomes. Results presented include descriptive statistics regarding socio-demographics, mental health conditions, evidence of care for depression anxiety, and baseline differences in outcome by race/ethnicity. We present the associations between race/ethnicity and HIV outcomes after adjustment for care for depression or anxiety. Adjusted odds of receipt of HIV care processes and risk of emergency department visit, hospitalization, and death during the follow-up period are shown for the three groups of patients. Our results will provide meaningful information regarding the quality of care for a vulnerable population and inform policy regarding access to mental health care.

KEYWORDS: depression, HIV/AIDS, Medicaid, California, health outcomes

AUTHORS: R Benjamin-Johnson MD, MSc, UCLA; William Cunningham MD, MPH, UCLA; Alison Moore MD, MPH, UCLA; David Zingmond MD, PhD, UCLA

Through Our Eyes: Perspectives of Young Black Men on Factors Affecting Transition to Manhood

PURPOSE: To have young, Black men from Los Angeles County identify and discuss factors affecting their transition to manhood using photovoice.

METHODS: We used CBPR/CPPR principles to form a 12-person collaborative of academic and community members from various organizations. To date, the collaborative has defined goals for the partnered project to address premature mortality in Black men, developed a project protocol, participated in data collection and analysis, and developed a preliminary dissemination plan. The protocol was approved by the RAND Corporation IRB. Eligible participants were 16-26 year old Black men who had lived most of their lives in Los Angeles. Candidates were recruited by advisory board members. We used photovoice for data collection. Each participant was given a digital camera to take a minimum of 50 and maximum of 300 photographs over four months. Participants individually discussed photographs with an advisory board
member using the SHOWeD method. Each participant used pile-sorting methods to discuss major themes with an advisory board member. Participants then selected 6-10 representative pictures to put into a group collection of photographs. In addition to an individual pile sort, each participant, pile-sorted the group photographs and discussed themes with an advisory board member. All pile-sorting sessions were audio recorded and transcribed. Pile sorts of group pictures were analyzed using multidimensional scaling and hierarchical cluster analysis to systematically compare participants’ themes and identify patterns of associations between sorted photographs. Major themes and related quotes were also elicited from the pile-sorting transcripts.

RESULTS: Twelve of the fourteen recruited participants completed all phases of the project. The participants had a mean age of 20 years, 25% were enrolled in higher education, 33% employed full time, 75% grew up in single-parent/fostercare homes, and 25% had been incarcerated. Four clusters emerged from the group collection of photographs. The participants interpreted the clusters as: 1) Daily challenges faced in manhood. A picture depicting a young boy pointing a real gun evoked in the participants a feeling of “always [being] on the defensive” and “a sense of [the] fatalism [of] violence”. 2) Inspiration and social support. Pictures depicted family, friends, and religion. 3) Sports and teamwork. A picture of men playing basketball elicited the response that “the court is the one place we can congregate without being harassed”. 4) Los Angeles lifestyle. Pictures showed expensive cars, clothes, highways, and palm trees, as well as representation of successful careers in entertainment. The theme analysis of experiences, which is ongoing, will generate additional themes that participants identify from their individual photos as important in their transition to manhood. Based on the project findings, priority areas will be identified by the advisory board and participants. Community dissemination of the results may include sharing findings with community, school-based, and policy organizations that affect healthy outcomes for Black men through workshops, town hall meetings, interactive gallery exhibit, and popular press articles.

CONCLUSIONS: CBPR and photovoice are effective methods to engage young, Black men to identify and discuss factors affecting their transition to manhood, contextualize research findings, and participate in dissemination.

KEY WORDS: photovoice, black men, CBPR, transition to manhood

AUTHORS: Nazleen Bharal, MD, MPP, UCLA; Arleen Brown, MD, PhD, UCLA; David Kennedy, PhD, RAND Corporation

JAMES BOEHNLEIN
(UNIVERSITY OF PENNSYLVANIA 1985-1987)
Oregon Health and Science University, Department of Psychiatry, Intercultural Psychiatric Program

Mental Health Education Consultation in Cambodia: The Effects of Psychological Trauma in Post-Conflict Countries

This education project is part of an ongoing consultation to the Documentation Center of Cambodia (DC-Cam), a non-governmental organization (NGO) devoted to genocide research and education. The goal of this consultation is to improve mental health knowledge and skills among professionals, and mental health awareness among rural community leaders and villagers in Cambodia. The initial education and training in December 2008, sponsored by the Congressionally created and funded United States Institute of Peace (USIP), centered on educating health professionals, students, and the public about the long term effects of psychological trauma in advance of the joint United Nations/Cambodian war crimes trials of Khmer Rouge leaders that began in February 2009. The 1975-1979 Khmer Rouge genocide resulted in the deaths of 1.5 million people (out of a total population of 7 million) from disease, starvation, and execution. Cambodians with advanced education, such as teachers, physicians, and monks, were particularly singled out for execution, but the broad devastation of those four years has left many multigenerational legacies of trauma across all sectors of Cambodian society. Health, education, and other social systems that were destroyed during those four years have been very slow to recover, even with international aid. All families were impacted by the tragedy, with massive loss of life, along with the loss of social and cultural traditions that provide intergenerational stability. Because of these traumas and hardships, many Cambodians must deal with chronic depression and posttraumatic stress disorder (PTSD), along with the usual public health problems that are prevalent in the developing world. Poverty and lack of basic health and mental health services remain serious problems. Because of the numerous health and mental health challenges facing providers and the public in one of the world’s poorest countries, a curriculum was developed to enhance the knowledge and skills of Cambodian health professionals in recognizing and treating common co-morbid mental health conditions that follow trauma (PTSD, depression, substance abuse) and how those interact with illnesses encountered in primary care to adversely affect individual and community functioning. In addition, this curriculum was modified and presented to community leaders...
and the general public in rural provinces to encourage general health and mental health awareness, to encourage healthy proactive responses to stress, illness, and social disruption, and to decrease stigma. This presentation will present the rationale for this education intervention and a brief summary of its content. Current strengths and potential future challenges for meeting the immense mental health needs of Cambodia will be discussed, particularly since this project is one of the initial steps in developing a maximally effective and culturally responsive national mental health system. The ability to undertake this education consultation is the result of 25 years of clinical and teaching experience in Cambodian mental health care that began as a Clinical Scholar. This presentation will illustrate how it is possible to longitudinally integrate knowledge and skills from work in clinical medicine, medical anthropology, and social systems to enhance professional and public perceptions of mental health in developing, post-conflict countries.

AUTHORS: James Boehnlein, M.D., M.Sc., Oregon Health and Science University

C A R O L I N E  B O N H A M
CSP / UNIVERSITY OF MICHIGAN (2008-2010)

Medical Students in The Community: Are Students Participating in Community Partnerships That Promote Reciprocal Knowledge Transfer?

BACKGROUND: Traditionally, medical students received their education on inpatient units at academic medical centers (AMCs). AMCs are sometimes criticized because they receive substantial public funding, yet they can be isolated from the communities they serve. Medical education is also criticized for overemphasizing the biological causes of disease while neglecting the community factors that influence health. Finally, as the length of stay on inpatient units declined, medical schools needed to find new venues to train medical students. In response to these three considerations, many medical schools developed programs to place students in the community. Often, these programs are influenced by the philosophy of service learning. Service learning encourages the development of active partnerships between communities and AMCs and emphasizes the idea of reciprocal learning what we refer to as reciprocal knowledge transfer.

AIM: To review current medical education literature on community placements for medical students to learn: 1. What goals are emphasized in these programs? 2. To what extent are partnerships discussed? 3. Who identifies unmet community needs: community partners, academic faculty, or both?

METHODS: We performed a systematic qualitative content analysis of articles that addressed community placements for medical students. We retrieved 61 articles from North American allopathic medical schools published in peer reviewed journals since 1990. We used the following keywords to identify relevant articles: service learning; community oriented medical education; community based education; community based medical education, health professions education; medical school curriculum; medical student; undergraduate medical education; and medical education. We analyzed the content of these heterogeneous articles using a process of open and focused coding of the text. After our initial analysis, we conveyed our findings to community partners and asked for input on questions that they considered to be important in medical education. We then refined our analysis based on topics that were prioritized by our partners.

RESULTS: We identified three main findings across the articles: (1) Faculty at AMCs are interested in using community placements as venues for teaching medical students about professionalism. Yet, very few articles mention involving community members as potential teachers in these sessions. (2) Partnerships between community agencies and AMCs are considered to be important facilitators in establishing and sustaining programs with medical students. However, the rights and responsibilities of the community partners are rarely discussed. (3) Very few articles mention the involvement of community members when identifying community health needs. Programs with ongoing community-based participatory research (CBPR) relationships were more likely to involve community members partners when identifying needs in health education or clinical service.

CONCLUSIONS: Partnerships between communities and AMCs that promote reciprocal knowledge transfer represent a model of medical education that can potentially benefit students, AMCs and communities. We are concerned that there is little emphasis on the reciprocal nature of these partnerships. We propose that the principle of community partnership be incorporated into discussions of professionalism during medical school. We also suggest that policies for medical school accreditation be revised to include an evaluation of community partnerships.

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A Community-Partnered Approach to Evaluating Access to Care for Patients with Neurological Disorders in a Los Angeles Safety Net System

To apply a community-partnered approach to assessing barriers in referral access from community-based primary-care practices to outpatient Neurological specialty care at a Los Angeles safety-net medical center.

Valley Care Community Consortium (VCCC) is a health planning collaborative providing healthcare coordination to 2 million residents of the San Fernando and Santa Clarita Valleys of Los Angeles, of whom 250,000 residents, predominantly Latino, lack health insurance. VCCC leadership had identified Neurology as a top medical specialty in need of improved access, and during residency training the PI (CB) observed challenges in capacity for neurological care at Olive View Medical Center (OVMC), the primary VCCC referral facility within the Los Angeles County Department of Health Services (LAC-DHS) healthcare system. Meetings between the VCCC program director (UN) and the PI, based on a common interest to improve access to neurological care for patients in this safety-net system, led to a research partnership to investigate barriers that might be overcome through system re-design.

To elucidate specific barriers, the PI initiated a preliminary data collection phase, conducting semi-structured interviews with the OVMC Neurology Chair, two of the seven adult OVMC-Neurologists, three primary-care providers, two OVMC-Emergency Department (ED) physicians, and four administrators of the LAC-DHS who recently implemented a county- and specialty-wide web-based Referral Processing System (RPS). Topics discussed included: capacity constraints, consultation wait-times, referral procedures, constraints in discharge of stable patients from OVMC-Neurology into primary care, use of RPS, and communication between OVMC-Neurology and referring providers. Additionally, the PI documented variation in the OVMC Neurology referral triage process by observing four adult OVMC-Neurologists screen referrals. Interview data were recorded in notes, summarized, and reviewed with VCCC.

Identified barriers to accessing Neurological care include: 1) capacity constraints including limited neurologists and clinic space, resulting in lengthy wait-times, 2) variation in the referral process and triage criteria, 3) lack of availability and underuse of neurological referral guidelines for primary care providers, 4) limited provider knowledge of RPS capabilities for enhancing communication around referrals, 5) high no-show rates with no process for re-scheduling, 6) low rates of discharge of stable neurological patients back to referring providers due to capacity constraints in primary care, and 7) substantial responsibility placed on patients to follow-up on referral scheduling steps.

Based on these observations, a model will be constructed to guide additional data collection and inform a future system re-design intervention. First, a series of prospective referrals to OVMC-Neurology will be audited to evaluate the referral problem mix, clinical appropriateness, and efficiency of the referral process. Second, a qualitative study will be conducted in order to delineate OVMC-Neurology patient-perceived barriers and variation in primary-care provider referral practices. Results will be shared with VCCC, referring providers, OVMC-Neurology, and LAC-DHS, to elicit feedback and to collaboratively design an intervention for improving access. There are numerous barriers to accessing Neurological specialty care in the Los Angeles safety-net system. In a system with severe resource constraints, a community-partnered approach to identifying these barriers is needed in order to develop effective strategies for improving access to care.

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Changing Health Behavior by Influencing Knowledge, Attitudes, and Practice: a Partnership Between a Clinical Scholar and New Haven Healthy Start

New Haven community leaders have identified infant mortality as an important health issue that may be modified by influencing certain social determinants of health. New Haven’s infant mortality rates are consistently higher than that of other urban areas. In 2004, the rate was over twice that of Bridgeport and nearly 70% greater than that of Hartford, two similarly poor and urban areas in Connecticut. New Haven Healthy Start (NHHS) is a community initiative with a consortium comprised of community members, community leaders and health providers. NHHS has a mission to reduce
infant mortality, low birth weight and racial inequities in perinatal outcomes in New Haven. NHHS' targets various groups throughout the community: participants in NHHS’ educational workshops, program participants who make contact with NHHS through care coordinators, outreach workers and Baby Buddies (para-professional health coaches who reside with New Haven housing projects), and community participants who attend meetings of the NHHS consortium and other educational activities. We seek to understand how some health behaviors surrounding the issue of infant mortality and low birth weight may be influenced by a series of health education tools developed in partnership with the community they hope to impact. Prior work has demonstrated that the process of changing health behavior can be divided into three domains: knowledge, attitudes and practice. We will utilize these domains to assess our affect on the community. Through a collaboration between the Yale Clinical Scholars Program and the NHHS consortium we will develop, pilot, refine and evaluate a series of health education tools to be distributed through a multi-pronged approach including all levels at which NHHS currently engages members of the community. The content of the health education tools, determined in partnership with the consortium, will include information on staying healthy throughout pregnancy, strategies for new parents, nutrition, stress (including depression), and joining the consortium. We will assess participants’ knowledge, attitudes and practices before and after receiving the educational tools using surveys administered by NHHS (knowledge and attitudes) as well as participants’ use of coupons and other incentives for healthy activities (behavior). The anticipated output is an understanding of the potential impact of a series of health education tools on the health behaviors of a specific, targeted community. In addition, we anticipate gaining a better understanding of to conduct research into the effect of health interventions in this community. The findings of this work will contribute to local knowledge surrounding how best to positively influence health behavior to reducing infant mortality. More broadly, our research to understand how health behaviors can be influenced within the domains of knowledge, attitudes and practice, may be more broadly applicable to health education for other vulnerable populations.

KEY WORDS: community-based participatory research, health literacy, infant mortality

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LISA DE CAMP
CSP / UNIVERSITY OF MICHIGAN (2008-2010)

Voces Para Niños Saludables: An Assessment of Pediatric Primary Care by Latina Mothers with Limited English Proficiency

PURPOSE: A key goal of the American Academy of Pediatrics is for all children to have a medical home, defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Even if Latino children have a usual source of care, they are less likely to receive care in a medical home than non-Latino white children, and, if they do receive care in a medical home, it is more likely to be of lower quality. Little is known about Latino families’ preferences for health care provider and health center characteristics that lead to selection and continued use of a primary care clinic or provider for their child. This study explores Latino families’ preferences and expectations for pediatric primary care to 1) increase understanding of why Latino children experience disparities in medical home access and quality; and 2) contribute to improved quality of primary care for Latino children.

METHODS: This study was developed in partnership with Community Health and Social Services Center (CHASS) in Southwest Detroit. CHASS-Southwest Center is a federally-qualified health center that aims to provide family- and community-centered care using the medical home model for local low-income, limited English proficient Latino families. This study uses semi-structured interviews to elicit participants’ experiences and opinions about the process of choosing a primary care provider for their child, their level of satisfaction with the primary care provider, their assessment of medical home services provided by the primary care provider, and their conception of an ideal primary care provider for their child. We are using a purposeful sampling to enroll 40 primarily Spanish-speaking, low-income Latina mothers who identify a primary care clinic/provider for their children and have at least one child less than 3 years old, to ensure frequent recent interactions with the primary care provider. We are also are recruiting a mix of first-time mothers, mothers with more than one child, and mothers of children with special health care needs. Approximately one-third of the sample will obtain primary care at CHASS, and the remainder will use other local clinics. The CHASS executive and medical directors, University of Michigan researchers, and Southwest Detroit residents have jointly developed the research methods and materials.
RESULTS: Study interviews will begin in September 2009. CHASS staff and community residents are members of the research team collecting and analyzing the data and interpreting the findings.

CONCLUSIONS: This study will have both local and national implications. At the local level, study findings will be used to improve pediatric care services provided by CHASS, and other local pediatric providers, including building their capacities to serve as a medical home. Additionally, findings from this study will be used to develop hypotheses that will inform future community-based studies addressing unmet pediatric primary care needs among low-income, limited English proficiency Latino families. Finally, this study could inform the national discourse on underlying mechanisms that contribute to health disparities and guide policies and programs targeted at reducing health disparities.

KEY WORDS: disparities, Latino, limited English proficiency, medical home, pediatrics

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LIS A D I A M O N D
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Linguistic Access Services in The United States: Do They Measure Up to The National Culturally and Linguistically Accessible Services Standards?

Federal regulations require health care organizations to provide language services for limited English proficiency (LEP) patients. The National Standards on Culturally and Linguistically Appropriate Services (CLAS standards) in Health Care, issued by the Office of Minority Health, include 4 that outline what it means to provide adequate linguistic access services to LEP patients as proscribed in Title VI of the Civil Rights Act. It is not known how US hospitals have incorporated the CLAS standards into practice. We sampled 239 hospitals using 2 different methods: a directed and a national sample. Both samples were generated as a part of the Hospitals, Language, and Culture Study (HLC), recently conducted by The Joint Commission. We received survey responses from 135/221 (61%). We used standard frequency analyses to describe the study sample and their responses. We conducted bivariate analyses using the #967;2 or Fishers Exact test, where appropriate, to assess differences between responders and nonresponders and between the directed and national sample subgroups. Seventy-eight percent of hospitals were able to provide interpreters for their most common language within 15 minutes during business hours, but only 48% could provide interpreters in that same time frame for their third most common language. Hospitals were more challenged to inform patients of their right to linguistically accessible services. Less than 50% did so via Patients’ Bill of Rights forms and posters in other languages and in English (48% and 44%), forms or brochures in other languages and in English (40% and 29%), multilingual posters (32%), verbally in other languages (33%), through interpreter services outreach (4%) and media campaigns (2%). Most hospitals did not meet the standard regarding use of competent interpreters either: 62% reported that family members or friends of patients were used as interpreters, even though 70% of these hospitals also reported having a policy prohibiting this. Most hospitals required that staff (79%) and contract (63%) interpreters undergo interpreter training but ad-hoc interpreters, such as volunteers and bilingual staff, usually did not. Finally, hospitals made the following translated documents available in their most commonly requested language: Advance directives (65%), patients’ rights (61%), discharge instructions (58%), informed consent (57%) and hospital signage (51%). Less than a third of hospitals had these written documents available in two or more non-English languages. Very few hospitals could provide all of these forms in their most common language (17%). Our study documents that many hospitals are not providing language access services as required by federal law, even those that are upheld as example institutions. Enforcement of Title VI is difficult and infrequent and the threat of enforcement is not a big enough concern to motivate hospitals. Hospitals will likely be moved into greater compliance due to efforts by The Joint Commission, the National Quality Forum, and the National Committee for Quality Assurance, all of which are using the CLAS standards to develop guidelines for linguistically accessible care. Our study reinforces the importance of these efforts and helps target interventions to improve the delivery of care to LEP patients.

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Evan Fieldston
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Patient Flow at Children’s Hospitals: Assessment, Research, Improvement

BACKGROUND: Hospital crowding adversely affects access to emergent elective care, quality safety of care, patient staff satisfaction, and finances. Sentinel events medical errors seem to increase when hospital occupancy exceeds 85%-90%, but there is more to efficient hospital operations than static occupancy levels. Traditional measures of hospital utilization, such as midnight census or patient days, do not account for the complex dynamic realities of patient flow, particularly at children’s hospitals with a mix of rapid turnover patients and complex, chronically-ill patients.

OBJECTIVE: To lay a foundation for evaluation and improvement of patient flow at children’s hospitals across three basic domains: (1) Measurement of dynamic workload and throughput with valid and reliable metrics; (2) Linking non-optimized patient flow to outcomes (e.g. quality, access, satisfaction, educational, and financial); and, (3) Operational strategies to avoid non-optimized flow and mitigate its effects if and when it does occur.

METHODS: To address one aspect of patient flow, dynamic movement of patients, we developed a tool to identify, measure, and analyze operational efficiency or inefficiency at the hospital. The tool was developed through clinical and operational expert input and through iterative pilot use. It was then used to collected over 20,000 bed-hours of real-time observation of patient flow in the pediatric intensive care unit (PICU) over 5 weeks. Analysis using descriptive statistics, operations management techniques, and simulation software are underway to evaluate flow and bottlenecks in the PICU and hospital.

RESULTS: Preliminary results show that the PICU has a high burden of complex disease, with over half of all the bed-hours observed (including unoccupied beds) for patients with ventilator assistance and/or a continuous infusion requiring the PICU. Though prolonged logistical delays accounted for less than 10% of bed-hours, these were relevant to flow of patients out of and into the PICU.

CONCLUSIONS: Based on the PICU observation project and other work, it is clear that children’s hospitals are frequently at high levels of occupancy and have high throughput and turnover, but systems and staffing are not necessarily in place to handle this situation. Real-time data, using novel methods such as direct observation, generation of actionable immediate information, and context-dependent improvement work are needed to improve flow and related access, safety, and quality. Better measures of census, occupancy, and throughput, particularly related to staffing levels, are still needed and computer systems need to incorporate this coding into regular output data. More evidence is needed to link crowding to outcomes for patients, staff, and finances, including greater understanding of the threshold when problems begin or worsen. Finally, operational strategies need to be further evaluated to determine the best approaches to avoid crowding or mitigate its effects, recognizing that local context is important. Future work is designed to develop these tools and disseminate them for local adaptation and improvement. Multiple research methods are and will be used, including retrospective cohort studies using single-institution and national research network administrative date sets; primary data collection through real-time operations observation; quality improvement project involvement and evaluation; and simulation.

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Stanley Frencher Jr
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Cutting through the Uncertainty of Prostate Cancer for Black Men Using Barbershop Outreach

BACKGROUND: African American (AA) men diagnosed with prostate cancer are typically younger in age, with more aggressive disease and with higher likelihood of dying from this disease. Nevertheless, screening remains controversial because the mortality benefit of population-based screening, even for AA men, remains unclear. However, given the disparities in prostate cancer among AA men, aggressive outreach may still be warranted. Patient decision-aids have been developed and tested in clinical settings to assist men in making this preference sensitive decision. But neither their effectiveness in community settings has been established, nor have these men been followed to determine if once informed they have access to prostate care, use it, and if the care received is appropriate given their individual preferences.

PURPOSE: To develop a collaboration between UCLA and the Black Barbershop Health Outreach Program (BBHOP) and as-
sessed the impact of prostate cancer decisionaids in Los Angeles barbershops on decisions made by AA men about prostate cancer screening.

METHODS: BBHOP, founded by Bill Releford, DPM, currently works to address cardiovascular disease (CVD) in black men by partnering with AA-owned barbershops to provide health education and screening services. Since 2007, BBHOP has screened nearly 10,000 men in barbershops across 13 states. In response to a call from AA men in the community to address their concerns about prostate cancer screening, BBHOP and UCLA researchers formed a collaboration to evaluate methods of promoting active, informed participation in prostate cancer screening decision-making. Using a community-partnered participatory approach, we will use a cluster-randomized design to compare AA men over age 40 years exposed to a prostate cancer decision aid to those exposed to the standard (CVD) BBHOP. Barbershops will represent the unit of randomization. The primary outcome of the study will be to determine if exposure to a prostate cancer decision aid in barbershops, complemented by a clinical referral network, leads to AA men consulting with a healthcare provider in order to arrive at a shared-decision about prostate cancer screening. Secondarily, using validated survey instruments, we will develop an understanding of the determinants of AA men’s preferences in making decisions related to prostate cancer screening and treatment by measuring decision quality, knowledge, resultant prostate cancer care (i.e., screening, diagnosis, treatment and follow-up) and participation in other medical care. Data will be collected at baseline, post-intervention and at 3 months follow-up. Trained community members, employed by and integrated into the research team, will facilitate data collection and recruitment. We aim to demonstrate that by disseminating prostate cancer information to men in a credible, convenient setting, such as barbershops, we will enable AA men to cope better with the uncertainties and participate more fully in this difficult clinical decision—whether or not they decide to undergo prostate screening.

KEY WORDS: barbershop outreach, community-based participatory research, prostate cancer, decision-aids

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KATHERINE GOODRICH
CSP / YALE UNIVERSITY (2008-2010)

Care Transitions and Patient Readmission: Where Does Literacy Fit In?

Almost one fifth of hospitalized Medicare beneficiaries are readmitted within 30 days of discharge. Patients with low health literacy may be at greater risk for this outcome, yet little is known about this potential association or whether modifiable mediating factors exist. Our aims were 1) to explore the association between health literacy level and 30 day readmission in Medicare beneficiaries and 2) to explore the association between health literacy level and patient understanding of discharge instructions. We are conducting a prospective cohort study of hospitalized patients over the age of 65 with normal cognitive status and a diagnosis of Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF), or Community Acquired Pneumonia (CAP). We will assess health literacy level during hospitalization using the Rapid Estimate for Adult Literacy in Medicine (REALM). After discharge, we will perform a quantitative assessment of patient understanding of their discharge instructions as well as an evaluation of the content of the discharge instructions. The primary outcome variable is readmissions within 30 days of discharge. We will test the association between literacy level and 30 day readmission rate, adjusting for patient characteristics, using Poisson regression.

We will use logistic regression to test the association between literacy level and understanding of specific aspects of the discharge instructions, adjusting for patient characteristics. This work will add to the growing body of literature about the relationship between health literacy and important health outcomes. With the current national focus on public reporting of 30 day readmission of patients with AMI, CHF, and CAP, this work may guide hospitals in their efforts to improve care transitions. Specifically this study will generate hypotheses about the relationship between discharge communication and adverse outcomes, and may lead to the development of targeted discharge tools for patients with limited health literacy.

KEY WORDS: health literacy, hospital readmission, care transitions, discharge process

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Opening of Ambulatory Surgery Centers and Procedure Use in the Elderly

**PURPOSE:** Compared to hospitals, ambulatory surgery centers (ASCs) potentially deliver surgical care more efficiently and at a lower cost per episode than hospitals. However, ASC proliferation may increase the overall use of discretionary procedures because of the financial incentives for the physicians who staff them. Motivated by this, we measured the effect of the opening of an ASC in a health care market, as defined by the hospital service area (HSA), on overall procedure use.

**METHODS:** With a 100% sample of outpatient surgery encounters from Florida (1998 to 2006), we measured annual HSA-level rates of use for discretionary (cataract surgery, colonoscopy, and upper endoscopy) and imperative (cancer-directed breast surgery) procedures among Medicare-eligible persons. We adjusted all rates by age and gender to the 2000 U.S. population using direct standardization methods. Using a multiple time series research design, we then compared the rate of change in procedure use for HSAs where ASCs opened to HSAs where an ASC was never present.

**RESULTS:** In HSAs where an ASC opened, colonoscopy use increased by 1610 procedures per 100,000 per year (95% confidence interval [CI], 736 – 2485; P<0.001) and endoscopy use.
increased by 775 procedures per 100,000 per year (95% CI, 159 – 1391; P equals 0.014). However, rates of cancer-direct-
ed breast surgery remained flat. Four years after opening, the relative increases in colonoscopy and upper endoscopy were approximately 117% and 95% higher, respectively, for HSAs where ASCs opened compared to those without them. In HSAs affected by ASC entry, the proportion of patients undergoing screening colonoscopy decreased significantly the year after opening (P<0.001), while the proportion of patients who under-
went upper endoscopy for vague indications increased sign-
ificantly (P equals 0.008).

CONCLUSIONS: ASC opening within an HSA was associated with significant increases in the use of colonoscopy and upper endoscopy. This growth was attributable, in part to the growing use of these procedures for more discretionary indications. In contrast, ASC opening did not affect rates of cancer-direct-
ed breast surgery.

KEY WORDS: ambulatory surgery center, utilization, physi-
cians’ practice patterns

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LARA JOHNSON
CSP / YALE UNIVERSITY (2008-2010)

The Role of School Based Health Centers in Teen Pregnancy Prevention: Experiences of New Haven Public School Students

BACKGROUND/OBJECTIVES: Teen pregnancy rates are increasing nationally, and rates in New Haven, CT are consistently higher than national averages. In response to these trends the mayor of New Haven formed a multidisciplinary, community-based council to understand and to decrease teen pregnancy rates. Increasing the availability of reproductive services overall, and at school based health centers (SBHC) specifically, has been identified by the council as a means to prevent teen pregnancy. We sought to determine the association between adolescents’ access to SBHCs and adolescents’ perceptions of their ability to obtain contraception.

METHODS: In partnership with the Teen Pregnancy Prevention Council of New Haven, we designed survey items for use with the annual New Haven Public Schools-administered Youth Risk Behavior Survey. The additional survey items concerned students’ reports of access to and use of SBHC, perceived ability to obtain routine and emergency contraception, as well as reports of previous pregnancies, and desire to become pregnant. All students in grades 8-11 were eligible to participate. We will use bi-

JANE S. JUE
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Higher Education and Weight Gain

The obesity epidemic is a large public health threat that now af-
ficts all sectors of the American population. Moreover, studies suggest that the risk of weight gain is highest among young adults. However limited infor-
mation exists regarding factors and proposed mechanisms associated with weight gain in young adults. One of the only areas of study around weight gain in young adults is in col-
lege students around the “freshman fifteen.”
Robert Wood Johnson Foundation Clinical Scholars Abstract

However, no study has compared the weight gain in young adults between those who do and don’t attend college. There is currently no evidence that higher education confers additional risk for weight gain during that period beyond that which is age related. In fact, it goes against cross-sectional evidence associating higher education with lower risk for obesity. Given this fairly well-studied association and the implication of education as a social determinant of health more broadly, it is important to enhance our current understanding of the relationship between higher education and weight gain and obesity. Examining differences in weight curves will help clarify if the protective effect of higher education is something conferred during the time of higher education, at an earlier time period, or at a later time period. Understanding these relationships is important to help dissect and address the disparities around obesity. These analyses will also help provide direction both for efforts into prevention and treatment of weight gain in young adults and for appropriate further research. In this study, we will use individual-level longitudinal cohort data to examine weight gain in college and weight curves of those who do and do not attend college. The study is primarily meant to be exploratory and descriptive and has two objectives: (1) to determine if the phenomenon of college weight gain exists and if it is distinct from weight gain that occurs at the same age for those who are not in college, and (2) to examine the differences in the weight curves between those who attend and don’t attend college, focusing on whether variation and change occurs at the college period, before or afterwards. Data used will be from the National Longitudinal Survey of Youth 1997 cohort (NLSY97), an ongoing nationally representative longitudinal study of 8,984 American youth born between 1980-84. Self-reported weight is our primary dependent variable for the first objective. In our second objective we will look at changes in weight over time. Participation in higher education will be the key predictor. Analyses will be completed and presented in November 2009.

KEY WORDS: higher education, college, young adults, obesity, weight gain

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CARLA C. KEIRNS
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The Asthma Epidemic, 1979-2009: The Rise and Fall of a Public Problem

In the mid-1980s, asthma mortality started to rise, particularly in US cities and minority communities. By 1992, Chicago and New York had seen dramatic increases in asthma on the South Side and South Bronx respectively, and local physicians and political leaders were looking for answers. By 1995, asthma was on the front page of the New York Times and the cover of Time and Newsweek as the new urban scourge. In 1997, the Office of the First Lady issued a public statement about the important new federal initiatives, and federal and state departments of health and environmental quality saw relief from asthma as a major issue for public health, environmental quality, social justice, and cost savings. Health disparities in asthma hospitalizations and mortality for asthma had increased across the country and around the world. There was talk of a pandemic and questions about what kind of genetic, environmental, infectious or other factor could have increased rates so quickly across so many places, races, social classes and environments. Foundations, governments, and private individuals created programs, initiatives, projects, policies, published books, articles, and reports, and held meetings from the international to the neighborhood scale to decide what to do about it. A decade later, things are little changed in the south Bronx, the eastside of Detroit, and dozens of other vulnerable communities, with school absences, hospitalizations, and mortality continuing to be 3 to 4 times the national average. But the sense of crisis is gone. 1999 was the peak year for asthma mortality in the United States and hospitalizations stabilized in the 1990s. Disparities rose as asthma rates rose, and continued to rise as asthma rates fell. Following models from media studies and political science of agenda-setting, coalition-building and splitting, and cycles of public problems, and using epidemiological data and documentary evidence from the media and policy environments, this paper will explore the evolution of asthma from a minor childhood ailment to a major public problem, and back off the public agenda. In particular, this example will illustrate the relationship between epidemiologic data, identification of clinical problems and health disparities, and the aspects of the media and public policy process that lead a problem to center stage for possible action. It will follow the place of asthma in debates about the creation of S-CHIP, hospitalization rules for HMOs, and the 1997 standards for particulate air pollution. Finally, it will explore the disappearance of a problem from the pubic stage despite failure to resolve it in the clinical and community settings, and the persistence of rising health disparities, with lessons for those working to affect health policy for other problems.

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A Comparative Effectiveness Study Piloting a Rapid HIV Testing Algorithm in the Los Angeles County Jail

PURPOSE: In partnership with the LA County Sheriff’s Department (LASD) and LA Office of AIDS Programs and Policies, we plan to pilot a rapid testing algorithm (RTA) in the LA Men’s Central Jail to determine whether an RTA is feasible in a large urban jail, associated with improved access to medical care and case management referral, and is more cost-effective than conventional testing in this population.

METHODS: The LASD operates the world’s largest jail system, with approximately 180,000 inmates processed annually and 500 inmates classified per day. The LA Men’s Central Jail houses 5,000 inmates and represents 40% of the LASD jail system’s average census. Every month, the jail’s Medical Services Bureau tests approximately 450 inmates who report a history of HIV positivity and need documentation, request an HIV test, have had an alteration with custody, or are referred for HIV testing by a clinician. The conventional testing strategy currently used relies on ELISA and Western Blot analyses that take one week for results and therefore leads to delays in care. We hypothesize that implementation of a rapid testing algorithm can efficiently identify HIV positive individuals earlier and expedite access to medical care and case management. In order to best approach the pilot as a comparative effectiveness trial, our study will be conducted as a non-blinded controlled trial of an HIV RTA versus conventional testing. All inmates referred for HIV testing by Medical Services Bureau staff will be included. The RTA will be implemented in a staggered design over four months, alternating months of RTA and conventional testing. Conventional testing will be conducted by Jail Medical Services staff under the current model. During RTA months rapid testing will be conducted by trained public health staff. We will perform an intent-to-treat analysis to determine the feasibility of the RTA testing strategy in the jail. To examine whether the RTA improved receipt of results, we will compare conventional testing and RTA groups for the mean number of days to receipt of results and the proportion of inmates who receive their confirmed HIV test results before release. In order to assess whether the RTA is associated with improved access to care, we will compare the proportion of HIV positive inmates who receive the following prior to release or within two weeks of testing: an HIV medical visit, CD4 counts/viral load tests, HIV medications as appropriate, and referral for case management initiated.

RESULTS: Data collection will begin in the Winter of 2009; results are not yet available.

CONCLUSIONS: Data generated by this project will provide the first formal assessment of an HIV rapid testing algorithm in a correctional setting. In addition, by virtue of collaboration between a correctional institution, public health, and academic partners, the findings of this project are likely to directly inform design and implementation of HIV testing programs in the Los Angeles County jails and serve as a model for other correctional institutions.

KEYWORDS: HIV, HIV testing, correctional medicine, vulnerable populations

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OB Cares: The Obstetric Clinics and Resources Study: Provider Views on Delivering Perinatal Depression Care

BACKGROUND: Numerous medical organizations, from psychiatry to obstetrics to pediatrics, have identified perinatal depression as a public health priority. Even with this increasing awareness of perinatal depression, most pregnant women with depressive illness are undetected and under treated. In fact, the provision of depression care is still an emerging concept within obstetrics.

METHODS: We conducted an exploratory qualitative analysis using a snowball sampling technique at two institutions to recruit obstetric providers for semi-structured interviews. Interview content addressed perceived patient-related barriers to mental health treatment, provider thoughts about treatment during pregnancy and providing depression care in the obstetric setting, past clinic experiences with mental health care, and visions for ideal treatment delivery. Two reviewers analyzed the data using grounded
RESULTS: This study identified four main themes (the provider “toolbox”, provider perspectives on delivering mental health care, roles responsibilities, and views of motherhood) with eleven sub-themes. Within the theme of “toolbox,” we identified three sub-themes of the basic “tools” that providers need to provide depression care: knowledge; clinic resources; and a coordinated system. Providers’ perspectives of delivering mental health care were related to five sub-themes of trust, familiarity, prior experiences, comfort, and provider engagement style. The theme of roles and responsibilities contained three sub-themes of provider sense of task, system-level norms, and motivations for providing care. Finally, views of motherhood and mental illness referred to the impact that cultural norms have on providing depression care to an obstetric population. Our preliminary conceptual model showed that decisions on the delivery of perinatal depression care reflect a dynamic interplay of factors at the patient, system, and provider levels.

CONCLUSION: This study identified several themes of influence on the provision of perinatal depression care, including knowledge, logistical concerns, cultural norms, and affective components (trust, comfort, familiarity, and style). Future interventions should utilize these areas of influence to improve linkage to care for depressed women.

KEY WORDS: depression; pregnancy; obstetrics; mental health

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Emergency Department Information System Adoption in the United States

BACKGROUND/OBJECTIVE: Health information technology (HIT) has the potential to improve health care. The United States has been slow to adopt HIT in hospitals and outpatient offices; however, limited data have been published on HIT in the emergency department (ED). We determined the prevalence of US Emergency Department Information System (EDIS) adoption using two classifications and identified the ED characteristics associated with EDIS use.

METHODS: We performed an analysis of the 2006 National Hospital Ambulatory Medical Care Survey (NHAMCS), a nationally representative sample of ED visits that also surveyed participating EDs on EDIS use. All data were weighted to produce national estimates. We calculated EDIS adoption rates using two definitions: (1) Self-reported: based on response to a single survey question as to whether the EDIS was complete, partial, or none; and (2) Feature-based: based on the reported features supported by the EDIS we categorized EDIS systems as fully-functional, basic, other, or none. Fully functional and basic systems needed to meet sets of features we defined. EDs that had some EDIS features, but did not meet our requirements for fully functional or basic were classified as other. EDs with no features were classified as no EDIS. EDIS adoption rates were then calculated using the self-reported and feature-based system type classifications. Bivariate analysis and multinomial logistic regression were performed to identify ED characteristics associated with feature-based system type.

RESULTS: Three hundred and fifty-six EDs participated, representing 4,622 US EDs. Using the self-reported classification, 16.1% had complete, 30.4% partial, and 53.5% no EDIS. In contrast, using our feature-based categorization, 1.7% had fully functional, 12.3% basic, 32.1% other, and 53.9% no EDIS. In multivariable analysis, pediatric EDs (OR 5.09, 95% CI 1.1-24.7) and EDs in urban areas (OR 11.4, 95% CI 1.6-80.2) were more likely to have a fully functional or basic EDIS than general EDs or EDs in rural areas. No differences in EDIS adoption were seen by ED ownership type, geographic region, teaching status, Hispanic/black patient composition, patient insurance status, percentage of admitted patients or average length of ED visit.

CONCLUSION: Despite more optimistic self-reported estimates, fewer than 2% of our nation’s EDs actually have fully-functional EDIS. Pediatric EDs and EDs in urban areas have higher odds of EDIS adoption; while other EDs have similarly low rates of adoption. To realize the potential value of EDIS for improved emergency care, we need to better understand and to promote EDIS adoption.

KEY WORDS: Emergency Department, Information Systems, Informatics

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Cognitive Health Among Older Adults in the United States and in England  

PURPOSE: Cognitive function is a key determinant of independence and quality of life among older adults. Compared to adults in England, US adults have a greater prevalence of cardiovascular risk factors and disease that may lead to poorer cognitive function. We compared cognitive performance of older adults in the US and England, and sought to identify sociodemographic and medical factors associated with differences in cognitive function between the two countries.  

METHODS: Data were from the 2002 waves of the US Health and Retirement Study (HRS) (n equals 8,299) and the English Longitudinal Study of Ageing (ELSA) (n equals 5,276), nationally representative population-based studies designed to facilitate direct comparisons of health, wealth, and well-being. In each country, we assessed cognitive performance in non-hispanic whites aged 65 and over using the same tests of memory and orientation (0 to 24 point scale).  

RESULTS: US adults scored significantly better than English adults on the 24-point cognitive scale (unadjusted mean: 12.8 vs. 11.4, P<.001; age- and sex-adjusted: 13.2 vs. 11.7, P<.001). The US cognitive advantage was apparent even though US adults had a significantly higher prevalence of cardiovascular risk factors and disease. In a series of OLS regression analyses that controlled for a range of sociodemographic and medical factors, higher levels of education and wealth, and lower levels of depressive symptoms, accounted for some of the US cognitive advantage. US adults were also more likely to be taking medications for hypertension, and hypertension treatment was associated with significantly better cognitive function in the US, but not in England (P<.01 for treatment X country interaction).  

CONCLUSIONS: US adults aged > 65 were cognitively healthier than English adults, even though they had a higher burden of cardiovascular risk factors and disease. More aggressive treatment of cardiovascular risks in the United States, especially hypertension, may be providing cognitive benefits to US adults. Given the growing number of older adults worldwide, future cross-national studies aimed at identifying the medical and social factors that might prevent or delay cognitive decline in older adults would make important and valuable contributions to public health.  

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Disparate Disparities?  
Dental Care and Insurance in U.S. Adults  

PURPOSE: Preventive dental care (PDC) is a cornerstone of good oral health. However, unlike the case for children, adult disparities in dental care utilization have received little notice. Meanwhile, states have largely erased dental benefits for adults on Medicaid and eliminated adult public health dental services. Using a nationally representative dataset, we sought to: 1) characterize PDC use and dental insurance among adults in 2006, 2) identify population subgroups with disparities in PDC and dental insurance, and 3) compare PDC to preventive medical care utilization among groups at risk for health disparities.  

METHODS: We relied on the 2006 Medical Expenditure Panel Survey (MEPS) Household Component and Dental Event data to describe the prevalence of 2 outcomes, by income and race/ethnicity: 1) PDC in the previous year and 2) dental insurance
approximately 56% of individuals <200% FPL had a medical check-up in the last year. Approximately 47% of whites but only 20% of Latinos, 25% of blacks, 23% of Native Americans and (all p<.0001). Among poor and low-income adults (i.e., <200% of the Federal Poverty Level—FPL), 22% had a PDV in the last year compared to 53% of individuals at greater than 400% of FPL (p<.0001). In contrast, 61% of Americans had a medical check-up in the last year but, with the exception of Latinos, there was relatively little variation by race/ethnicity; 62% of whites, 50% of Latinos, 69% of blacks, and 61% of Native Americans had a medical check-up in the last year. Approximately 56% of individuals <200% FPL had a medical check-up in the last year compared to 66% of those at >400% FPL.

RESULTS: In 2006, 40% of US adults had at least 1 preventive dental visit (PDV), although there were considerable differences among population subgroups. A PDV in the previous year occurred for approximately 47% of whites but only 20% of Latinos, 25% of blacks, 23% of Native Americans and (all p<.0001). Among poor and low-income adults (i.e., <200% of the Federal Poverty Level—FPL), 22% had a PDV in the last year compared to 53% of individuals at greater than 400% of FPL (p<.0001). In contrast, 61% of Americans had a medical check-up in the last year but, with the exception of Latinos, there was relatively little variation by race/ethnicity; 62% of whites, 50% of Latinos, 69% of blacks, and 61% of Native Americans had a medical check-up in the last year. Approximately 56% of individuals <200% FPL had a medical check-up in the last year compared to 66% of those at >400% FPL.

CONCLUSIONS: Substantial disparities in preventive dental utilization and insurance coverage exists for US adults, with an independent effect of race on the odds of a PDV. The magnitude of these disparities is larger than those of involving preventive medical care. However, adult dental disparities have received little attention. Among national health quality indicators and improvement efforts, adult dental care is largely absent. We believe that dental care for adults needs to be considered in efforts to reform our health care system, decrease health disparities and expand insurance coverage.

KEY WORDS: Dental Care, Adults, Disparities, Oral Health

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Groovi Care: A Community Coalition to Engage With Veterans of Operations Enduring Freedom and Iraqi Freedom (Oef/Oif) About Their Health

KEYWORDS: Veterans, CBPR, engagement, OEF, OIF PURPOSE: Neuropsychiatric disorders are prevalent among veterans of the conflicts in Afghanistan (OEF: Operation Enduring Freedom) and Iraq (OIF: Operation Iraqi Freedom), yet many OEF/OIF veterans with neuropsychiatric concerns do not seek mental health care services. This presentation presents Phase 1 of a community-based participatory research program to improve appropriate health care seeking, particularly mental health care seeking, by OEF/OIF veterans.

METHODS: Community-based participatory research principles were used to develop a new community coalition focused on engaging with OEF/OIF veterans about their health, particularly their mental health.

RESULTS: Multiple potential structures for the community coalition, and many potential frames for our research, were considered. The following organizations were initially included in the coalition because they were felt to have the most potential influence on OEF/OIF veteran health care seeking: OEF/OIF veterans; their friends and family members; the Veterans Health Administration (VHA); the Vet Centers; ten officially-chartered veteran service organizations (VSOs); one non-chartered VSO; one college and university student veteran organization; the California Veterans Education Opportunities Partnership; and academic researchers from UCLA and VHA. Geographically, the coalition focused on OEF/OIF veterans residing within the area encompassed by the 22nd Veterans Integrated Service Network. Each organization participated in developing a list of engagement concerns important to improving appropriate health care seeking by OEF/OIF veterans. An advisory overview of these concerns was presented to the coalition. From this, we developed conceptual models of high-quality engagement, established preliminary descriptions of current outreach, and planned a formal multi-stakeholder assessment. The multi-stakeholder assessment explored the themes felt to be most important to engaging with OEF/OIF veterans about their health: (1) subpopulations of OEF/OIF veterans who tend to have similar social networks and health-care-seeking influences; (2) who OEF/OIF veterans are most likely to turn to for advice on their health needs and who is most likely to have the biggest influence on health-care-seeking by these veterans; (3) the characteristics of typical health- and health-care-related conversations held between OEF/OIF veterans and the key social contacts influential to their health-care-seeking; (4) the
Overuse and Underuse of Imaging to Stage Newly Diagnosed Cancer Patients in the Medicare Population

PURPOSE: Imaging for the staging evaluation of newly diagnosed prostate cancer (CaP) has a limited role. The National Comprehensive Cancer Network (NCCN) has issued consensus guidelines regarding when men with newly diagnosed CaP should be imaged, on the basis of tumor characteristics. Until recently, population-based data allowing classification of patients into NCCN risk groups were unavailable. We sought to determine the correlates of imaging overuse and underuse as well as their regional variation among men newly diagnosed with CaP.

METHODS: We used data from the SEER-Medicare linked database, including men with CaP diagnosed in 2004-5, aged 66-85, and missing <3 of the following: PSA, clinical stage and Gleason score. Patients were divided into low (staging imaging not recommended) and high (imaging recommended) risk groups. Low risk patients had none of the following high risk features: PSA>10ng/mL, Gleason grade>7, or clinical stage>T2. To study imaging overuse among low risk patients, we used logistic regression to model receipt of any staging imaging (i.e. 35.8% underuse). Among low risk patients, logistic regression demonstrated higher odds of imaging overuse as age, income, clinical stage, Gleason grade, and comorbidity increased. Imaging underuse in high risk men was associated with increased clinical stage and black race, and was less likely with increased age, income, and Gleason grade. Regions with higher pOv tended to have lower pUn. The registry most likely to image a newly diagnosed CaP patient was New Jersey, with a pOv of 0.71 and a pUn of 0.22; the registry least likely to image was Utah, with a pOv of 0.26 and a pUn of 0.46. In a registry-level scatterplot of pOv as a function of pUn, we found correlation with a Spearman rho of -0.54, p=0.03.

CONCLUSIONS: At the population level, we found poor compliance with the NCCN recommended imaging staging evaluation for men newly diagnosed with CaP, with approximately half of patients receiving guideline inappropriate care. Imaging use appears to be determined strongly by regional practice patterns and affinity for imaging. These behaviors must be considered prior to instituting policy-level solutions, as addressing overuse in low risk patients may potentially have an adverse affect on access to imaging for high risk patients.

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Balancing Budgets, Regulating Dentists and Dry Cleaners, and Taking on Tobacco: Lessons From a Year in Urban Public Health

In this session, I will highlight the varied and unanticipated challenges faced by urban public health agencies, using Philadelphia as a case study. Specifically, I will review successes, failures, and lessons learned from three issues addressed by the Philadelphia Department of Public Health over the course of the prior year. The goal of this session is for current Scholars to appreciate the ability to effect change through local public health. First, I will discuss the two sides of the funding coin, including how the Department planned for 10%, 20% and 30% city budget cuts and concurrently attempted to leverage federal Recovery dollars. The Department’s 8 federally qualified look-alike health centers played a prominent role as we sought to avoid closures, generate revenue through sliding-scale patient charging, and fought to become eligible for federal funds. Second, I will examine how the Department’s Air Pollution Control Board dealt with potentially carcinogenic chemical emissions from dry cleaning facilities. Despite months of internal proceedings and engagement of the dry cleaning industry, the initial regulation failed to even make it to a full Board vote. This setback, however, inspired the Board to review its regulatory process, including its strategies for engaging the regulated industry and ways to partner with academic experts to provide scientific input. Lastly, I will describe how the Department proceeded with planning and priority setting in the midst of unexpected public health crises such as swine flu. Much like other big cities and the nation as a whole, tobacco use is the leading actual cause of death in Philadelphia. But unlike many of its peer metropolitan areas, Philadelphia has rates of adult tobacco use that continue to increase. The Department is taking a multifaceted approach to reduce tobacco’s burden by: 1) highlighting tobacco-related morbidity and mortality in public health reporting, 2) revamping youth sales enforcement, 3) exploring options for increasing the cost of tobacco products through local action, and 4) investigating non-traditional methods for distributing nicotine replacement therapy.

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Christian Clergy’s Portrayal of Mental Illness in Televised Sermons

PURPOSE: To describe themes in televised Christian clergy sermons about mental illness and treatment recommendations.

METHODS: 400 religious programs were video recorded during prime time viewing hours on two Protestant religious networks. The principal investigator (PI) randomly selected 100 sermons and the PI and another researcher independently viewed each program to determine if the program was a sermon with any health related content that referenced any mental illness or how to prevent, manage, or eliminate its symptoms. Sermons containing information about symptoms associated with mental illness or how to prevent, manage or eliminate the symptoms were identified, transcribed, and entered into Ethnography, a data management system. Four researchers reviewed sermons and developed a codebook of definitions using an inductive approach and then analyzed transcripts of sermons using constant comparison techniques.

RESULTS: 23 Protestant Christian clergy in the Non-denominational, Evangelical, or Pentecostal denominations were represented. Four white female clergy were included with 19 males (14 Whites, 4 African-American, and 1 Latino). Most had some college education. Generally, the congregations were based in the South (n equals 18) with a range of 5,000 – 40,000 parishioners. All clergy had regional, national, and international audiences through satellite television, books, ministry websites, and/or conferences. They did not make any references to mental or psychiatric illnesses. However, they did reference emotional, mood, or anxiety disturbances (EMoAD) like worry, anxiety, depression within a spiritual/religious explanatory model. That model was evident in 1) their causal attributions about the presence of EMoAD and 2) their recommendations to prevent, manage, or eliminate EMoAD. Clergy’s explanations for the causal attributions were diverse. They ranged from “contaminated faith,” “immature love”, and not applying relevant scriptures to the situations prompting the EMoAD to the devil “placing thoughts in your mind” that causes EMoAD. The myriad explanations tended to suggest: 1a) Signals about the believers’ (The persistence of EMoAD provided signals or information about the religious or spiritual behaviors or characteristics) and 1b) Indicators about their relationship with the supernatural (The persistence of EMoAD suggested that individuals were being influenced by the devil or their distance from God). Since clergy attributed EMoAD to spiritual or religious reasons, this framework informed their recommendations to prevent, manage, or eliminate EMoAD.

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Christian Clergy’s Portrayal of Mental Illness in Televised Sermons

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They could generally be categorized as: 2a) Spiritual cognitive strategies (like replacing certain anxiety provoking thoughts with relevant Biblical scriptural assertions or recognizing that the devil was the source of the thought and that they had “authority” or “power” over the devil) and 2b) Religious behavioral strategies (prayer, forgiveness, or thankfulness).

**CONCLUSIONS:** Our findings provide insight into these clergy’s religious/spiritual explanatory models of EMoAD. The medical model was absent without any reference EMoAD as potential indicators of medical conditions that might warrant medical investigation even in instances when severe impairment or self mutilation was present. Medical management was never discouraged nor was it ever mentioned. Future research should explore consequences of televised faith-based messages for met and unmet mental health need as well as clarify forms of counseling and behavioral recommendations provided in faith-based settings.

**KEY WORDS:** MENTAL HEALTH, CLERGY, FAITH, SERMONS

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**S I E R R A  R. M A T U L A**
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**Operation Access: A Proven Model for Providing Volunteer Surgical Services to the Uninsured in The United States**

**CONTEXT:** Numerous studies have shown that patients without insurance lack access to timely coordinated care and face barriers to specialty services. Operation Access (OA) is a non-profit organization that partners with medical volunteers, hospitals and local clinics to provide non-emergent surgical and specialty services to the uninsured within the greater Bay Area of northern California. Participating clinics and primary care providers refer patients to OA. After screening, patients are assigned to and evaluated by volunteer surgeons. If surgery is indicated, the patient is scheduled for the next available surgery session. OA’s administrative functions are supported by philanthropic donations; hospital resources and staff time are all donated by participating providers.

**PURPOSE:** We aimed to review the 15 year experience of surgical and specialty volunteer outreach efforts through OA and to assess the quality of care provided.

**METHODS:** Using data from OA’s internal database, we performed a retrospective cohort study evaluating the quality of care provided to all patients eligible for OA services from 1994-2008. We used the general framework developed by the Institute of Medicine to measure some aspects of 6 quality aims: safety, efficiency, effectiveness, timeliness, patient-centeredness, and equity. Safety was measured by assessing types and rates of complications associated with OA operating room procedures. Efficiency was assessed by examining patient compliance with appointments and instructions, as well as by counting the value of donated services. Effectiveness was indirectly measured by means of patient selection criteria and organizational structure of the program. Timeliness was evaluated by measuring the time from referral until both the time of first specialist appointment and date of operation or medical intervention. Patient centeredness was assessed indirectly by reviewing OA’s organizational structure. Equity was assessed by an organizational review and assessment of the demographics of eligible patients referred to OA.

**RESULTS:** 6,542 patients were referred to OA over the past 15 years; 83.4% met eligibility criteria. Of these, 3,518 patients received 3,098 surgical, endoscopic and minor procedures. 12 of 1,880 surgical patients experienced a complication requiring hospitalization. 95% of all patients kept their appointments with specialists; 95% of 1,880 surgical patients kept their operating room appointments and were compliant with pre-operative instructions. Hospitals and physicians provided $8 of services for every dollar of philanthropic support. The median times from referral to surgical or specialist appointment and operation or medical intervention was 68 and 83 days respectively. The organization provided translation services when needed; case managers are similar to patient navigators for this vulnerable population. A higher percentage of Latinos and a lower percentage of African Americans relative to the geographic demographics received OA services.

**CONCLUSION:** A volunteer program providing low risk outpatient surgery using the OA model delivers safe, efficient, effective, timely and patient-centered care. This study further demonstrates that the OA patient population has a disproportionately high percentage of Latinos and a disproportionately low percentage of African Americans. The reasons for this disproportionate are unknown but may reflect the locations of and populations served by the Bay Area community clinics.

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Robert Wood Johnson Foundation Clinical Scholars Abstract

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**Prehospital Care for Chest Pain Patients Differs by Gender But Not Race**

**BACKGROUND:** Race and gender disparities in diagnosis and treatment of chest pain/suspected angina (CP) have been demonstrated in multiple clinical settings. Prehospital care for CP is protocol-driven and may be less likely to demonstrate differences between patients due to race or gender.

**OBJECTIVE:** To investigate the relationship between gender, race and the prehospital treatment of patients with CP. Specifically, we sought to test the hypothesis that prehospital care for patients with CP en-route to the hospital would differ by gender and race.

**METHODS:** A one-year retrospective cohort study of 683 emergency medical services (EMS) patients with a complaint of chest pain was conducted. From the 12,335 patients transported to one of the three hospitals during the study period with a dispatch chief complaint of chest pain, 800 patients were selected using a random number generator. Included were patients taken to any one of three hospitals (all cardiac referral centers) by the Philadelphia municipal EMS service. Excluded were patients transported by basic life support units and patients younger than 30. Independent and dependent variables were abstracted from the pre-hospital record by trained researchers. The following process measures were identified and recorded from the prehospital records: patient gender, race, age, destination hospital, medic gender, measurement of cardiac markers (troponin I, CK-MB), utilization of 12 lead electrocardiogram (ECG), and the value of troponin I if obtained. Multivariable regression was used to adjust for potential confounders. The main outcome was adherence to state EMS protocols for treatment of patients over age 30 with undifferentiated chest pain. Rates of administration of aspirin, nitroglycerin, oxygen, establishment of intravenous access (IV), and cardiac monitoring were measured.

**RESULTS:** 342 women and 341 men were included. 71% of the patients were Black. Women were less likely than men to receive aspirin (RR 0.76; 95% CI 0.59-0.96) or nitroglycerin (RR 0.76; 95% CI 0.60-0.96), or to receive an IV (RR 0.86; 95% CI 0.77-0.96). These differences persisted after adjustment for demographics and emergency department (ED) evaluation for acute coronary syndrome as a blunt marker for cardiac risk. Women were also less likely to receive these treatments among the subgroup of patients who were later diagnosed with acute myocardial infarction. Race (white vs. nonwhite) was not statistically associated with unadjusted or adjusted differences rates of prehospital aspirin (unadjusted RR 0.89, 95% CI 0.66 to 1.20), nitroglycerin (unadjusted RR 0.99, 95% CI 0.76 to 1.3), oxygen (unadjusted RR 1.08, 95% CI 0.98 to 1.19), monitor (unadjusted RR 1.01, 95% CI 0.93 to 1.11) or IV (unadjusted RR 1.08, 95% CI 0.95 to 1.2).

**CONCLUSIONS:** In this cohort, for prehospital patients with chest pain, gender but not racial differences in treatment are significant and do not appear to be explained by demographic differences or underlying cardiac risk.

**KEYWORDS:** Disparities, EMS, Emergency Care, Chest Pain

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CSP / UNIVERSITY OF PENNSYLVANIA (2007-2010)

**Racial Disparities in Survival After Out-Of Hospital Cardiac Arrest**

**PURPOSE:** Racial disparities in survival after out-of-hospital cardiac arrest have been reported but their causes remain uncertain. Hospitals with substantial minority populations have worse outcomes for myocardial infarction and we hypothesized that the same may be true for cardiac arrest. We sought to determine if hospital racial composition accounts for differences in survival for patients hospitalized after cardiac arrest.

**METHODS:** We evaluated hospitalizations of white and black Medicare beneficiaries (January 2000-September 2007) admitted from the emergency department to the ICU with a diagnosis of cardiac arrest or ventricular fibrillation. We examined unadjusted survival rates and developed a multivariable logistic regression model which included age, comorbidities, inpatient...
concurrent diagnoses, and hospital factors including racial composition. The main outcome measure was survival to hospital discharge,

**RESULTS:** 68,115 cardiac arrest admissions were analyzed. Unadjusted survival to hospital discharge was worse for blacks (0.30 vs. 0.33, p=0.001). In multivariate analyses accounting for patient and hospital factors, adjusted probability of survival was worse for blacks at hospitals with disproportionately more black patients (0.31, 95% CI: 0.29-0.33) compared with hospitals with predominately white patients (0.46, 95% CI: 0.36-0.57; p equals 0.003). Similarly, whites had worse risk adjusted survival at hospitals with large black populations (0.28, 95% CI: 0.27-0.30) compared to predominately white hospitals (0.32, 95% CI: 0.31-0.33, p equals 0.006) Blacks were more likely to be admitted to hospitals with higher proportions of black patients (0.63 vs. 0.15, p=0.001) and low survival rates (0.23 vs. 0.15, p<0.001).

**CONCLUSIONS:** Hospitals with large black patient populations had worse cardiac arrest outcomes than predominantly white hospitals, and blacks were more likely to be admitted to these high mortality hospitals. Understanding differences in survival outcomes between hospitals with differing racial composition may uncover the underlying causes for these disparities and lead to improved survival for all cardiac arrest victims.

**KEY WORDS:** cardiac arrest, disparities, resuscitation

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**GERARDO MORENO**  
CSP / UNIVERSITY OF CALIFORNIA, LOS ANGELES (2007-2010)

**Opportunities to Improve Quality of Care, Self-Care Behaviors, and Interpersonal Care for Patients with Diabetes in a Migrant Health Center**

**PURPOSE:** Migrant and seasonal agricultural workers are vulnerable to receiving suboptimal health care for chronic conditions because of frequent traveling and their transient lifestyle, low socioeconomic status, occupational exposures, lack of health insurance, and cultural and linguistic barriers. Little information is known about opportunities to improve the quality of care that agricultural workers with diabetes receive. The purpose of this study was to examine patient and provider level factors associated with the quality of diabetes care received by Latino patients with diabetes receiving care in a large migrant health center that serves two California counties.

**METHODS:** Cross sectional observational cohort study on a convenience sample of 250 male and female patients 21 years of age and older with diabetes who consented to completing a patient survey that will be linked to medical chart information, and electronic diabetes registry data. The primary outcomes are receipt of seven processes of care (hemoglobin A1C [HbA1C] and LDL cholesterol in last 12 months, foot exams 2-3/year, smoking cessation counseling for smokers, eye exam and flu vaccine in past 12 months, and aspirin use), participation in self care, and control of three intermediate outcomes (LDL cholesterol level < 100 mg/dl, HbA1C < 7.0%, and blood pressure < 130/80 mmHg). The main predictor variable is ratings of interpersonal care. Secondary predictor variables are migrant/seasonal status, geographic distance to health center, years of agricultural work, cultural and linguistic barriers, health insurance status, and social support in the U.S. Migrant status is defined as the establishment of temporary housing for purposes pertaining to seasonal agricultural employment. We will compute item frequencies and compare patient self-care participation, receipt of seven process of care, and ratings of interpersonal care by the predictor variables. All eligible process measures received during the 12 months prior to survey interviews will be summed in a 0-7 score. We will use multiple variable regression models (one for each process of care) to estimate the effect of agricultural worker factors on the receipt of each of the seven processes of care while controlling for physician’s panel (random effects). Similar methods will be used to investigate the association between ratings of interpersonal care and patient self-care behavior.

**RESULTS:** The results will be available in November 2009.

**CONCLUSIONS:** This is the first quality of care study that has focused on migrant and seasonal workers with diabetes that we are aware of. Our results should provide important information for health care and community-based organizations seeking to improve diabetes care for migrant and seasonal agricultural workers with diabetes.

**KEY WORDS:** diabetes, agricultural workers, quality of care, interpersonal care

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ARDEN MORRIS  
(UNIVERSITY OF WASHINGTON 2000-2002)  
University of Michigan  
Understanding Black-White Differences in Colorectal Cancer Treatment: A Mixed-Methods Study

BERGEN NELSON  
CSP / UNIVERSITY OF CALIFORNIA, LOS ANGELES (2008-2010)  
A Tiered Approach to Developmental and Behavioral Services in Preschool: Stakeholder Perceptions and Referral Outcomes  
The federally-funded Head Start preschool program serves an important role in coordinating health, education and social services for low-income children between the ages of 3-5 years old. For children with developmental and behavioral concerns, intervention services are typically provided through local public school districts’ special education programs. During the 2008-2009 school year, a large Head Start agency operating multiple preschools in Los Angeles County, serving predominantly Latino families, formed a partnership with the Los Angeles Unified School District (LAUSD) to implement a tiered approach to intervention services for children with developmental and behavioral concerns, called response to intervention (RTI). Under the RTI model, all children are screened for concerns (tier 1), children deemed to be at-risk are provided with initial services and observation (tier 2) and the most intensive level of intervention (tier 3, special education) is reserved for children who do not respond adequately to lower-tier interventions. RTI is being implemented nationally in primary and secondary schools, and has been touted as a potentially important and cost-effective innovation in allocating resources to meet the needs of individual children, but has never been evaluated in a high-risk preschool program. This study uses a community-based participatory research approach, and both qualitative and quantitative methods, to evaluate the pilot RTI program implemented in Head Start by LAUSD in 2008-2009. Community partnerships have been formed between the UCLA/Robert Wood Johnson Clinical Scholars Program and both the local Head Start agency and the LAUSD early childhood programs, to create an evaluation study that reflects the priorities of multiple stakeholders. In the qualitative component, semi-structured interviews with 65 staff members and providers from Head Start and LAUSD, as well as 9 parent focus groups including families most affected by the pilot RTI program, are being conducted to understand the strengths and challenges of the program from varied stakeholders’ perspectives. In the quantitative component, multidimensional scaling and logistic regression analyses are being used to understand how results of structured screening tools may predict referrals to the tiered intervention services for the 1200 children in this preschool community. Preliminary results will be available by Fall 2009 and will help us evaluate whether this RTI model for a tiered response to developmental and behavioral concerns is feasible and acceptable in a community-based preschool setting.  
KEY WORDS: early childhood development, developmental screening, early intervention, preschool special education, response to intervention  
AUTHORS: Bergen Nelson, MD, UCLA; Sheryl Kataoka Endo, MD, MSHS, UCLA; Paul Chung, MD, MSHS, UCLA/RAND Corporation; Gery Ryan, Ph.D., RAND Corporation; Helen DuPlessis, MD, MPH, UCLA; Susan Savage, Ph.D., Olivia Pillado and Gail Archie, Child Care Resource Center; Whitcomb Hayslip, Los Angeles Unified School District; Kenneth Wells, MD, MPH, UCLA

MARK D. NEUMAN  
CSP / UNIVERSITY OF PENNSYLVANIA (2008-2010)  
Non-Operative Care for Hip Fracture in the Elderly: The Influence of Race, Income, and Comorbidities  
PURPOSE: Efforts to examine variations in the utilization of surgical services have historically been limited by the inability to observe the full population of patients eligible for a given surgical procedure, and have focused primarily on patients receiving the procedure of interest. Hip fracture offers unique advantages for the study of surgical care; ICD-9-CM codes reliably identify patients with hip fracture, providing detailed information on fracture characteristics and the procedures used for treatment. Operative repair is the standard of care for medi-
cally stable patients with hip fracture; however, a fraction of the 340,000 individuals who break their hips each year in the U.S. undergo non-operative treatment. This is associated with increased pain, functional disability, and greater mortality. We examined the influence of race, income, comorbidity, and hospital on the odds of non-operative treatment for hip fracture.

METHODS: We examined inpatient Medicare claims for 167,892 hip fracture admissions from 2002-2006 in New York, Illinois, and Texas. We identified patients over age 65 with first-time femoral neck, intertrochanteric, or subtrochanteric fractures by the following ICD-9-CM codes: 820.00-09, 820.21-22, and 820.8. We excluded patients with prior hip fracture, identified by a 3-month look-back, patients admitted for rehabilitation, and those with pelvic fractures. Patients were classified as having undergone surgery within one month of admission by 104 ICD-9-CM procedure codes corresponding to operations involving the femur or hip joint. The logistic regression model predicting operative or non-operative treatment for hip fracture included 14 variables for fracture characteristics, 33 variables for comorbidities, variables for patient sex, age, source of admission, income, and 21 significant interactions. We also fit a conditional logistic model, fixing on the individual hospital, to examine differences in care delivered within the same hospital.

RESULTS: 10,360 patients (6.17%) underwent non-operative treatment for hip fracture. After adjusting for patient factors, the odds of non-operative treatment were 81% higher for black patients compared to whites (95% CI 66%, 96%), P< 0.0001. This did not change with adjustment for income. After adjusting for individual hospitals, the odds of non-operative treatment remained 57% higher for blacks compared to whites, (95% CI

AUTHORS: Mark D. Neuman, M.D., University of Pennsylvania; Lee A. Fleisher, M.D., University of Pennsylvania; Lanyu Mi, MS, The Children’s Hospital of Philadelphia; Jeffrey H. Silber, M.D., PhD., The Children’s Hospital of Philadelphia
munity, the guiding principles it has followed are relevant to any population. This will allow others to share our vision and replicate our methods in diverse communities nationwide. By advancing this expansive model for health promotion, Puente de Salud demonstrates that universities and communities working side-by-side can play a leading role in combating our nation’s greatest health care challenges.

KARA ODOM WALKER
CSP / UNIVERSITY OF CALIFORNIA, LOS ANGELES (2007-2010)

Understanding Delays in Care and Unmet Need in South Los Angeles: Age-Related Variation

PURPOSE: The safety net in Los Angeles County has been altered by the 2007 shutdown of Martin Luther King, Jr. (MLK) hospital and emergency department (ED). Although the hospital’s ambulatory clinic remains open, there has been a 30% decrease in outpatient visits and substantial reductions in the numbers of primary care and specialty providers. Prior to the closure, patients ages >50 years represented almost half of hospital discharges and outpatient visits. We used community-based participatory research methods to understand unmet need for care among middle-aged and older residents of communities previously served by MLK hospital.

METHODS: With our community partners, we designed and conducted a population-based survey of African Americans and Latinos ages >50 years who spoke English or Spanish and were randomly sampled from South Los Angeles zip codes.

The telephone survey explored health status, delays in care, and unmet healthcare needs. To assess age differences in unmet need for care, we constructed logistic regression models adjusted for race, gender, language, income, insurance coverage, and chronic conditions.

RESULTS: Of 708 study participants (response rate 63%), 48% were ages 50-64 years; 59% were female; 26% conducted the survey in Spanish, 28% had household income below the federal poverty level; and 43% had a high school education or less. Hypertension was reported by 63%, 42% had arthritis, 25% diabetes, and 12% asthma; 93% reported a usual source of care, and 31% had visited an ED in the past year. Compared to older residents, those ages 50-64 years were less likely to report having had a flu shot in the prior year or colonoscopy in 10 years, and women were less likely to have had a mammogram (see Table). The younger group also reported higher rates of delays in getting care and difficulty receiving needed medical care. Interim results have been shared in a preliminary report to the Task Force for Los Angeles Healthcare Options of the California Endowment (available at www.calendow.org). We expect to report results of analyses underway to compare findings to population-based survey data collected prior to hospital closure in November 2009.

CONCLUSIONS: We observed high rates of unmet need for primary and specialty care, particularly among those ages 50-64 years, compared to older persons. Information from these analyses will be used in collaboration with our community partners and the Task Force to help inform policy decisions around restructuring safety net services in the communities previously served by MLK hospital.

KEYWORDS: community based participatory research, preventive care, age variation, survey research

AUTHORS: Kara Odom Walker, MD, MPH, UCLA; Neil Steers, PhD, UCLA; Leo Morales, MD, PhD, University of Washington-Seattle; Li-Jung Liang, PhD, UCLA; Nell G. Forge, PhD, Charles Drew University; Loretta Jones, MS, Healthy African American Families II; and Arleen F. Brown, MD, PhD, UCLA

### Table: Age-related differences in rates of preventive care and delays in care

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1Weighted for zip-code level poverty, age, and race

*Adjusted for age, gender, race, income, insurance, and chronic conditions

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*Adjusted for age, gender, race, income, insurance, and chronic conditions
NICHOLAS H. OSBORNE  
CSP / UNIVERSITY OF MICHIGAN (2008-2010)  

Evaluating Popular Media and Internet-Based Hospital Quality Ratings for High-Risk Surgery  

OBJECTIVE: Patients are increasingly turning to hospital ratings from the popular media and Internet to help them choose hospitals. It is unclear whether these rankings will help patients choose high quality hospitals for surgery. We sought to evaluate the validity of two popular rankings.  

METHODS: Using 2005-2006 Medicare data, we studied all patients undergoing pancreatotomy, esophagectomy, coronary artery bypass surgery (CABG), aortic valve repair (AVR) and mitral valve repair (MVR) (N=273,017). The primary outcome was risk-adjusted mortality, adjusting for patient characteristics and surgical acuity. We compared mortality at Americas best hospitals, according to US News and World ReportTM and HealthgradesTM, to all other hospitals. We adjusted for hospital volume to determine whether hospital experience accounts for differences between Americas best hospitals and other hospitals.  

RESULTS: Risk-adjusted mortality was significantly lower in US News and World Report best hospitals for 2 of 5 procedures: esophagectomy (OR 0.48, 95%CI 0.37-0.62) and pancreatotomy (OR 0.42, 95%CI 0.30-0.58). Risk-adjusted mortality was significantly lower in Healthgrades best hospitals following CABG (OR 0.78, 95%CI 0.68-0.89), AVR (OR 0.71, 95%CI 0.59-0.85) and MVR (OR 0.77, 95%CI 0.61-0.99).  

However, accounting for hospital volume, risk-adjusted morality was not significantly lower at the US News and World Report best hospitals for any procedures. Adjusting for hospital volume, risk-adjusted mortality was lower at Healthgrades best hospitals following CABG and AVR (OR 0.77, 95%CI 0.64-0.92 and OR 0.81, 95%CI 0.71-0.94).  

CONCLUSIONS: Patients can reduce their chance of death by choosing a best hospital according to popular media and Internet ratings. However, the lower mortality rates at these hospitals can be mostly explained by hospital volume.  

AUTHORS: Nicholas H. Osborne, MD; Gilbert R Uphurch Jr, MD; Justin B Dimick, MD MPH  

AA SIM P ADEL A  
CSP / UNIVERSITY OF MICHIGAN (2008-2010)  

Muslim Health Beliefs and Healthcare Seeking Practices- Interactions with and Implications for the US Healthcare System  

PURPOSE: There are an estimated seven million Muslims in the United States comprised of near equal numbers of Arabs, South Asians and African Americans. This growing American subpopulation while ethnically and racially diverse is bound together by a lived religious tradition that informs cultural values around health and healthcare. These religious values and practices may play a role in health disparities as they affect how, when and how healthcare is sought by this population. Further value differences may pose ethical challenges to equitable healthcare delivery. While various guides to help healthcare providers treat Muslim patients exist, there has been scant empirical research performed in collaboration with Muslim American communities to better understand their health beliefs and practices and how these might influence interactions with the medical system. Through qualitative inquiry we aim to 1) Identify beliefs about health and illness and health practices within the Muslim American community; 2) Better understand how these beliefs and practices affect healthcare-seeking in Muslim Americans and 3) Identify clinical scenarios or healthcare areas that present Muslim patients with ethical dilemmas and/or conflicts with non-Muslim providers.  

METHODS: This study has been formulated through a community-based participatory model of research and will utilize both focus groups and semi-structured interviews with three phases of data collection. Phase one will begin with semi-structured interviews of community gate-keepers and leaders to solicit Muslim health beliefs, practices and perceived areas of conflict and challenge within the healthcare system. Phase two will explore these themes and concepts gained from Phase one in a series of focus-group interviews with first- and second-generation self-identified Muslim Americans recruited through purposive sampling in area mosques. Phase three will entail in-depth semi-structured individual interviews to clarify concepts from focus groups and explore emergent themes. Data analysis will utilize a framework approach with detailed content analysis according to the conventions of the qualitative method.  

CONCLUSIONS: This study will inform efforts to deliver high quality and equitable care to Muslim Americans. We will better understand the links between Islamic beliefs and practices and healthcare behavior thus informing a healthcare disparity
model for Muslim Americans. Understanding challenges that current healthcare delivery modalities pose for Muslim Americans will also help us guide culturally sensitive interventions and health outreach efforts within this community.

**KEY WORDS:** Healthcare disparities, Muslims, cultural competence, ethical challenge, health behaviors

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**AUTHORS:** A. I. Padela MD MS, University of Michigan; A. Killawi MSW University of Michigan; S. Duffy PhD RN, University of Michigan; A. Hammad PhD Community Health and Research Center, Arab Community Center for Economic Social Services, Dearborn MI; A. Safih BA University of Michigan; M. D. Fetters MD MPH MA, University of Michigan; M. Heisler MD MPA University of Michigan

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**JOHN PASCOE**  
(UNC 1977-1979)  
Wright State University, Boonshoft School of Medicine

**A New Social Capital Scale: Geographic Stability Compared to Income, Personal Support and Depressive Symptoms**

Social capital has been shown to be related to a number of health outcomes. The purpose of this paper is to describe the use of a new social capital scale (SCS), initially developed in pediatric subspecialty clinics for families with special needs children; for this study the SCS was administered to parents of children in pediatric primary care offices as well as a developmental clinic within a children’s hospital. A convenience sample of parents from the Southwestern Ohio Ambulatory Research Network (SOAR-Net) and the Developmental Clinic at The Children’s Medical Center of Dayton were recruited between January 2006 and January 2009, 861 parents were asked to participate, 136 refused and 26 surveys were incomplete. Therefore, analyses were performed on 699 completed surveys (593 from SOAR-Net). The survey included several validated instruments including the Parental Social Support Index (PSSI) (range 0-39), the Center for Epidemiological Studies Depression Scale (CES-D) (range 0-20). The 20 item Social Capital Scale (SCS) (range 20-100) was developed over several years by one of the investigators (WL). There are five factors (community involvement, sense of belonging, spiritual community, school connection and informing/asking). Overall coefficient alpha equals .84 and test-retest correlation equals .90. Demographic characteristics, as well as scores on the SCS, PSSI and CES-D were similar for SOAR-Net and Developmental Clinic parents, therefore the two subgroups were combined for this analysis. Almost 90% of the surveys were completed by birth mothers, two thirds were Euro-American, 66% were married or had a live-in partner, 85% had at least a high school education.

One quarter had a positive score (greater than 15) on the CES-D and median annual household income (MAHI) was $27,500. Parents with MAHI below the sample median were more likely to report positive CES-D (38.0% vs 17.8%) and score below the sample median on the PSSI (63.3% vs 27.6%) (p equals 0.0001 for each comparison) compared to parents with MAHI above the sample median. There was a relatively small, but significant difference in SCS scores below the sample median between the same two subgroups (53.3% vs 44.2%, p equals 0.02). Mean SCS scores were more stable across the seven study zipcodes (n equals 234) with at least 25 families (range 68.3-72.5, p equals 0.675), MAHI varied significantly across the zipcodes (p equals 0.01) as well as CES-D (range 9.7-15.1, p equals 0.04), PSSI (range 19.6-24.7, p equals 0.03). Parents in the study zipcode with the lowest MAHI, reported the highest mean SCS score (72.5), the lowest mean PSSI (19.6) and the second highest mean CES-D (14.4). A new social capital scale is very stable across zipcodes compared to measures of income, depressive symptoms and personal social support. Members of lower income communities, who report lower social support and higher depressive symptoms, may experience similar or even higher levels of social capital compared to members of higher income communities. Future studies should examine the putative health promotion effects of higher levels of social capital in low income communities.

**AUTHORS:** John Pascoe, MD, MPH, Wright State University; Sandy Specht, PhD, Wright State University; Greg Eberhart, MD, Wright State University; Taunya Jasper, MD, Wright State University; Alyssa Gans, MD, Wright State University; Caroline McNicholas, BS, Wright State University; Wendy Looman, PhD, University of Minnesota
Epidemiology and Outcomes of Fever Burden Among Patients with Acute Ischemic Stroke

BACKGROUND: Fever occurs in approximately 35–40% of acute ischemic stroke patients. Although post-stroke fever has been associated with poor patient outcomes, little is known about which aspects of fever (e.g., timing, severity, or duration) affect outcomes.

OBJECTIVE: We sought to describe the clinical epidemiology of post-stroke fever and the association between fever burden and stroke outcomes.

METHODS: We used data from a retrospective cohort of acute ischemic stroke patients who were admitted at one of five hospitals (1998–2003). A fever event was defined as a period with a temperature ≥100.0°F (37.8°C), where the event ended when the temperature fell below 100.0°F for at least 24 hours. Fever burden was defined as the maximum temperature (Tmax) minus 100.0°F, multiplied by the number of days with a fever. Fever burden (in degree-days) was categorized as low (0.1 to ≤2 events; and the mean total fever days was 2.9 (standard deviation, 3.3). The first fever occurred within 72 hours of symptom onset in 58.0%. Patients with any fever event had higher combined outcome rates after adjusting for age, gender, race, stroke severity, hypoxia, worsening symptom course, admission do not resuscitate code status, and impaired mobility: adjusted odds ratio [aOR] 2.1 (95%CI, 1.3–3.4). Higher fever burden was also associated with the combined outcome: high burden aOR 4.4 (95%CI, 2.4–7.8); medium burden aOR 2.6 (95%CI, 1.3–5.3); and low burden aOR 1.0 (95%CI, 0.5–1.8). The timing of the first fever did not affect the combined outcome.

CONCLUSIONS: This study confirms previous findings that post-stroke fever occurs commonly and is associated with worse outcomes. This study is the first to describe the clinical epidemiology of elevated temperatures post-stroke; demonstrating that patients with high fever burden have a four-fold increased odds of death or discharge to hospice. Both patients with high fevers for a brief period (Tmax of 104°F for one day) or low-grade fevers for an extended period (101°F for four days), are at markedly increased risk of poor outcomes. Future research should examine the potential benefit of anti-pyretics and/or cooling strategies among these higher risk patients.

AUTHORS: Michael S. Phipps, MD; Rani Desai, PhD; Charles Wira, MD; Dawn M. Bravata, MD

The Impact of Resident Duty Hour Reform on Hospital Readmission Rates

This study seeks to evaluate the impact of resident duty hour reform on hospital readmission rates. On July 1, 2003, the Accreditation Council for Graduate Medical Education (ACGME) instituted a new policy that limits the number of hours medical residents are allowed to work. The effect of this reform on hospital readmission rates is unknown. Hospital readmissions are common and costly, and therefore have become an increasingly popular target for cost and quality control in health care reform. Determining the impact of resident duty hour reform on readmission rates will be useful for graduate medical education policy and health care quality policy. To answer this question, this study will utilize an interrupted time series analysis of all Medicare admissions to short-term, acute-care general US nonfederal hospitals during the three years prior and the two years after duty hour reform. All-cause readmission rates following index hospitalizations for a group of medical (congestive heart failure, acute myocardial infarction, gastrointestinal bleed, and stroke) and a group of surgical (general, orthopedic, and vascular) conditions will be assessed. Logistic regression will be used to determine the relative change in readmission rates for more versus less teaching intensive hospitals, adjusting for patient comorbidities, common time trend, and hospital site. In addition, secondary analyses will be performed, including an examination of differences in diagnoses at the time of readmission, in patient location at the time of readmission, and in effects on patients with varying comorbidities. At this time, results are pending but will be available shortly.

KEY WORDS: graduate medical education, hospital readmissions

AUTHORS: Matthew J. Press, MD, University of Pennsylvania; Kevin G. Volpp, MD, PHD, University of Pennsylvania;
Robert Wood Johnson Foundation Clinical Scholars Abstract

Amy K. Rosen, PHD, Boston University; Paul R. Rosenbaum, PHD, University of Pennsylvania; Patrick S. Romano, MD, MPH, University of California, Davis; Kamal M.F. Itani, MD, Boston University; Lisa Bellini, MD, University of Pennsylvania; Orit Even-Shoshan, MS, University of Pennsylvania; Yanli Wang, MS, The Children’s Hospital of Philadelphia; Michael J. Halenar, BA, University of Pennsylvania; Jeffrey H. Silber, MD, PHD, University of Pennsylvania

MITESH B. RAO
(YALE 2007-2009)
Yale University

The Shortage of On-Call Surgical Coverage:
A National Survey of Emergency Department Directors

PURPOSE: Shortages of on-call surgical specialists have been identified as a significant problem for our nation’s health care system, yet little is known about either the full extent of these shortages in emergency departments or their impact on emergency care provision. The purpose of our study was to report the experiences of a national sample of emergency department (ED) directors regarding the degree of difficulty in providing surgical specialist coverage and the impact of on-call coverage shortages on emergency patient care.

METHODS: We conducted a cross-sectional self-administered survey of a national random sample of ED Directors distributed proportionally across all 48 contiguous states. 14 multi-level quantitative questions directed at each of our primary and sub-domains constituted the bulk of our instrument. We designed and piloted the instrument in conjunction with the Yale University Emergency Medicine Department. We used a five-wave method of administration to maximize response rate. Data was analyzed using SAS 9.1 Statistical Software, with responses compared by hospital (trauma level, ownership) and geographic variables.

RESULTS: Our response rate was 62%. Seventy-two percent of ED directors reported on-call coverage problems with specialist surgeons. Among those reporting on-call shortages, 72% reported that, in the past four years, their institution has lost the ability to provide 24/7 coverage for a specialty and 28% reported that specialist on-call participation shortages have resulted in loss or suspension of their hospital’s trauma capabilities. Twenty-nine percent reported increases during the past year in the number of patients leaving their ED after completion of initial evaluation but before being seen by a medically needed specialist. Teaching hospitals were less likely to report problems with inadequate on-call specialist surgeon coverage than non-teaching hospitals (66% versus 76%, p= 0.03). Teaching hospitals were also more likely to report an increase in incoming ED transfers (42% vs. 17%, p<0.01), while non-teaching hospitals were more likely to report an increase in outgoing ED transfers (57% vs. 37%, p<0.01).

CONCLUSIONS: Shortages in surgical specialty on-call coverage are a pervasive problem for EDs. The effects of these shortages range from negative effects on trauma capabilities to increasing numbers of patients leaving before receiving appropriate care. Surgical specialist shortages are more severe for non-teaching hospitals, and the subsequent transfers may create an increased burden of care provision for teaching institutions.

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(2008-2010)

Airing Our Dirty Laundry: Community Based Participatory Research Methods to Explore Occupational Hazards and Coping Mechanisms Among Latina Household Workers

BACKGROUND: High demand for low cost labor in the United States has led to a rapid rise in the number of Latin American immigrants working in the informal sector. Evidence suggests that male day laborers experience dramatically high rates of occupational injury and death, but little is known about the hazards faced by their female counterparts who work in households and remain largely invisible to occupational health surveillance systems. Published surveys among household workers suggest that non-payment of wages and exposure to toxic chemicals and violence is common. However, much remains unknown about the context of these risks, their relationship to mental health, or the coping strategies employed by household workers to reduce these risks. Community partnered participa-
Early Readmission Following Gastric Cancer Resection in California

PURPOSE: The types of post-surgical complications following gastric cancer surgery that result in readmission or death and the role of providers in decreasing these complications are not well-understood. Among surgically treated gastric cancer patients in California, we examined predictors of readmission, diagnoses of patients presenting at readmission, and among those readmitted, predictors of mortality, including readmission to the hospital of index surgery.

METHODS: Operatively managed gastric cancer patients from 1994-2004 were identified through the California Cancer Registry and were linked to the Office of Statewide Health Planning and Development Inpatient Discharge file. Readmissions through 2006 were available. Bivariate statistics were examined at both the patient and hospital level by index or same vs. different hospital at readmission. After identifying major diagnoses of the first readmission, we tested patient and hospital characteristics associated with readmission to the same (vs. different) hospital within 90 days of discharge using multivariate logistic regression analysis. In addition, a multivariate probit regression model was used to examine death within one year of surgery according to same (vs. different) hospital readmission.

RESULTS: Of 12,707 gastric cancer patients surgically treated at 369 hospitals, 3,542 (28%) were readmitted within 90 days. 2,915 (82% of those readmitted) returned to the same hospital on first readmission. 1,884 deaths (15%) occurred within 90 days of surgery, while 4,694 (37%) died within 365 days. The five most frequent diagnoses for those readmitted within 90 days were: surgical complication (such as wound infection and intestinal obstruction/adhesions), 33% of all readmissions; hypovolemia, 24%; progression of disease, 19%; hypertension, 14%; and pulmonary dysfunction (including pneumonia/empyema and acute respiratory failure), 13%. The proportion of surgical complications on readmission was significantly higher in those returning to the same as compared to a different hospital, while proportions of acute respiratory failure were significantly lower (p<0.01). Controlling for sociodemographic, tumor, treatment, and hospital characteristics, factors significantly associated with readmission were scheduled surgery [Odds Ratio or OR (95% CI) 1.33 (1.05-1.71)] and discharge to home [OR...
Robert Wood Johnson Foundation Clinical Scholars Abstract

2.87 (2.27-3.63). Lower adjusted odds of readmission to the same hospital was associated with longer length of stay [OR 0.98 (0.98-0.99)], while a higher adjusted odds was associated with treatment at a hospital of annual procedural volume in the middle tercile [OR 1.34 (1.02-1.77)]. When controlling for all of the above, those patients first readmitted to the same (vs. different) hospital had a lower death rate at one year following surgery [adjusted RR 0.767 (0.765-0.768)].

CONCLUSIONS: A significant number of early readmissions following gastric tumor resection involve complications of surgery and cancer disease course. Among individuals with early readmission, return to the hospital that performed the primary procedure is associated with lower mortality. Further research is needed to understand what caused this effect and whether policies are needed to promote the continuity of inpatient hospital care following cancer surgery.

KEYWORDS: gastric cancer, readmission, mortality

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Small Area Variations in Bystander CPR: Do Neighborhoods Matter?

CONTEXT: Bystander-initiated cardiopulmonary resuscitation (BCPR) can have a substantial effect on the probability of survival after out-of-hospital cardiac arrest (OHCA). Substantial geographic variations in OHCA outcome exist, but the source of that variation is unknown.

OBJECTIVE: To understand the association between neighborhood and individual characteristics of OHCA and bystander CPR (BCPR).

DESIGN, SETTING AND PATIENTS: We conducted a multi-level analysis of OHCA cases that occurred in Fulton County (Atlanta), Georgia and were submitted to the Cardiac Arrest Registry to Enhance Survival (CARES) between October 1, 2005 to November 30, 2008.

MAIN OUTCOME MEASURES: The numbers of cardiac arrest events year by year and the effect of individual and neighborhood-level characteristics on the likelihood that an OHCA victim will receive BCPR.

RESULTS: Of the 1,108 cases of OHCA eligible for BCPR, 25.2% (n=279) received it. Forty-one patients survived to hospital discharge, of whom 20 received BCPR. Provision of BCPR was more common in witnessed events (OR 1.64, 95% CI 1.21-2.22, p value <0.001) and those that occurred in public locations (OR 1.67, 95%CI 1.16-2.40, p value <0.05). Other individual-level characteristics (e.g., age, sex, race) were not significantly associated with BCPR. Numbers of cardiac arrests and the incidence rates of BCPR varied from neighborhood to neighborhood but were stable within neighborhoods from year to year. After controlling for other factors, BCPR was much more common in the highest-income census tracts than the lowest-income census tracts (OR 4.98 (95% CI 1.65-15.04, p value<0.05)).

CONCLUSION: Patients in the highest income census tracts were much more likely to receive BCPR, even after controlling for victim characteristics (i.e. type and location of the arrest). Neighborhoods that have high numbers of OHCA in one year are likely to have similarly high levels the next year, making neighborhood an appropriate level for targeted interventions, such as CPR training.

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Men Who Perpetrate Intimate Partner Violence: Associations with Health Care Service Use, Prior Family Violence, and Substance Use Disorders

BACKGROUND: Few studies have addressed how to identify and treat men who abuse their partner. The prevalence of intimate partner violence (IPV) perpetration, by male patients in primary care, emergency department and obstetrical settings, is 7-41%. IPV perpetration is treated through referral to a batterer intervention program.

PURPOSE: (1) assess the prevalence of physical IPV perpetration in a nationally-representative sample of men, (2) determine the health services use of male IPV perpe-
METHODS: Data was analyzed from the 2001-2003 National Comorbidity Survey-Replication (NCS-R). The NCS-R used a multi-stage clustered sampling design to conduct face-to-face interviews of non-institutionalized U.S. adults aged 18 years and older. The NCS-R includes measures for perpetration and victimization of child physical abuse and IPV, based on items from the Conflict Tactics Scale. Physical IPV perpetration was dichotomized as the dependent variable in analyses. Independent variables included demographics, prior relationship violence, health service use, physical health conditions, mental health diagnoses, and substance use. Bivariate and multivariate logistic regression was performed to examine predictors of IPV perpetration.

RESULTS: Of 715 married or cohabiting men in the sample who also reported chronic health problems, 132 (18.4%) of men reported IPV perpetration in a relationship begun after age 21. Of that sample of 132 men, the average age was 44 years, 64 (48.5%) had education beyond high school, and 104 (81.9%) were employed. 81 (70.4%) were physically abused as children, 45 (34.6%) witnessed IPV between their parents, and 81 (61.8%) reported perpetration of child physical abuse. 94 (71.2%) had a doctor for routine care, with 81 (61.4%) having >1 routine health visit in the past year. 79 (59.8%) reported some type of chronic pain, and 38 (28.8%) reported high blood pressure. 48 (36.4%) had a substance use disorder, and 44 (33.3%) reported a mood or anxiety disorder. In bivariate analyses, age in decades (O.R. 0.85, 95% C.I. 0.75-0.96), being physically abused as a child (O.R. 2.07, 95% C.I. 1.33-3.21), witnessing parental physical abuse (O.R. 2.96, 95% C.I. 1.93-4.53), any IPV as a young adult (O.R. 2.89, 95% C.I. 1.78-4.69), perpetration of child physical abuse (O.R. 2.43, 95% C.I. 1.64-3.58), having a regular doctor for routine care (O.R. 0.68, 95% C.I. 0.42-0.98), chronic pain from headaches (O.R. 1.68, 95% C.I. 1.07-2.62), substance use disorders (O.R. 2.12, 95% C.I. 1.41-3.18), and mood or anxiety disorders (O.R. 1.33, 95% C.I. 0.89-2.00) predicted IPV perpetration in a current relationship. In multivariate analyses, only witnessing parental abuse (O.R. 2.21, 95% C.I. 1.26-3.86), and being physically abused as a child (O.R. 1.98, 95% C.I. 1.18-3.32) predicted IPV perpetration in a current relationship.

CONCLUSIONS: Male IPV perpetrators seek routine medical services, thus providing an opportunity for primary care providers to both identify at-risk men and offer treatment. Primary care visits offer locations to prevent IPV perpetration among men with a history of witnessing parental violence or childhood physical abuse.

KEY WORDS: intimate partner violence, perpetration, prevention

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Participatory Evaluation of a Community Youth Violence Prevention Initiative

Youth gun violence disproportionately affects persons of color. In New Haven, in 2007, there were 162 shooting victims among 124,000 residents and persons of color represented the vast majority of the shooting victims. The Street Outreach Worker Program (SOWP) operated by a community-based organization, aims to reduce gun violence among 13 to 24 year olds. The SOWP connects youth at risk for violence with Street Outreach Workers (SOWs), adults previously involved in violence but now committed to mentoring youth. In order to improve program performance we conducted a process evaluation of the SOWP where we examined the internal dynamics of program implementation and described perceptions and experiences of those involved. We formed a community-academic partnership to conduct a participatory evaluation of this program. We gathered data from SOW daily journals and in-depth interviews with 17 youth participants, 6 SOWs and 4 NHFA administrators. We designed the evaluation to:

ELICIT DATA ON: 1) program components that keep youth engaged with the program, 2) program components that prevent gun violence, 3) specific barriers and facilitators of program participation and 4) quantitative measures that would best identify program success. A systematic content analysis of 400 pages of daily journals was conducted to characterize and classify the scope of program activities aimed at reducing gun violence. Interviews were conducted using a semi-structured discussion guide and were audiotaped, transcribed and synthesized into common and recurrent themes using the constant comparative method of qualitative analysis.

FOUR THEMES DESCRIBED ENGAGING AND RETAINING YOUTH: SOWs use a range of strategies; meeting the basic needs of youth participants is essential; retention requires continuous engagement; and certain youth resist the program.

THEMES CENTRAL TO UNDERSTANDING THE PRO-
GRAM’S ROLE IN GUN VIOLENCE PREVENTION ARE: violence is pervasive in the lives of the youth; youth perceive SOWs as proxy family members; relationships with SOWs enhance youth participants’ sense of self-worth and; because the roots of violence are complex, SOWs must employ a multifaceted approach. Perceived facilitators to success include setting realistic expectations, supporting SOWs in their work, and role modeling and mentoring to advance behavioral change. The SOWs relationship with the police is perceived as both a potential barrier and facilitator to program success. Demonstrated program successes include SOWs being visible in the community, serving as positive role models, advocating for youth in court and in school, and enhancing school engagement, and youth improving their lives through positive interactions with their families, adhering to probation plans, and beginning employment. Participants perceive investment in human capital, addressing root causes, and the availability of pro-social activities as essential to the prevention of gun violence. Success of SOW programs requires targeting resources to sustain comprehensive program components required for supporting mentor/youth relationships and building capacity for youth to pursue viable economic opportunities.

KEY WORDS: youth violence, participatory evaluation, health promotion

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PURPOSE: Current health care reform proposals prioritize the needs of the uninsured; however, insurance coverage does not guarantee access to a usual source of care (USOC), that is, a regular place to go when sick or in need of medical advice. To examine this issue we focused on the treatment of hypercholesterolemia and hypertension, two common and important risk factors for cardiovascular disease. We evaluated the association between having a USOC and the likelihood of receiving treatment for hypercholesterolemia and hypertension, controlling for clinical and sociodemographic characteristics, including insurance status.

METHODS: Data for this study came from the 2003-2006 National Health and Nutrition Examination Survey (NHANES), a multistage probability sample of the non-institutionalized population of the U.S. The sample included 1,134 adults (=50.6 million persons) and 3,278 adults (=61.9 million persons) who were eligible for treatment for hypercholesterolemia and hypertension, respectively. All subjects were aged ≥35 years and determined eligible for treatment if they either (1) were currently taking a lipid-lowering medication (LLM; any statin, fibrate, or ezetimibe), or were not on an LLM but met the Adult Treatment Panel (ATP) III guidelines for treatment; or, (2) reported taking a medication for high blood pressure, or self-reported, ‘no,’ to treatment but met the Joint National Committee (JNC 7) recommendations for treatment. The primary independent variable of interest was USOC (doctor’s office, outpatient hospital department, or health center vs. emergency department or none). Multivariable logistic regression modeling was used to examine the association between USOC and receipt of treatment for hypercholesterolemia and hypertension, controlling for age, sex, race/ethnicity, presence of comorbid hypertension and diabetes, and insurance status. In addition, separate multivariable models were examined stratified by insurance status. All analyses were performed using SAS-callable SUDAAN to appropriately weight the data and account for the complex sample design.

RESULTS: Overall 42.8% of subjects with an ATPIII indication for LLM and 32.5% of subjects with a JNC 7 indication for anti-hypertensive medication were untreated. Compared with persons with a USOC, persons without a USOC were significantly more likely to be untreated for both conditions (p<0.001, p<0.001). The association between lack of a USOC and being untreated persisted even after controlling for sociodemographic characteristics, clinical factors, and insurance status (hypercholesteremia, adjusted OR: 3.87 [1.65-9.13]; hypertension, adjusted OR: 5.47 [2.82-10.59]). Furthermore, not having a USOC remained a significant predictor of not being treated for hypercholesterolemia among subjects with insurance (adjusted OR: 2.75 [0.95-7.92]), as well as subjects without insurance (adjusted OR: 20.23 [4.72-86.72]). The same was true of treatment for hypertension for persons with insurance (adjusted OR: 6.33 [2.64-15.17]), and for persons without insurance (adjusted OR: 5.39 [1.60-18.20]).

CONCLUSIONS: Lack of a usual source of care is significantly associated with being untreated for two common cardiovascular risk factors, hypercholesterolemia and hypertension, even among individuals with insurance. Our findings suggest that universal coverage may not be sufficient to achieving qual-
ity outcomes for the uninsured. Addressing the needs of the uninsured will require organizational and policy changes that prioritize the importance of a usual source of care.

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**Who Should Use Aspirin to Prevent Cardiovascular Disease?**

**PURPOSE:** We developed a practical decision rule to help determine who would benefit from aspirin for the primary prevention of cardiovascular disease.

**METHODS:** We created a simulation model to estimate the individual benefit of aspirin for cardiovascular disease primary prevention. We created a representative sample of Americans without cardiovascular disease using the National Health and Nutrition Examination Survey 2005-2006. Using risk predictors, such as Framingham risk calculators, we estimated the risk of heart attack, ischemic stroke, hemorrhagic stroke, and gastrointestinal bleeding. We used data from randomized trials to assess the potential risks and benefits of taking aspirin. With this information we created an assessment tool to compare the risk-benefit profiles from four treatment strategies: the 2009 recommendations of the US Preventive Services Task Force, the 2002 American College of Cardiology/American Heart Association guidelines, and two strategies of our own. In one strategy, we assumed that aspirin has the same effects in men and women; in the other we examined the controversial observation that aspirin may prevent heart attacks though not strokes in men, but strokes though not heart attacks in women. We then examined how many Americans would be treated differently by each of these strategies and how efficiently each strategy would decrease events.

**CONCLUSION:** How and when to use aspirin in primary prevention of cardiovascular disease is a complicated and controversial subject. We hope to lessen this confusion by examining not only if aspirin decreases events, but in whom and at what rate it does so. Future research will involve constructing decision tools that help physicians and patients in shared decision-making.

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**ANJE VAN BERCKELAER**
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**Family- and Provider-Level Predictors of Health Care Utilization in Medicaid-Eligible Infants in Philadelphia.**

**PURPOSE:** To assess how environmental factors (healthcare site type) and population factors (such as maternal health literacy, maternal health insurance status, presence of other children in the household, maternal occupational status, single parenthood, and presence of a grandparent in the household) affect 1) adherence to recommended well-child care (WCC) schedules (according to Early Periodic Screening, Diagnosis and Testing program standards), and 2) number of emergency department (ED) visits per 6-month period among Medicaid-eligible infants from 0 to 24 months of age.

**METHODS:** This was a secondary analysis of a cohort of 744 Medicaid-eligible children followed from birth to 24 months. Structured telephone surveys to assess self-reported healthcare utilization, maternal well-being and social support, and demographic information were administered every six months for up to two years. Initial univariate analyses were used to select predictors for the model, with a significance threshold of <0.2 to be included in the model. Logistic regression was used to assess the influence of care site and family factors on recommended WCC adherence, and a poisson regression model was used for the outcome of number of ED visits per 6 months of follow-up.

**PRELIMINARY RESULTS:** Of the 579 mothers completing 6-month follow-up, 92% are African-American, 97% receive Medicaid, 87% are single, 76% earn less than $12000/yr. At 6 months, 88% were adherent to the recommended WCC schedule and 46% had visited the ED. Of those who completed at
least 18 months of follow-up, only 45% had been completely adherent to WCC visit frequency. The adjusted poisson regression model showed that children with a chronic condition and children of unmarried mothers had more ED visits per 6-month period. While the maternal health literacy effect (children of more literate mothers having fewer ED visits) did not reach statistical significance, it did improve the model’s predictive power. Children with a chronic condition and those whose mothers regularly attended prenatal care were more likely to be adherent to WCC visits at all visits. Provider site (academic medical center outpatient clinic, community health center, or private provider) had no significant effect on utilization of either office or ED visits.

**CONCLUSIONS:** Post-partum maternal education efforts should emphasize the importance of establishing WCC and a medical home, especially for single mothers. Additionally, women who have not been adherent to prenatal care schedules and those who are employed or in school full time may benefit from additional social services to facilitate well-child visits.

**KEY WORDS:** health care utilization maternal health literacy Medicaid

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**Challenges to Implementing Dementia Collaborative Care in Community Practices**

To analyze specific barriers and challenges to implementing an effective collaborative care model for dementia in diverse community practice settings. A guideline-based, comprehensive dementia care management program was developed, tested using a cluster randomized controlled trial design, and found to substantially improve quality and outcomes for dementia patients and caregivers. The chronic care model-based program involved collaboration among community agencies, patients and caregivers, and three different San Diego-area healthcare organizations, and incorporated specially-trained social worker or nurse care managers following dementia care protocols developed collaboratively by all participating organizations and caregiver “consumer” representatives. To understand how the program operated to improve care quality, and to prepare for subsequent scale-up and spread of the program to additional practice settings, we interviewed participating healthcare organizations’ key administrators, surveyed its primary care providers, and conducted secondary analyses of our trial data. These analyses were designed to (1) examine impact of individual components of the program (e.g., clinician education) to identify opportunities to reduce its complexity and enhance feasibility while retaining elements essential to its effectiveness; (2) identify factors likely to influence implementation and spread of the intervention to other practice settings (such as costs from the payer perspective), and (3) identify patient/caregiver subgroups that had higher benefit from the program. We also interviewed administrators and providers at three different healthcare settings in the Los Angeles area: a county safety-net medical center; a large medical group with a patient base of 500,000; and a non-profit Medicare HMO.

**These organizations had indicated an interest in adapting and incorporating a collaborative care model for dementia. Our analyses determined that (1) there was little intervention impact on primary care provider knowledge, and (2) caregivers with lowest levels of education had greatest improvements in care quality. These findings suggest that the dementia care manager – trained to use specific assessment and management protocols and to provide ongoing follow-up was central to the program’s effectiveness. Regarding factors affecting subsequent implementation and spread, there was no statistically significant cost offset of the dementia care model compared to usual care over 18 months. Program costs were dominated by cost of the dementia care managers. Interviews with administrators and providers from the three Los Angeles-area organizations interested in implementing the program identified several barriers to adoption, including cost constraints, perceived complexity of the comprehensive care management approach (despite availability of tools and training materials from the randomized trial), lack of prior experience with forging new relationships with community organizations and between physicians and care managers, and inability to elucidate which components of the multi-faceted intervention were critical for its effectiveness. Further, in the safety-net medical center, which served a largely Hispanic population, lack of procedures to identify and refer patients with dementia into the program was an additional barrier. However, all three organizations have now incorporated a dementia care management program, making adaptations to address these barriers, facilitated by academic researchers, and including an evaluation. Implementation of effective care models beyond initial study sites requires research-guided adaptation and ongoing evaluation.

**KEYWORDS:** Dementia, chronic care model, implementation

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**Family and Gender Impact Career Goals: Results of a National Survey of 4,586 Surgery Residents**

**PURPOSE:** General surgery residents’ pursuit of fellowship training in a surgical specialty is influenced by the proliferation of fellowships, the pressure to fast track into a surgical specialty, and the overwhelming interest in tailoring traditional general surgery training to fit the surgical specialty. Despite efforts to understand the complex motivations for pursuing fellowship, little is known about the role of gender, marriage, and children in the resident’s decision to pursue specialty training or influence views on general surgery as a profession. Through careful examination of gender differences representative of the US general surgery resident cohort, we seek to identify the influence of marriage and family on weighting of desires for future lifestyle and income.

**METHODS:** A national longitudinal prospective cohort study of all U.S. general surgery residents was utilized to describe the variables which influenced surgery residents to pursue specialty training following the 2008 ABSITE survey.

**RESULTS:** Survey response rate was 77% (n equals 4586). Mean age was 31 years; 32% were female, 51% married, and 25% had children. Approximately 29% of respondents believed general surgery is becoming obsolete (30% of men, 26% of women, p<0.01); 55% felt specialty training is necessary for success (56% of men, 53% of women, p equals 0.02). Single residents and residents without children were more likely to plan for fellowship (59% single vs. 52% married; 57% no children vs. 50% with children, p<0.05). In our multivariate analyses, male gender was an independent predictor of worry that general surgery is becoming obsolete; male gender, being single, and having no children were independent predictors of believing that specialty training is necessary following residency (all p<0.05). Female residents who were single or without children tended to identify lifestyle rather than income as a motivator for specialty training.

**CONCLUSIONS:** Marital status, children, and gender appear to have a powerful effect on general surgery residents’ career planning. Residency and fellowship programs must consider these important factors as they revise graduate surgical education to reflect the changing needs of the surgical workforce.

**KEY WORDS:** surgery residency, specialty training, fellowship

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**JOANNE WOOD**  
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**Socioeconomic and Racial Variations in Evaluation For and Diagnosis of Abuse in Infants with Traumatic Brain Injury**

**PURPOSE:** Previous research suggesting racial and socioeconomic bias in evaluating and reporting suspected abuse within health care systems have been regionally focused and potentially limited in generalizability. The goal of this study was to evaluate the association of race and socioeconomic status with radiographic evaluation and subsequent diagnosis of child abuse following traumatic brain injury (TBI) in infants across a national network of children’s hospitals.

**METHODS:** A retrospective cohort study of children under 1 y.o with TBI was identified from admissions data from 39 pediatric hospitals in the Pediatric Hospital Information System between 01/01/2004 and 06/30/2008. Infants involved in motor vehicle crashes or with preceding coagulation disorders were excluded. The primary outcomes were evaluation for suspected abuse (as defined by receipt of a total-body skeletal survey) and diagnosis of child abuse (as defined by E-codes).

Predictor variables included patient demographics (race, insurance, age) and injury characteristics (other injuries, type and severity of TBI). Multivariate logistic regression controlling for clustering by hospital examined the influence of race and socioeconomic status with the principal outcomes across categories of injury severity; output was transformed to standardized probabilities of skeletal survey use or child abuse diagnosis.

**RESULTS:** Of the 3,036 infants included in the study, 46% were white, 20% were black, and 18% were Hispanic; 61% had government insurance or were uninsured and 21% had private insurance. After adjusting for type and severity of injury, age, and presence of other injuries, infants with government insurance were more likely to receive skeletal surveys than infants with private insurance. This effect was modified by a child’s race, such that there was a much larger drop-off in the adjusted probability of skeletal survey receipt in white children with private insurance (from 82% to 53%) than among black (from 85% to 75%) or Hispanic (from 72% to 55%, p equals 0.02). Among infants evaluated for abuse, white race and government insurance were associated with a higher like-
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Glenda Wrenn
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Racial Differences in Barriers to Mental Health Care Utilization Among Veterans of Operations Enduring Freedom and Iraqi Freedom (Oef/Oif)

BACKGROUND: Mental health care in the military has unique features that distinguish it from civilian populations and provide an interesting setting to explore health disparities. African Americans and Hispanics deployed to OEF/OIF remain at higher risk for mental health problems, but there is no racial/ethnic disparity in access to mental health care within the military. Currently, there is no population-level empirical evidence about whether stigma and other barriers remains an additional impediment to treatment seeking for minorities within this population. Assessing treatment seeking barriers among veterans of the armed conflicts in Iraq and Afghanistan provides a dual opportunity to explore whether there are unique barriers faced by minorities within this population as well as examine the impact of access on reducing disparities in service utilization.

PURPOSE: The goal of this research is to inform the ongoing policy issue of mental health service delivery for Iraq and Afghanistan war veterans and explore the impact of widespread access to mental health care on racial and ethnic disparities in barriers to mental health service utilization.

METHODS: Using data from a random digit dial telephone survey from 24 geographic areas containing large numbers of previously-deployed individuals; we conducted an analysis of active duty, enlisted service members (1259). We examined demographic, mental health, and service utilization characteristics. We then conducted chi square tests (with adjustment for multiple comparisons) to identify differences between white, black, and Hispanic service members on each barrier endorsed by more than 10% of the overall sample. We also compared the pattern of barrier endorsement among respondents with possible mental health need (207).

RESULTS: Although the response rates for each barrier were higher among the group with possible mental health need, the pattern of endorsement was the same. Therefore we conducted the barrier analysis on the overall sample. In the overall sample, 13 out of 23 barriers assessed had >10% endorsement rate and were included in the analysis. The only barrier that emerged as having a significant racial difference was ‘religious counseling would be more helpful to me than mental health treatment’.

CONCLUSIONS: This study rules out large racial/ethnic differences in barriers to mental health service utilization with the notable exception of African Americans being more likely to report the belief that religious counseling would be more effective than mental health care. This has important implications for system delivery within the Chaplain’s Corps for active duty personnel, and underscores continued need for streamlined referrals between lay and professional counselors for this population. The remaining null findings provide some evidence that widespread access to mental health care may be sufficient to eliminate the racial disparity in stigma related barriers.

KEY WORDS: mental health, barriers to care, disparities

AUTHORS: Glenda Wrenn, MD, University of Pennsylvania; Terry Schell, RAND Corporation; Lisa Jaycox, PhD, RAND Corporation; Grant Marshall, PhD, RAND Corporation
CHARMAINE WRIGHT
CSP / UNIVERSITY OF PENNSYLVANIA (2008-2010)

Characteristics of 98 Low-Income Women in a Philadelphia Postpartum Weight Retention Study

Excess gestational weight gain is associated with increased maternal and child morbidity. Few studies have examined how the interplay of psychosocial factors and race affect gestational weight gain. We analyzed survey responses of 98 low-income postpartum women 2-6 weeks post delivery, from July 1-December 31, 2008. Subjects were clients of the Maternity Care Coalition (MCC), a Philadelphia community-based pregnancy outreach and advocacy agency. Excess weight gain was defined as Institute of Medicine recommendations based on pre-pregnancy body mass index (BMI). Mean (SD) age of women was 24.6(5.7) years, with 7% white, 66% black, 22% Hispanic. 35% of women had normal pre-pregnant BMI, 32% overweight, and 26% obese. Black women had higher rates of classification of women into the excessive weight gain category were no different among black and Hispanic women (46% vs. 43%, p equals 0.83). In multivariate analysis, there was a significant association of reported feeling of control over pregnancy weight gain with gestational weight gain (beta -12 pounds, p equals 0.025). Pre-pregnant obesity was also associated with decreased gestational weight gain (beta -13 pounds, p equals 0.03); age, race, and ethnicity did not have significant association.

KEY WORDS: Maternal obesity, gestational weight gain

AUTHORS: Charmaine Smith Wright MD, University of Pennsylvania; Debbie Bilder MPH Maternity Care Coalition; Marjie Mogul PhD Maternity Care Coalition; Michelle Allen BS Maternity Care Coalition; David Rubin MD MSCE Children’s Hospital of Philadelphia; Judy Shea PhD University of Pennsylvania

DONNA M. ZULMAN
CSP / UNIVERSITY OF MICHIGAN (2008-2010)

Understanding the Temporal Relationship Between Patient Attributes and Self-Management, and Outcomes in Diabetes

BACKGROUND: Patient self-management is critical to prevent adverse outcomes in diabetes, yet difficult to achieve and sustain. Diabetes self-management interventions often seek to modify patient attributes such as self-efficacy, diabetes-specific emotional distress, and diabetes care understanding. Little is known, however, about how these attributes influence self-management, and whether the relationship between these attributes and self-management ability differentially affects outcomes over time.

AIM: To explore the relationship between diabetes self-management and health and utilization outcomes over five years, and to determine the degree to which diabetes-specific attributes such as self-efficacy account for any observed relationships.

METHODS: We developed a conceptual model illustrating hypothesized associations among diabetes-specific attributes (self-efficacy, risk awareness, care understanding, diabetes prioritization, and diabetes-specific emotional distress), self-management, and outcomes in diabetes. We explored these relationships using the Health and Retirement Study (HRS), a biennial nationally representative longitudinal study of adults aged 51 years and older. In 2003, 1901 HRS respondents with diabetes completed an in-depth survey on their diabetes history, difficulty with self-management tasks in five domains (medications, exercise, diet, checking blood sugar, and checking feet), and diabetes-specific attributes. Responses to this survey were linked to responses to the 2002 through 2008 HRS questionnaires, which provided estimates of changes in health and functional status, as well as hospitalizations over time. Mortality was assessed through death records.

RESULTS: In multivariate cross-sectional analyses controlling for baseline sociodemographics and health covariates, each diabetes-specific attribute was independently associated with patient-reported difficulty with self-management tasks (all p < 0.01), and highly-rated self-management was significantly associated with lower hemoglobin A1C (p < 0.01). Of the diabetes-specific attributes, self-efficacy was associated with lower cross-sectional hemoglobin A1C (p < 0.01), and diabetes prioritization and emotional distress were associated with higher hemoglobin A1C (p < 0.05 and p < 0.01, respectively). In bivariate analyses with 2004 outcomes, lower-rated baseline self-management was associated with all negative outcomes except for mortality. After controlling for sociodemographics and health covariates, a correlation with decreased...
health status (p < 0.05) and diabetes status (p < 0.05) persisted, with diabetes-specific attributes accounting for part of this relationship. In analyses with 2006 and 2008 data, lower-rated baseline self-management was associated only with worsening diabetes status, and this relationship disappeared after controlling for covariates. Diabetes-specific attributes, however, were significantly correlated with most 2006 and 2008 outcomes in bivariate analyses, although only the relationship with health and functional status persisted in multivariate analyses.

**CONCLUSIONS:** In this nationally representative sample of adults with diabetes, we confirmed a strong cross-sectional association between a patient’s reported self-management and diabetes-specific attributes such as self-efficacy, and showed that these attributes may account for part of the relationship between self-management and positive short-term health outcomes. However, patient self-management assessments at baseline were not associated with longer-term health outcomes. Understanding the temporal dynamics of these relationships is an important step in the development of effective diabetes interventions that target patient attributes and self-management.

**AUTHORS:** Donna M. Zulman, MD, University of Michigan; Ann-Marie Rosland MD, MS, University of Michigan; Kenneth M. Langa MD, PhD, University of Michigan; Michele Heisler MD, MPA, University of Michigan
Common Interest Sessions

Wednesday and Thursday, 3 PM - 4 PM

To promote informal interaction among current and former Scholars, program faculty, national advisory committee members, community partners and guests with common interests, the following groups have been scheduled per recommendations of current Clinical Scholars. Each session has designated Clinical Scholar facilitator(s) who will start the discussion and help direct the session. Each group will have a designated table (seating 8-10) as identified by table signs.

**WEDNESDAY, NOVEMBER 4**

- **Community Engagement: Challenges and Successes**
  Adriana Izquierdo (UCLA)
  **LOCATION** Grande Patio

- **Emergency Medicine: Finding Solutions to ED Overcrowding Outside of the Ambulance Bay Doors**
  Medell Briggs-Malonson (UCLA)
  **LOCATION** Grande Patio

- **Off-site Policy Experiences during the Clinical Scholar program**
  Kate Goodrich (Yale)
  Adam Landman (Yale)
  Zachary Meisel (Penn)
  **LOCATION** Garden Suite

- **Pediatrician Interest Group**
  Rebecca Dudovitz
  Ray Perry (UCLA)
  **LOCATION** Cypress

- **PSA Screening for Prostate Cancer**
  Danil Makarov (Yale)
  **LOCATION** La Jolla Pre-function A

- **Research in a Foreign Language**
  Lisa DeCamp (Michigan)
  **LOCATION** La Jolla Pre-function B

- **Surgeon Interest Group**
  Nick Osborne (Michigan)
  **LOCATION** La Jolla Garden

**THURSDAY, NOVEMBER 5**

- **Carving Out a Dual Appointment Academic Position**
  Aasim Padela (Michigan)
  **LOCATION** Grande Patio

- **Clinical and Public Health Methods to Prevent Violence**
  Vijay Singh (Michigan)
  **LOCATION** Grande Patio

- **Institutional Leadership**
  Rhondee Benjamin Johnson (UCLA)
  **LOCATION** Garden Suite

- **Integrating Quality of Care into Medical Training**
  Ryan Greysen (Yale)
  **LOCATION** La Jolla Garden

- **Nutrition and Obesity: Community and Policy Approaches to Encouraging Health Lifestyles**
  Jeff Kullgren (Penn)
  Lenard Lesser (UCLA)
  **LOCATION** La Jolla Pre-function A

- **Patient-Provider Interventions to Increase Screening Adherence**
  Alejandra Casillas
  Demetria Malloy (UCLA)
  **LOCATION** La Jolla Pre-function B

- **The Safety Net in a Changing Health System**
  Anje Van Berckelaer (Penn)
  **LOCATION** La Jolla Pre-function B

- **Working with Hollywood Television Writers to Increase Accuracy of Health Messages in Television Storylines**
  Rhonda Mattox (UCLA)
  **LOCATION** Cypress
# Poster Presentations

**4:00 PM – 5:20 PM | WEDNESDAY, NOVEMBER 4**

<table>
<thead>
<tr>
<th>ROOM LA JOLLA A</th>
<th>ROOM LA JOLLA B</th>
<th>ROOM LA JOLLA C</th>
<th>ROOM LA JOLLA D</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Beliefs/Behaviors</strong></td>
<td><strong>Prevention &amp; Screening</strong></td>
<td><strong>Variation in Care</strong></td>
<td><strong>Vulnerable Populations</strong></td>
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<tr>
<td>Glenda Wrenn University of Pennsylvania</td>
<td>Stanley Frencher Jr UCLA</td>
<td>Katherine Goodrich Yale University</td>
<td>Adam Richards UCLA</td>
</tr>
<tr>
<td>‘I Stuffed It’: Exploring the Help Seeking Process in African American Women Following Sexual Assault</td>
<td>Cutting Through the Uncertainty of Prostate Cancer for Black Men Using Barbershop Outreach</td>
<td>Care Transitions and Patient Readmission: Where Does Literacy Fit In?</td>
<td>Airing Our Dirty Laundry: Community Based Participatory Methods to Explore Occupational Hazards and Coping Mechanisms Among Latina Household Workers</td>
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<td><strong>4:00 PM - 4:20 PM</strong></td>
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<td><strong>Prevention &amp; Screening</strong></td>
<td><strong>Variation in Care</strong></td>
<td><strong>Vulnerable Populations</strong></td>
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<tr>
<td>Aasim Padela University of Michigan</td>
<td>Lara Johnson Yale University</td>
<td>Danil Makarov Yale University</td>
<td>Anje Van Berckelaer University of Pennsylvania</td>
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<tr>
<td>Rhonda Mattox UCLA</td>
<td>Bergen Nelson UCLA</td>
<td>John Hollingsworth University of Michigan</td>
<td>Caroline Bonham University of Michigan</td>
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<tr>
<td>Christian Clergy’s Portrayal of Mental Illness in Televised Sermons</td>
<td>A Tiered Approach to Developmental and Behavioral Services in Preschool: Stakeholder Perceptions and Referral Outcomes</td>
<td>Opening of Ambulatory Surgery Centers and Procedure Use in the Elderly</td>
<td>Medical Students in the Community: Are Students Participating in Community Partnerships that Promote Reciprocal Knowledge Transfer?</td>
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<tr>
<td>Donna Zulman University of Michigan</td>
<td>Jeremy Sussman University of Michigan</td>
<td>Matthew Press University of Pennsylvania</td>
<td>Mark D. Neuman University of Pennsylvania</td>
</tr>
<tr>
<td>Understanding the Temporal Relationship Between Patient Attributes and Self-Management, and Outcomes in Diabetes</td>
<td>Who Should Use Aspirin to Prevent Cardiovascular Disease?</td>
<td>The Impact of Resident Duty Hour Reform</td>
<td>Non-Operative Care for Hip Fracture in the Elderly: The Influence of Race, Income, and Comorbidities</td>
</tr>
</tbody>
</table>
# Poster Presentations

**4:00 PM – 5:00 PM | Thursday, November 5**

<table>
<thead>
<tr>
<th>Room La Jolla A</th>
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<tbody>
<tr>
<td><strong>Access To Care – Health Disparities</strong></td>
<td><strong>Patient Level Factors &amp; Health Outcomes</strong></td>
<td><strong>System Level Factors, Quality Of Care, Other</strong></td>
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<tr>
<td>4:00 PM - 4:20 PM</td>
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<tr>
<td>Sierra Matula UCLA</td>
<td>Lisa DeCamp University of Michigan</td>
<td>Erica Spatz Yale University</td>
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<tr>
<td>4:20 PM - 4:40 PM</td>
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<tr>
<td>Sonali Kulkarni UCLA</td>
<td>J. Jane S. Jue University of Pennsylvania</td>
<td>Adam Landman Yale University</td>
</tr>
<tr>
<td>A Comprehensive Effectiveness Study Piloting Rapid HIV Testing Algorithm in the Los Angeles County Jail</td>
<td>Higher Education and Weight Gain</td>
<td>Emergency Department Information System Adoption in the United States</td>
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<td>4:40 PM - 5:00 PM</td>
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<tr>
<td>Christine Bower Baca UCLA</td>
<td>Michael Phipps Yale University</td>
<td>Nicholas Osborne University of Michigan</td>
</tr>
<tr>
<td>A Community-Partnered Approach to Evaluating Access to Care for Patients with Neurological Disorders in a Los Angeles Safety-Net System</td>
<td>Epidemiology and Outcomes of Elevated Temperature Among Patients with Acute Ischemic Stroke</td>
<td>Evaluating Popular Media and Internet-Based Hospital Quality Ratings for High-Risk Surgery</td>
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<tr>
<td>5:00 PM - 5:20 PM</td>
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<tr>
<td>Zachary Meisel University of Pennsylvania</td>
<td>Charmaine Wright University of Pennsylvania</td>
<td>Kate Viola Yale University</td>
</tr>
<tr>
<td>Prehospital Care for Chest Pain Patients Differs by Gender But Not by Race</td>
<td>Characteristics of 98 Low-Income Woman in a Philadelphia Postpartum Weight Retention Study</td>
<td>Family and Gender Impact Career Goals: Results of a National Survey of 4586 Surgery Residents</td>
</tr>
</tbody>
</table>
National Program Office

The National Program Office (NPO) provides overall direction, technical assistance and development of core curriculum for the Clinical Scholars program. Since March 1, 2007, the NPO has been located at the University of North Carolina at Chapel Hill in the Department of Social Medicine.

Desmond Runyan, MD, DrPH  
National Program Director  
drunyan@med.unc.edu

Terri McGowan  
Administrator  
tmcgowan@med.unc.edu

Kristin Siebenaler, MPA  
Deputy Director  
ksieben@med.unc.edu

Allan Beckmann  
Graduate Research Assistant  
beckmann@med.unc.edu
The National Advisory Committee of the Robert Wood Johnson Clinical Scholars program is involved in a wide range of activities including program design, scholar selection, training site selection and training site oversight. Scholars will have a unique opportunity to interact with the medical leaders who serve on the program’s National Advisory Committee. The program will assign each scholar a NAC mentor, who will discuss career development and other issues, to complement the mentors at the participating university. The NAC mentors will meet with the scholars in person at the program’s annual meetings, and will be available throughout the year as required. The National Advisory Committee members are national leaders in health and health care who have been selected not only because of their prestige but their commitment to the goals of this program and its scholars.
Robert Wood Johnson Foundation Clinical Scholars

Stuart C. Gilman, MD, MPH
V.A. Liaison
Director, Special Fellowships Programs
Office of Academic Affiliations
Veterans Health Administration
Washington, D.C.

Gary L. Gottlieb, MD, MBA
President
Brigham and Women’s Hospital
Professor of Psychiatry
Harvard Medical School
Boston, Massachusetts

Lawrence W. Green, DrPH
Professor, Epidemiology and Biostatistics
University of California at San Francisco School of Medicine
UCSF Comprehensive Cancer Center
San Francisco, California

Karen Hein, MD
Professor of Pediatrics
Albert Einstein College of Medicine
New York

Lisa I. Iezzoni, MD, MSc
Professor of Medicine
Harvard Medical School
Associate Director, Institute for Health Policy
Massachusetts General Hospital
Boston, Massachusetts

Renee R. Jenkins, MD
Professor and Chair
Department of Pediatrics and Child Health
Howard University College of Medicine
Washington, D.C.

Arthur Kellermann, MD, MPH, FACEP
Associate Dean for Health Policy
Emory University School of Medicine and Professor at the Department of Emergency Medicine and Department of Environmental and Occupational Health, Rollins School of Public Health, Emory University

Kathleen G. Nelson, MD
Professor of Pediatrics
Senior Associate Dean for Faculty Development
University of Alabama School of Medicine
Birmingham, Alabama

Herminia Palacio, MD, MPH
Director of Harris County Public Health & Environmental Services
Houston, Texas

Carlos Pellegrini, MD
Professor and Chair of Surgery
University of Washington

Somnath Saha, MD, MPH
Associate Professor of Medicine
Oregon Health & Science University
Portland VA Medical Center
Portland, Oregon
Participating Universities

Four universities are currently participating as training sites in the Robert Wood Johnson Foundation Clinical Scholars program. They are the University of California, Los Angeles; the University of Michigan; the University of Pennsylvania; and Yale University. Although their programs vary in design and emphasis, each institution has developed core programs to introduce scholars to the basic disciplines and methods used in health care research.

Program Leadership

**UCLA**

Robert H. Brook, M.D., Sc. D., F.A.C.P.
Co-director the UCLA Robert Wood Johnson Foundation Clinical Scholars program

Carol M. Mangione, M.D.
Co-Director of the UCLA Robert Wood Johnson Foundation Clinical Scholars program

Kenneth B. Wells, M.D.
Co-Director of the UCLA Robert Wood Johnson Foundation Clinical Scholars program

**UNIVERSITY OF MICHIGAN**

Rodney A. Hayward, M.D.
Director of the Michigan Robert Wood Johnson Foundation Clinical Scholars program

Peter A. Ubel, M.D.
Co-Director of the Michigan Robert Wood Johnson Foundation Clinical Scholars program

Michele Heisler, M.D., M.P.H.
Co-Director
Michigan Robert Wood Johnson Foundation Clinical Scholars Program

Matthew M. Davis, M.D., M.A.P.P.
Co-Director, Michigan Robert Wood Johnson Foundation Clinical Scholars Program

**UNIVERSITY OF PENNSYLVANIA**

Katrina Armstrong, M.D., M.S.C. E.
Co-Director of the Pennsylvania Robert Wood Johnson Clinical Scholars Program

Joshua Metlay, M.D., Ph.D.
Co-Director of the Pennsylvania Robert Wood Johnson Clinical Scholars Program

**YALE UNIVERSITY**

Harlan M. Krumholz, M.D.
Director of the Yale Robert Wood Johnson Foundation Clinical Scholars program

Georgina Lucas, MSW
Deputy Director of the Yale Robert Wood Johnson Foundation Clinical Scholars program

Cary Gross, MD
Associate Director of the Yale Robert Wood Johnson Foundation Clinical Scholars program

Marjorie Rosenthal, MD, MPH
Assistant Director of the Yale Robert Wood Johnson Foundation Clinical Scholars program

Marcella Nunez Smith
Assistant Director of the Yale Robert Wood Johnson Foundation Clinical Scholars program
The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation’s largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. The Foundation seeks to:

- Assure that all Americans have access to quality health care at reasonable cost.
- Improve the quality of care and support for people with chronic health conditions.
- Promote healthy communities and lifestyles.
- Reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

Staff members responsible for the Clinical Scholars Program at The Robert Wood Johnson Foundation are:

- **David Krol, MD**, Program Officer
- **John Lumpkin, MD, MPH**, Senior Vice President and Director, Health Care Group
- **Christine Phares**, Grants Administrator
- **Linda Wright Moore**, Senior Communications Officer

For more than 30 years the Foundation has brought experience, commitment and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime.

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Clinical Scholars

Rhondee Benjamin-Johnson, MD, MA
University of California, Los Angeles
Research Interests: Improve the healthcare delivery systems for low-income and minority populations.

Peggy Chen, MD, MSc
Yale University
Research Interests: Health care for vulnerable populations, particularly children and immigrants. Dissemination of research results to research participants.

Evan S. Fieldston, MD, MBA
University of Pennsylvania
Research Interests: Child health, behavioral economics and the role of incentives on individuals and organizations, process improvement and systems re-engineering, patient flow, coverage and benefit design.

Christie Lancaster, MD
University of Michigan
Research Interests: Perinatal Depression.

Patrick Link, MD
University of California, Los Angeles
Research Interests: Examine the interface between the VA, the Veterans Centers, veteran service organizations, and the social networks of veterans of the conflicts in Iraq and Afghanistan.

Raina Merchant, MD
University of Pennsylvania
Research Interests: Cardiac resuscitation, technology adoption, community interventions.

Gerardo Moreno, MD
University of California, Los Angeles
Research Interests: Immigrant and Latino Health, Diabetes, Physician Workforce Policy Issues.

Matthew O’Brien, MD
University of Pennsylvania
Research Interests: Primary care delivery, disparities, latino health.

Kara Odom, MD, MPH
University of California, Los Angeles
Research Interests: Access to healthcare for vulnerable populations and diversity in the physician workforce.

Joan Ryoo, MD
University of California, Los Angeles
Research Interests: Variation in surgical cancer care.

Comilla Sasson, MD
University of Michigan
Research Interests: In-hospital and out of hospital cardiac arrest, variations in the provision of bystander CPR.
Vijay Singh, MD, MPH  
University of Michigan  
**Research Interests:** Family Medicine, family violence, public health and health services research, immigration and cultural competency, spirituality.

Joanne N. Wood, MD  
University of Pennsylvania  
**Research Interests:** The evaluation of physical injuries in victims of child abuse.
### 2nd Year Clinical Scholars | 2008-2010 Cohort

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Research Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline Bonham, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> How best to better involve those engaged in a patient’s social support (i.e., family/friends) into the assessment and management in their mental health problems.</td>
</tr>
<tr>
<td>Christine Bower, MD</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Assess potential barriers to coordinated care in patients with epilepsy; Assess how awareness and knowledge of epilepsy (in patients, providers, teachers, etc) may influence access to care for patients with epilepsy; and Assess access and utilization of mental health care in those patients with epilepsy who have comorbid psychiatric disease.</td>
</tr>
<tr>
<td>Lisa Ross DeCamp, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> Issues related to health care and coverage continuity and health promotion, with a particular interest in underserved populations.</td>
</tr>
<tr>
<td>Stanley Frencher, MD, MPH</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Eliminate disparities in surgery.</td>
</tr>
<tr>
<td>Katherine Goodrich, MD</td>
<td>Yale University</td>
<td><strong>Research Interests:</strong> Transition of care from hospital to home, particularly as it affects patients with low health literacy and limited English proficiency; Inpatient quality of care and health outcomes.</td>
</tr>
<tr>
<td>John Hollingsworth, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> How financial and economic factors influence the efficiency and quality of subspecialty health care.</td>
</tr>
<tr>
<td>Lara Johnson, MD</td>
<td>Yale University</td>
<td><strong>Research Interests:</strong> Improve quality, safety, and education in pediatric inpatient settings.</td>
</tr>
<tr>
<td>J. Jane Shin Jue, MD</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Obesity in adolescents, media and health promotion, decision-making in physicians.</td>
</tr>
<tr>
<td>Sonali Kulkarni, MD, MPH</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Examine whether a history of incarceration is negatively associated with health status and health behaviors, as a means of exploring the contribution of incarceration on health disparities.</td>
</tr>
</tbody>
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# 2ND YEAR CLINICAL SCHOLARS | 2008-2010 Cohort

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
<th>Research Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adam Landman, MD</strong></td>
<td>Yale University</td>
<td>Innovative application of information technology to improve emergency care.</td>
</tr>
<tr>
<td><strong>Danil Makarov, MD</strong></td>
<td>Yale University</td>
<td>The analysis of technology diffusion and surgical outcomes in prostate cancer.</td>
</tr>
<tr>
<td><strong>Rhonda Mattox, MD</strong></td>
<td>University of California, Los Angeles</td>
<td>Media organizations and faith based organizations.</td>
</tr>
<tr>
<td><strong>Sierra Matula, MD</strong></td>
<td>University of California, Los Angeles</td>
<td>Economic consequences of disparities in access to timely surgical care, evaluate the potential impact of domestic surgical volunteerism in addressing specialty care needs of the uninsured, and investigate policy implications of quality improvement efforts in surgical care.</td>
</tr>
<tr>
<td><strong>Zachary Meisel, MD, MPH</strong></td>
<td>University of Pennsylvania</td>
<td>Patient safety and communication during emergency transitions of care; Gender/race disparities in EMS care; and How emergency care (especially prehospital care) influences downstream hospital-based care.</td>
</tr>
<tr>
<td><strong>Bergen Nelson, MD</strong></td>
<td>University of California, Los Angeles</td>
<td>Innovative models of community-based screening and referrals for early childhood developmental and educational services.</td>
</tr>
<tr>
<td><strong>Mark Neuman, MD</strong></td>
<td>University of Pennsylvania</td>
<td>Examine variation in surgical care of the frail elderly; improving outcomes after hip fracture repair.</td>
</tr>
<tr>
<td><strong>Nicolas Osborne, MD</strong></td>
<td>University of Michigan</td>
<td>Understand racial and socioeconomic disparities in vascular disease; Develop better methods of assessing hospital quality.</td>
</tr>
<tr>
<td><strong>Aasim Padela, MD, MSc</strong></td>
<td>University of Michigan</td>
<td>To improve health care for Arab-Americans.</td>
</tr>
<tr>
<td><strong>Michael Phipps, MD</strong></td>
<td>Yale University</td>
<td>Research topics related to stroke care including primary prevention, acute treatment and post-stroke rehabilitation.</td>
</tr>
<tr>
<td>Name</td>
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<td>Research Interests</td>
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<tr>
<td>Matthew Press, MD</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Hospital quality, with a particular focus on the impact of organizational behavior and culture on quality.</td>
</tr>
<tr>
<td>Adam Richards, MD, MPH</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Participatory methods to study current patterns of health care access and the health and human rights priorities and of migrant and/or undocumented workers in Los Angeles.</td>
</tr>
<tr>
<td>Charmaine Smith Wright, MD</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Maternal-child health, prenatal risk factors and childhood obesity, fetal determinants of adult disease.</td>
</tr>
<tr>
<td>Erica Spatz, MD</td>
<td>Yale University</td>
<td><strong>Research Interests:</strong> Cardiovascular disease prevention in urban, underserved populations. Development and translation of evidence-based strategies for cardiovascular risk reduction.</td>
</tr>
<tr>
<td>Jeremy Sussman, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> How to use evidence-based medicine to improve care for underserved populations.</td>
</tr>
<tr>
<td>Kate Viola, MD</td>
<td>Yale University</td>
<td><strong>Research Interests:</strong> Surgery residency attrition and genetic biomarkers associated with familial lung cancer.</td>
</tr>
<tr>
<td>Anje Van Berckelaer, MD</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Barriers to enrollment and unintended consequences of state policy choices in SCHIP. Public insurance programs - improving access &amp; quality.</td>
</tr>
<tr>
<td>Glenda Wrenn, MD</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Enhance resilience in vulnerable populations, exploring and addressing mental health disparities and quality inequities influenced by fragmented systems of care and stigma.</td>
</tr>
<tr>
<td>Donna Zulman, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> Medical systems in order to improve the care of older patients with multiple comorbid conditions.</td>
</tr>
</tbody>
</table>
### 1ST Year Clinical Scholars | 2009-2011 Cohort

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
<th>Research Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahshid Abir, MD</td>
<td>University of Michigan</td>
<td>Improve effectiveness and efficiency of healthcare delivery in the acute phase of mass disasters.</td>
</tr>
<tr>
<td>Medell Briggs-Malonson, MD, MPH</td>
<td>University of California, Los Angeles</td>
<td>Racial and socioeconomic health disparities, healthcare financing, and emergency health services accessibility; impact that declining emergency services has upon the health of low income communities. Also interested in Development of Emergency Department and Hospital based interventions to address the problem of youth violence.</td>
</tr>
<tr>
<td>Deepa Camenga, MD, MPH</td>
<td>Yale University</td>
<td>Adolescent smoking cessation; parental attitudes towards second hand smoke exposure among premature and term newborns; experiences of low income adolescents and young adults as they transition from pediatric to adult care.</td>
</tr>
<tr>
<td>Aleksandra Casillas, MD, MPH</td>
<td>University of California, Los Angeles</td>
<td>Health of Latino immigrants—primarily women’s health issues and exploring the trauma and stigma of immigration to the US and how this impacts health care utilization and perceived health needs. Use of Spanish-speaking media to develop educational tools on prevalent chronic medical problems in the Latino population.</td>
</tr>
<tr>
<td>Colin Cooke, MD, MSc</td>
<td>University of Michigan</td>
<td>Characterize and remove disparities in ICU processes of care and research participation in clinical trials; understand how families and physicians integrate prognostic information in the care of patients with critical illness.</td>
</tr>
<tr>
<td>Rebecca Dudovitz, MD</td>
<td>University of California, Los Angeles</td>
<td>Improve academic performance in school age children. Understanding better the relationship between health and education and on finding ways to improve educational outcomes for students in high-risk populations.</td>
</tr>
<tr>
<td>E. Jennifer Edelman, MD</td>
<td>Yale University</td>
<td>Improving screening strategies for HIV and the care of those already infected.</td>
</tr>
<tr>
<td>Clinical Scholars</td>
<td>Research Interests</td>
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</tbody>
</table>
| Neera Goyal, MD   | University of Pennsylvania  
Research Interests: Disparities in hospitalization rates, patterns of hospital and outpatient resource use for different pediatric populations. |
| Ryan Greysen, MD, MA | Yale University  
Research Interests: Intersections of health policy and medical education including quality improvement, disparities in care, workforce expansion, medical student debt, diversity, and primary care. |
| Stephen Henry, MD | University of Michigan  
Research Interests: Clinical decision-making; especially identification of factors influencing patient and clinician choices through direct observation. |
| Adriana Izquierdo, MD, MSCE | University of California, Los Angeles  
Research Interests: Identify the determinants of health disparities in Mexican American populations with respect to HIV & women’s health, and develop targeted strategies to improve the clinical care and health care outcomes for at-risk populations of Latinos living in the United States. Evaluating how health policy and advocacy impacts the delivery of care for Spanish-speaking patients. |
| Sophia Jan, MD | University of Pennsylvania  
Research Interests: Healthcare transitions, access to care, physician incentives, children with special needs, adult survivors. |
| Kristin Jensen, MD | University of Michigan  
Research Interests: Issues related to health care and coverage continuity and health promotion, with a particular interest in underserved populations. |
| Elizabeth Krans, MD | University of Michigan  
Research Interests: Issues related to prenatal care content, structure and delivery, with a particular interest in underserved populations. |
| Jeffrey Kullgren, MD, MPH | University of Pennsylvania  
Research Interests: Access to care, health incentives, insurance benefit design, health behaviors. |
| Kelly Kyanko, MD | Yale University  
Research Interests: Improve care coordination and chronic disease management through physician practice and community-based initiatives. |
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</tr>
</thead>
<tbody>
<tr>
<td>Elise Lawson, MD</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Pursue research projects that evaluate, and ultimately improve, the quality of healthcare delivery in the field of surgical oncology (specifically, I would like to investigate the treatment of breast and colorectal cancer in the Los Angeles county hospital system.</td>
</tr>
<tr>
<td>Lenard Lesser, MD</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Social, economic, and environmental factors that influence nutrition; what types of interventions in communities can inform policies to reduce obesity and malnutrition; conflicts of interest in nutrition and how those conflicts influence policy decisions.</td>
</tr>
<tr>
<td>Kasia Lipska, MD</td>
<td>Yale University</td>
<td><strong>Research Interests:</strong> Cardiovascular health outcomes of patients with type 2 diabetes.</td>
</tr>
<tr>
<td>Demetria Malloy, MD</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Physician-patient communication, medical adherence, health disparities and neighborhood/environmental determinants of health.</td>
</tr>
<tr>
<td>Raymond Perry, MD</td>
<td>University of California, Los Angeles</td>
<td><strong>Research Interests:</strong> Health of urban, minority adolescent males. (disproportionately high rates of morbidity and mortality, and means of raising awareness and increasing participation in healthy behaviors among this at-risk group.)</td>
</tr>
<tr>
<td>Kerianne Quanstrum, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> Assess the impact of unwarranted and inefficient care on healthcare costs; and to study compensation policies and insurance structures that might decrease unwarranted care while creating incentives for quality.</td>
</tr>
<tr>
<td>Janice Scobie, MD, MS</td>
<td>University of Pennsylvania</td>
<td><strong>Research Interests:</strong> Cardiovascular disease prevention, Disparities in cardiovascular disease/care, Patient adherence to medical therapies after cardiovascular event, Appropriate utilization of CV technology and preventive therapies, Access to health care.</td>
</tr>
<tr>
<td>Kimberly Smith, MD</td>
<td>University of Michigan</td>
<td><strong>Research Interests:</strong> Improve primary care in chronic kidney disease.</td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Amy Tsou, MD, MAR</td>
<td>University of Pennsylvania</td>
<td>Decision making, effects of religious background on perceptions of healthcare, end of life issues, influence of media on healthcare utilization.</td>
</tr>
<tr>
<td>Brownsyne Tucker-Edmonds, MD, MPH</td>
<td>University of Pennsylvania</td>
<td>Substance Abuse among pregnant and parenting women, race and the doctor-patient relationship, medical ethics, humanism in medicine, cultural competency in medical education.</td>
</tr>
<tr>
<td>Oliver Wang, MD, MBA</td>
<td>Yale University</td>
<td>Evaluate and improve efficiency and delivery of cardiovascular health care.</td>
</tr>
<tr>
<td>Niamey Wilson, MD</td>
<td>University of Pennsylvania</td>
<td>Substance Abuse among pregnant and parenting women, race and the doctor-patient relationship, medical ethics, humanism in medicine, cultural competency in medical education.</td>
</tr>
<tr>
<td>Katherine Yun, MD</td>
<td>Yale University</td>
<td>Refugee and immigrant health; gender-based violence; health and human trafficking.</td>
</tr>
</tbody>
</table>
Clinical Scholars

Continuing Medical Education

Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The School of Medicine of The University of North Carolina at Chapel Hill and Robert Wood Johnson Clinical Scholars Program. The School of Medicine of The University of North Carolina at Chapel Hill is accredited by the ACCME to provide continuing medical education for physicians.

Credit Statement
The School of Medicine of The University of North Carolina at Chapel Hill designates this educational activity for a maximum of 15.75 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclosure Statement
CME Disclosure Form Required for All Speakers
If you are a speaker you will need to fill out a disclosure form during this registration process.

In accordance with the ACCME Essentials and Standards, everyone involved in planning or presenting this educational activity will be required to disclose any relevant financial relationships with commercial interests in the healthcare industry, and this information will be made available to participants at the start of the activity. In addition, speakers who incorporate information about off-label or investigational use of drugs or devices will be asked to disclose that information at the beginning of their presentation.

Educational Objectives
The information presented at this educational activity should improve your ability to:

• Recognize new approaches to measuring access to care and quality of health services
• Describe new programs addressing improved access to care and assess their impact on health status of special populations
• Examine the limitations and benefits of new proposals to extend health care to underserved populations through state and federal initiatives
• Identify threats to health status for special populations, such as children, the homeless, or the elderly
• Translate research into new interventions to address specific health problems.

CME Registration
If you are interested in obtaining CME credits, please fill out the on-line registration form that will be emailed to you after the meeting ends. You can record what sessions you attended. You will receive credit for only those sessions you attended.
Lodging & Meal Information

**Overnight Guests**
Includes Overnight Guest Room Accommodations, Breakfast, Lunch, Dinner, Refreshment Breaks, Tax and Service Fees. This rate also includes high-speed internet access in guestrooms and wireless internet access in guestrooms and in public spaces, toll free and local telephone calls, Fitness Center access, Business Center access, daily delivery of the San Diego Union Tribune newspaper and in-room gourmet coffee. The meal plan portion of the complete meeting package rate will be prorated.

**Single Rate**
$425.00 per night. If you are bringing a spouse/partner who will attend meals, the daily meal plan will apply ($210 per day). There is no extra charge for an additional guest in the sleeping room.

**Double Rate**
$315.00 per person per night (Current Scholars are expected to room together unless they are bringing a caregiver for an infant under 12 months of age).

**Parking**
The overnight rate is $25/day.

**Day Guests**
Attendees who are commuting each day are required to be a part of the daily meal plan. Unless alternate arrangements have been made with the hotel you will be required to pay the front desk for the days you attend the meeting. The daily meal package is $210.00 per day per guest (breakfast, lunch, dinner, refreshment breaks, and service fee) or $150.00 per day per guest (breakfast, lunch, refreshment breaks, and service fee). Tax is 8.75%. A credit card will be required and will be charged on site.

Please check in with the hotel front desk upon arrival to pay for your meal plan. Meals must be paid for in advance of attending the program. Then, proceed to registration.

**Parking**
Guests driving in just for the day, the rate is $10.