2011 Committee on Arrangements

Faculty & Scholars

David Rubin (Penn, COA Chair and Faculty)
Kalpana Narayan (Penn Scholar)
Anand Shah (Penn Scholar)
Traci Chupik (Penn Administrative Director)

Arlene Brown (UCLA Faculty)
Alejandra Casillas (UCLA Scholar)

Caroline Richardson (Michigan Faculty)
Jennifer Walter (Michigan Scholar)

Rani Desai (Yale Faculty)
Eric Hodgson (Yale Scholar)

National Advisory Committee

Dick Krugman
Joanne Elmore
Stuart Gilman
Malcolm Cox

National Program Office

Des Runyan
Kristin Siebenaler

National Meeting Presented by:
Department of Social Medicine, University of North Carolina at Chapel Hill

Jointly Sponsored by:
University of Colorado School of Medicine Office of Continuing Medical Education and
Robert Wood Johnson Foundation Clinical Scholars® National Program Office

This program is a part of the Colorado Statewide Extended Campus.
State funds were not used to develop or administer this program.

The committee offers special thanks to EMCVenues, particularly to Carmelita Marrow, Debbie Odden, Alex Calderon Estanol and Rick Bloom for excellent support in attendee management, pre-planning logistics, and on-site support for this meeting. We also thank Kate Sell, Research Associate at The Children’s Hospital of Philadelphia for her support to the Chair and this committee.
Dear Current & Former Scholars, NAC Members, RWJF Trustees & Staff, Faculty, Guest Speakers, and Community Partners:

Welcome to Washington, DC! We are delighted that you are joining us for the 2011 Robert Wood Johnson Foundation Clinical Scholars® program national meeting. The focus on innovative strategies to impact the health of communities at this year’s meeting could not come at a better time, with the transformative changes in healthcare occurring at a time in our nation’s history when we are faced with unprecedented economic challenges. Added to that is our meeting venue in Washington, DC, which has facilitated an exciting itinerary for the meeting and the opportunities for networking that should foster provocative debate and discussion by all those attending.

We are excited to introduce some fresh faces and new formats to the meeting this year that will help inspire vigorous and lively discussion during the meeting. The meeting has been oriented around four keynote panels that focus on issues critical to understanding and navigating today’s health care and public health landscapes, including: innovations in delivery and payment to improve quality; shaping the workforce; engaging with communities to create sustainable change; and practice/quality improvement across the Department of Veteran’s Affairs. The panels will be moderated by leaders chosen from the National Advisory Committee, and will devote the majority of allotted time to an interview and Q&A format with audience participation. Wrapped around these keynote panels will be alumni and current Scholar plenary presentations, which reflect the diverse contributions of our RWJF scholar network to the changes we are witnessing in our country today. Additionally, there will be Scholar poster presentations that will have assigned reviewers from National Advisory Committee, program faculty, and alumni speakers.

Finally, we are pleased to announce that alumna Molly Coye, MD, MPH, will be this year’s Annie Lea Shuster alumni speaker. Dr. Coye is a well-established leader in advancing innovation in health care delivery through her work in academia, government, and the private sector. Currently, Dr. Coye serves as the Chief Innovation Officer of the UCLA Health System.

On behalf of the National Program Office and the Committee of Arrangements, we hope that you enjoy the meeting. Our hope is that it will serve as a valuable forum for all of you to share your work with a diverse group of Scholars, alumni, faculty, and community partners, and to enrich these relationships as you move forward in your careers.

Sincerely,

Desmond Runyan, M.D., Dr.P.H.
National Program Director, RWJF CSP
Children’s Hospital, Colorado

Robert Runyan, M.D., Dr.P.H.
National Program Director
Robert Wood Johnson Foundation
Clinical Scholars

Desmond K. Runyan,
M.D., Dr.P.H.
National Program Director
Robert Wood Johnson Foundation
Clinical Scholars

Kristin Siebenaler, M.P.A.
Deputy Director

Participating Universities

University of California, Los Angeles
Co-directors
Robert H. Brook, M.D., Sc.D.
Carol M. Mangione, M.D., M.S.P.H.
Kenneth B. Wells, M.D., M.P.H.

University of Michigan
Director
Rodney A. Hayward, M.D.
Co-directors
Matthew M. Davis, M.D., M.A.P.P.
Michele Heisler, M.D., M.P.A.

University of Pennsylvania
Co-directors
Katrina Armstrong, M.D., M.S.C.E.
Joshua P. Metlay, M.D., Ph.D.

Yale University
Director
Harlan M. Krumholz, M.D.
Co-directors
Cary Gross, M.D.
Rani Desai, Ph.D., M.P.H.
# Agenda

Sessions marked with an asterisk (*) are available for CME credits.

Table assignments are located at end of Agenda as well as a map of the complex.

Program training site and years as a Scholar are in parentheses for alumni.

## TUESDAY, NOVEMBER 8, 2011

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Event Description</th>
<th>Moderator/Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 am - 11:30 am</td>
<td>Crystal Ballroom Foyer</td>
<td>REGISTRATION</td>
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<tr>
<td>11:45 am - 5:15 pm</td>
<td>Potomac View</td>
<td>SCHOLAR TRAINING DAY—SCHOLARS ONLY</td>
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</tbody>
</table>
| 11:45 am - 1:00 pm | 14th Floor North Tower     | LUNCH                                                  | Guest Speaker: Nicole Lurie M.D., M.S.P.H.  
Assistant Secretary for Preparedness and Response, DHHS  
Introduction by: Desmond Runyan M.D., Dr.P.H.  
Director, RWJF Clinical Scholars National Program Office |
| 1:15 pm - 2:30 pm | Salon A                   | ALUMNI CAREER PANEL*                                   | Moderator: Anand Shah M.D., VA Scholar (Penn 10-12)  
Stacy Lindau M.D., M.A.P.P (Chicago 00-02), University of Chicago Medical Center  
Anjali Jain M.D. (Yale 96-98), The Lewin Group  
Anish Mahajan M.D., M.P.H. (UCLA 06-09), UCLA School of Medicine  
Josh Newman M.D., M.H.S.H. (UCLA 06-08), Salesforce.com  
David Penson M.D., M.P.H. (Yale 97-99), Vanderbilt University Medical Center |
| 2:30 pm - 2:45 pm | Crystal Ballroom Foyer     | Break                                                  |                                                                                       |
| 2:45 pm - 3:45 pm | Crystal Ballroom Foyer     | TALES OF CONTROVERSY PANEL: ALUMNI REFLECTIONS*        | Moderator: Kalpana Narayan M.D. (Penn 10-12)  
Lawrence Kleinman M.D., M.P.H. (UCLA 90-92), Mount Sinai School of Medicine  
Arthur Kellermann M.D. (Washington 83-85), RAND Corporation  
Richard Deyo M.D., M.P.H. (Washington 79-81), Oregon Health and Science University |
| 3:45 pm - 4:00 pm | Crystal Ballroom Foyer     | Break                                                  |                                                                                       |
| 4:00 pm - 5:15 pm | Crystal Ballroom Foyer     | SPECIAL TOPICS SESSION*                                | Topic 1: Working with Media/Messaging  
Moderator: Eric Hodgson M.D. (Yale 10-12)  
Natalia Barolin, Health Communications Manager, IQ Solutions, Inc.  
Barrett Whitener, Senior Health Communications Manager, IQ Solutions, Inc.  

**Topic 2: Involvement with a Political Campaign**  
Moderator: Alejandra Casillas M.D. (UCLA 09-12)  
Vivek Murthy M.D., Physician, Brigham and Women’s Hospital; Instructor, Harvard Medical School; Co-founder and President, Epernicus; Co-founder and President, Doctors for America; Appointee, U.S. Presidential Advisory Council on Prevention, Health Promotion, Integrative and Public Health |

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Table assignments are located at end of Agenda as well as a map of the complex.

Program training site and years as a Scholar are in parentheses for alumni.
**Robert Wood Johnson Foundation**
**Clinical Scholars**

**TUESDAY, NOVEMBER 8, 2011 continued**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Location</th>
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<tbody>
<tr>
<td>3:00 pm - 6:00 pm</td>
<td><strong>REGISTRATION — All Attendees</strong></td>
<td>Crystal Ballroom</td>
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<td>Foyer</td>
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<tr>
<td>3:00 pm - 6:00 pm</td>
<td><strong>Speaker Ready Room</strong></td>
<td>Pentagon I</td>
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<tr>
<td>6:00 pm - 7:00 pm</td>
<td><strong>OPENING RECEPTION — All Attendees</strong></td>
<td>Washington Ballroom</td>
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<tr>
<td>7:00 pm - 8:30 pm</td>
<td><strong>DINNER — All Attendees</strong></td>
<td>Crystal Ballroom</td>
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<tr>
<td></td>
<td>Remarks by Desmond Runyan M.D., Dr.P.H. (UNC 79-81)</td>
<td>Salon AB</td>
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<tr>
<td></td>
<td>Director, RWJF Clinical Scholars National Program Office</td>
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<tr>
<td></td>
<td>Introduction of new Scholars by Program Faculty</td>
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<tr>
<td>8:30 pm - 11:00 pm</td>
<td><strong>HOSPITALITY SUITE</strong></td>
<td>South Tower Room</td>
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*Sessions marked with an asterik are available for CME credit.*
**WEDNESDAY, NOVEMBER 9, 2011**

<table>
<thead>
<tr>
<th>ALL DAY</th>
<th>REGISTRATION</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 am - 8:00 am</td>
<td>BREAKFAST</td>
<td>Crystal Ballroom Foyer</td>
</tr>
<tr>
<td>8:00 am - 8:30 am</td>
<td>WELCOME AND INTRODUCTIONS</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
<tr>
<td>8:30 am - 12:00 pm</td>
<td>PLENARY SESSION*</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
<tr>
<td>8:30 am - 8:50 am</td>
<td>Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on Pay-for-Performance Measures?</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
<tr>
<td>8:50 am - 9:10 am</td>
<td>When Coverage Expands, What Happens to Utilization of Health Care Services? CHIP as a Natural Experiment</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
<tr>
<td>9:10 am - 9:25 am</td>
<td>BREAK</td>
<td>Crystal Ballroom Foyer</td>
</tr>
<tr>
<td>9:25 am - 10:40 am</td>
<td>PANEL 1: Shaping The Health Care Workforce</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
</tbody>
</table>

*Sessions marked with an asterik are available for CME credit.*
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Location</th>
</tr>
</thead>
</table>
| 10:40 am - 11:00 am| **The Quality and Cost of Care for Veterans with Mental and Substance-Use Disorders**  
Kate Watkins M.D. (UCLA 96-98), Rand Corporation | Crystal Ballroom  |
| 11:00 am - 11:20 am| **Gender and the use of Veterans Health Administration Homeless Services Programs Among Iraq/Afghanistan Veterans**  
Oni Blackstock M.D., VA Scholar (Yale 2nd Year) | Salon AB          |
| 11:20 am - 12:00 pm| **ANNIE LEA SHUSTER ALUMNI SPEAKER**  
Molly Coye M.D., M.P.H. (UCSF 78-79)  
Chief Innovation Officer, UCLA Health System  
Introduction: Carol Mangione M.D.  
Co-Director UCLA Clinical Scholars |                  |
| 12:00 pm - 1:00 pm| **LUNCH**                                                                 | Potomac View/Windows Over Washington |
| 1:00 pm - 2:15 pm | **PANEL 2: Integration Of Health Services Research and Operations Management—U.S. Department Of Veterans Affairs**  
Moderator: Malcolm Cox M.D.  
Clinical Scholars National Advisory Committee  
Robert Jesse M.D.  
Department of Veterans Affairs Principal Deputy Under Secretary for Health  
Eve Kerr M.D., M.P.H. (UCLA 92-94)  
Director, VA Health Services Research and Development Center  
for Clinical Management Research;  
Professor, Internal Medicine, University of Michigan | Crystal Ballroom Salon AB  |
| 2:15 pm - 4:00 pm | **NETWORKING**                                                            | Van Buren         |
| 2:15 pm - 3:15 pm | **OPTIONAL SESSION**                                                      |                   |
|                   | **How do we Develop a Movement to Produce Value—Based Health Care?**     |                   |
|                   | Informal Discussion with                                                 |                   |
|                   | **Robert Brook M.D.**, Co-Director, UCLA Clinical Scholars               |                   |

*Sessions marked with an asterik are available for CME credit.*
### Community-Based Approaches to Improving Health

- **A Pilot Randomized Controlled Trial of Vacant Lot Greening and Violence Related Outcomes**
  - Eugenia Garvin M.D. (Penn 10-12)

- **Rating Fast Food by Calories Purchased: Is Subway Healthier than McDonald’s?**
  - Lenard Lesser M.D. (UCLA 09-12)

- **Perspectives on Community-Based Participatory Research: Experiences of Community and University Researchers in Partnerships**
  - Karen Wang M.D. (Yale 10-12)

### Screening and Prevention

- **Evaluation of a Conceptual Model for Substance Use Prevention**
  - Rebecca Dudovitz M.D. (UCLA 09-12)

- **Project C.O.A.C.H.: Counseling Others About Contacts and Exposures with HIV**
  - E. Jennifer Edelman M.D., VA Scholar (Yale 09-12)

- **Association Between Active Transport and Cardiovascular Disease Risk Factors**
  - Gregg Furie M.D., VA Scholar (Yale 10-12)

- **Understanding Barriers to Evaluation for Early Intervention Services**
  - Manny Jimenez M.D. (Penn 10-12)

- **Patients’ Willingness to Provide a Bio Specimen for Genetic Research at Screening Mammogram**
  - Christoph Lee M.D. (UCLA 10-12)

### Health Care Disparities

- **Hospitals at Risk? Race and Socioeconomic Predictors of Hospital Readmissions in California**
  - Medell Briggs-Malonson M.D., VA Scholar (UCLA 09-12)

- **Do Improvements in Race/Ethnicity Data Collection Affect Knowledge of Healthcare Disparities? The Case of Asian Americans and Acute Myocardial Infarction**
  - Rosette Chakkalakal M.D. (Yale 10-12)

- **The Patient-Centered Transition (PACT) Project: Improving the Transition from Hospital to Primary Care for Socioeconomically Vulnerable Patients**
  - Shreya Kangovi M.D., VA Scholar (Penn 10-12)

*Sessions marked with an asterik are available for CME credit.*
Vulnerable Populations
Perspectives of Adolescents in the Juvenile Justice System Regarding Recidivism
Mana Golzari M.D. (Penn 10-12)

Understanding the Knowledge, Attitudes, and Beliefs Regarding Contraception Use Among Adult, African American Women at Risk for Undesired Pregnancy
Eric Hodgson M.D. (Yale 10-12)

Erin Saleeby M.D. (UCLA 10-12)

Prenatal Care Utilization Patterns Among Refugee Women
Luwam Semere M.D. (UCLA 10-12)

5:00 pm - 6:00 pm

Clinical Epidemiology/Quality and Cost of Care
Jed Barash M.D., VA Scholar (Yale 10-12)

Incidence of Genital Warts Among Adolescents and Young Adults Prior to the Introduction of the Human Papillomavirus (HPV) Vaccine
Deepa Camenga M.D. (Yale 09-12)

Are Longer Resuscitation Efforts Associated with Improved Survival During In-Hospital Arrest?
Zachary Goldberger M.D. (Michigan 10-12)

The Role of Caregivers in the Emergency Department and Their Relationship with Patient Satisfaction, Disposition and Follow-up
Kalpana Narayan M.D. (Penn 10-12)

Relationship Between Debridement Timing and Amputation in Patients with Open Tibial Fracture: A National Study
Erika Sears M.D., VA Scholar (Michigan 10-12)

The Effect of Falling on Disability in Previously Non-Disabled Community Dwelling Older Adults Aged 65-69: A 10 Year Longitudinal Analysis
Nishant Sekaran M.D. (Michigan 10-12)

Factors Associated with Prognostic Goals-Of-Care Conversations for Critically Ill Children
Jennifer Walter M.D., Ph.D. (Michigan 10-12)

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>6:00 pm</td>
<td>DINNER “ON YOUR OWN”</td>
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<tr>
<td>6:00 pm - 7:00 pm</td>
<td>APPLICANT RECRUITMENT RECEPTION</td>
<td>Crystal Ballroom</td>
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<td></td>
<td>Reception for medical students and residents from area teaching hospitals</td>
<td>Salon CDE Foyer</td>
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<tr>
<td>8:30 pm - 11:00 pm</td>
<td>HOSPITALITY SUITE</td>
<td>South Tower</td>
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<td>Room TBD</td>
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</table>

* Sessions marked with an asterik are available for CME credit.*
# Robert Wood Johnson Foundation
## Clinical Scholars

**THURSDAY, NOVEMBER 10, 2011**  
**LOCATION**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>ALL DAY</td>
<td><strong>REGISTRATION</strong></td>
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<tr>
<td>7:30 am - 8:30 am</td>
<td><strong>BREAKFAST</strong></td>
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<tr>
<td>8:30 am - 12:00 pm</td>
<td><strong>PLENARY SESSION</strong>*</td>
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<tr>
<td></td>
<td>Facilitator: Greer Sullivan M.D., M.S.P.H. (UCLA 86-88)</td>
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<tr>
<td></td>
<td>Clinical Scholars National Advisory Committee</td>
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<tr>
<td>8:30 am - 8:50 am</td>
<td><strong>Routine Opt-Out HIV Screening and Patient Acceptability in</strong></td>
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<td>Safety-Net Clinics</td>
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<td></td>
<td>Anish Mahajan M.D., M.P.H. (UCLA 06-09), UCLA School of Medicine</td>
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<tr>
<td>8:50 am - 9:10 am</td>
<td><strong>The Association Between Local Food Environment and Obesity</strong></td>
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<td></td>
<td>and Diabetes in California Adults</td>
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<td></td>
<td>Demetria Malloy M.D., VA Scholar (UCLA 3rd Year)</td>
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<tr>
<td>9:10 am - 10:25 am</td>
<td><strong>PANEL 3: Innovations in Delivery and Payment to Improve Health Care</strong></td>
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<td><strong>Quality</strong></td>
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<td>Moderator: Lisa Iezzoni M.D., M.Sc.</td>
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<td></td>
<td>Clinical Scholars National Advisory Committee</td>
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<td>Elliott Fisher M.D., M.P.H. (Washington 83-85)</td>
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<td></td>
<td>Professor, Dartmouth Medical School, Director, Population Health and Policy, The Dartmouth Institute for Health Policy and Clinical Practice</td>
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<td>Jeffrey Brenner M.D.</td>
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<td>Founder and Executive Director, Camden Coalition of Healthcare Providers</td>
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<td>Robert Berenson M.D. (George Washington University 77-79)</td>
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<td></td>
<td>Institute Fellow, Urban Institute</td>
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<tr>
<td>10:25 am - 10:40 am</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>10:40 am - 11:00 am</td>
<td><strong>Electronic Health Records and Ambulatory Quality of Care</strong></td>
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<td>Lisa Kern M.D., M.P.H. (JHU 00-02), Weill Cornell Medical College</td>
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<tr>
<td>11:00 am - 11:20 am</td>
<td><strong>An Alternative Approach for Quantifying Hospital Resource</strong></td>
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<td><strong>Utilization: Implications of “Standard Costs” for Hospital</strong></td>
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<td><strong>Value Improvement, Performance Measurement, and</strong></td>
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<td><strong>Comparative Effectiveness Research</strong></td>
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<td></td>
<td>Tara Lagu M.D., M.P.H. (Penn 05-08), Tufts University School of Medicine</td>
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<tr>
<td>11:20 am - 11:40 am</td>
<td><strong>Impact of a Preventive Sexual Health Text-Messaging Service on</strong></td>
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<td><strong>Sexual Health Knowledge, Self-Efficacy, and Behaviors of Teens</strong></td>
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<td></td>
<td>Raymond Perry M.D. (UCLA 3rd Year)</td>
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<tr>
<td>11:40 am - 12:00 pm</td>
<td><strong>A Randomized Controlled Trial of Financial Incentives to Promote</strong></td>
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<td><strong>Weight Loss among Obese Employees</strong></td>
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<td>Jeffrey Kullgren M.D., VA Scholar (Penn 3rd Year)</td>
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<tr>
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<tbody>
<tr>
<td>12:00 pm - 1:15 pm</td>
<td>LUNCH&lt;br&gt;Guest Speaker: Arthur Rubenstein M.B.B.Ch.&lt;br&gt;Professor, Department of Medicine, Division of Endocrinology;&lt;br&gt;School of Medicine, University of Pennsylvania&lt;br&gt;Formally, Executive Vice President of the University of Pennsylvania&lt;br&gt;for the Health System and Dean, School of Medicine</td>
<td>Commonwealth Ballroom</td>
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<tr>
<td></td>
<td>Introduction by: Josh Metlay, M.D., Ph.D. and&lt;br&gt;Katrina Armstrong M.D., M.S.C.E., Co-Directors, Penn Clinical Scholars</td>
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<tr>
<td>1:15 pm - 1:45 pm</td>
<td>GROUP PHOTO/SITE PHOTOS</td>
<td>Presidential Hallway</td>
</tr>
<tr>
<td>1:45 pm - 2:45 pm</td>
<td>COMMON INTEREST ROUNDTABLE DISCUSSIONS*&lt;br&gt;Please attend desired discussion. See table tents for topics.</td>
<td>Wilson/Jackson Harrison</td>
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<td></td>
<td>Health Care Challenges Related to Robotic Surgery&lt;br&gt;Facilitator: Charlene Hooper M.D. (Yale)</td>
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<td>School-based Interventions and Partnerships&lt;br&gt;Facilitators: Ray Perry M.D. (UCLA), Deepa Camenga M.D. (Yale), and Rebecca Dudovitz M.D. (UCLA)</td>
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<td></td>
<td>HIV and Substance Abuse Interest Group&lt;br&gt;Facilitators: Oni Blackstock M.D., VA Scholar (Yale),&lt;br&gt;Deepa Camenga M.D. (Yale), E. Jennifer Edelman M.D., VA Scholar (Yale), and Karen Wang M.D. (Yale)</td>
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<td>Nudging People to Eat Less and Be More Active&lt;br&gt;Facilitators: Lenny Lesser M.D. (UCLA), and Jeff Kullgren M.D. (Penn)</td>
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<td>How to Use Popular Culture and Media to Improve Health&lt;br&gt;Facilitator: Tammy Chang M.D. (Michigan)</td>
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<td>Off-Site Policy Experiences&lt;br&gt;Facilitators: Anand Shah M.D., VA Scholar (Penn), Clara Filice M.D. (Yale), and Gregg Furie M.D., VA Scholar (Yale)</td>
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<td>RWJF CSP Global Health Interest Group: How does a global&lt;br&gt;perspective help us solve domestic health issues?&lt;br&gt;Facilitators: Sidney Coupet M.D. (Michigan), and Nurit Harari M.D. (Yale)</td>
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<td>Health reform and the underserved: Will We Be ready?&lt;br&gt;Facilitators: Robin Clarke M.D. (UCLA), Michael Hochman M.D., VA Scholar (UCLA), Katherine Neuhausen M.D. (UCLA), and Yoshi Laing M.D. (UCLA)</td>
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<td>The Doctor Will See You Now: A Discussion on Access to Care&lt;br&gt;Facilitators: Adam Sharp M.D. (Michigan), Alan Teo M.D. (Michigan), and Kathy Auger M.D. (Michigan)</td>
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<td>Linking Community Settings with Hospitals and Institutions to&lt;br&gt;Improve Outcomes&lt;br&gt;Facilitator: Nishant Sekaran M.D. (Michigan)</td>
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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>2:45 pm - 3:00 pm</td>
<td>BREAK</td>
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<tr>
<td>3:00 pm - 4:20 pm</td>
<td>PLENARY SESSION *&lt;br&gt;Facilitator: Sim Galazka M.D.&lt;br&gt;Clinical Scholars National Advisory Committee</td>
<td>Crystal Ballroom Salon AB</td>
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<tr>
<td>3:00 pm - 3:20 pm</td>
<td>Quality, Safety Cost of Care for Hospitalized Adolescents and Young Adults with Inflammatory Bowel Disease&lt;br&gt;Sophia Jan M.D. (Penn 3rd Year)</td>
<td>Crystal Ballroom Salon AB</td>
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<tr>
<td>3:20 pm - 3:40 pm</td>
<td>Readmission Following Surgical Procedures: Implications for Quality Improvement and Cost Savings&lt;br&gt;Elise Lawson M.D., VA Scholar (UCLA 3rd Year)</td>
<td>Crystal Ballroom Salon AB</td>
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<td>3:40 pm - 4:00 pm</td>
<td>Discussions about Pain are Associated with Heightened Patient Affect during Primary Care Visits in an Urban Clinic&lt;br&gt;Stephen Henry M.D., VA Scholar (Michigan 3rd Year)</td>
<td>Crystal Ballroom Salon AB</td>
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<td>4:00 pm - 4:20 pm</td>
<td>Does MRI Utilization Reduce Recurrent Stroke?&lt;br&gt;James Burke M.D., VA Scholar (Michigan 2nd Year)</td>
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<td>4:20 pm - 6:30 pm</td>
<td>NETWORKING</td>
<td>Jackson</td>
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<td>4:30 pm - 5:30 pm</td>
<td>NATIONAL ADVISORY COMMITTEE BUSINESS MEETING</td>
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<td>6:30 pm - 7:00 pm</td>
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<td>Crystal Ballroom Salon AB</td>
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<td>7:00 pm - 8:30 pm</td>
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<td>Crystal Ballroom Salon AB</td>
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<td>8:30 pm - 11:00 pm</td>
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* Sessions marked with an asterik are available for CME credit.
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<tr>
<td>7:30 am - 8:30 am</td>
<td>BREAKFAST</td>
<td>Potomac View/Windows Over Washington</td>
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<td>7:30 am - 8:30 am</td>
<td>BREAKFAST (Private) Program Directors and NPO</td>
<td>Pentagon I</td>
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<tr>
<td>7:30 am - 8:30 am</td>
<td>BREAKFAST (Private) VA Scholars with Drs. Cox and Gilman NPO</td>
<td>Pentagon II</td>
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<td>8:30 am - 11:40 am</td>
<td>PLENARY SESSION *&lt;br&gt;Facilitator: Somnath Saha MD, M.P.H. (Washington 96-98)&lt;br&gt;Clinical Scholar National Advisory Committee</td>
<td>Crystal Ballroom Salon AB</td>
</tr>
<tr>
<td>8:30 am - 9:45 am</td>
<td>PANEL: Engaging with Communities to Create Sustainable Change: How Can Communities Beat Depression?&lt;br&gt;The Evolution of a Community-Partnered Learning Collaborative</td>
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<tr>
<td>9:45 am - 10:05 am</td>
<td>The Police Health Survey: Community-Partnered Research with the New Haven Police Department&lt;br&gt;Justin Fox M.D. (Yale 2nd Year)</td>
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<tr>
<td>10:05 am - 10:25 am</td>
<td>Improving Transitions in Care from Hospital to Shelter in New Haven: Implementing Systems Change from Community-Based Participatory Research Findings&lt;br&gt;Ryan Greysen M.D., M.H.S., M.A. (Yale 09-11), UCSF Division of Hospital Medicine</td>
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<td>10:25 am - 10:40 am</td>
<td>BREAK</td>
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* Sessions marked with an asterisk are available for CME credit.
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<th>Time</th>
<th>Session</th>
<th>Location</th>
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<tr>
<td>10:40 am - 11:00 am</td>
<td>Messaging to the Messengers: An Ethnographic Study of Latino Ethnic Media and Health Reporting in the Los Angeles Market</td>
<td>Crystal Ballroom Salon AB</td>
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<tr>
<td>11:00 am - 11:20 am</td>
<td>Prevalance of Noncommunicable Chronic Conditions Among a Primary Care-Based Sample of Adult Refugees Katherine Yun M.D. (Yale 09-11), The Children’s Hospital of Philadelphia Research Institute</td>
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<td>11:20 am - 11:40 am</td>
<td>Which Terminally Ill Patients and Their Caregivers Value High-Cost, but Modestly Effective Therapies? Preferences for Riluzole use in Amyotrophic Lateral Sclerosis (ALS) Amy Tsou M.D., VA Scholar (Penn 3rd Year)</td>
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11:40 am

**ADJOURNMENT**

Box Lunches Available

*Sessions marked with an asterik are available for CME credit.*
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<td>Crystal Ballroom, Salon AB</td>
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<td></td>
<td>Alumni, NAC, RWJF Trustees &amp; Staff</td>
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<tr>
<td>Wednesday</td>
<td>Breakfast</td>
<td>Potomac View/Windows Over Washington</td>
<td>Reserved</td>
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<td>Reserved Tables: Current Scholars, NAC,</td>
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<td>and RWJF Trustees &amp; Staff</td>
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<td>Lunch</td>
<td>Potomac View/Windows Over Washington</td>
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<td>Reserved Tables: Current Scholars, Alumni and Community Partners</td>
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<td>Breakfast</td>
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<td>Mentors</td>
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<td>Lunch</td>
<td>Commonwealth Ballroom</td>
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<td>Reception &amp; Dinner</td>
<td>Salon AB</td>
<td>Reserved</td>
<td>7 (8)</td>
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<td>Reserved Tables: NPO, NAC, RWJF Trustees &amp; Staff, Program Directors &amp; Faculty, and Community Partners</td>
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<td>Friday</td>
<td>Breakfast</td>
<td>Potomac View/Windows Over Washington</td>
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<td>General Breakfast</td>
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<td>Pentagon I</td>
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<td>Reserved Tables A: Current VA Scholars</td>
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<td>with Drs. Cox &amp; Gilman</td>
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Keynote Speakers

Molly Joel Coye M.D., (UCSF 78-79)
Wednesday, November 9th • 11:20 am - 12:00 pm • Crystal Ballroom Salon AB
Chief Innovation Officer of the UCLA Health System | Annie Lea Shuster Alumni Speaker

Dr. Molly Joel Coye was named the Chief Innovation Officer of the UCLA Health System in September, 2010. Her charge is to promote and nurture innovation across the UCLA Health System in order to improve the quality of care delivered locally and globally, and to establish UCLA as a national leader in the development of successful innovations in healthcare.

Dr. Coye received her medical degree and a Masters in Public Health from the Johns Hopkins School of Hygiene and Public Health. She went on to serve the State of New Jersey for five years as the youngest Commissioner of Health in the U.S. Dr. Coye was elected to the National Academy of Public Administration and chaired the Board of Directors of the American Public Health Association and of the Association of State and Territorial Health Officers. She joined the faculty at Johns Hopkins to establish the first division of Public Health Practice. From there she returned to state government as Director of the California Department of Health Services.

Dr. Coye founded the Health Technology Center (HealthTech), a non-profit education and research organization established to advance the use of beneficial technologies in promoting healthier people and communities.

HealthTech established the Center for Technology and Aging in 2008 with support from the SCAN Foundation, and became a program of the Public Health Institute, in Oakland, California. While at HealthTech, Dr. Coye continued her active role in public policy development. As a member of the Institute of Medicine, Dr. Coye co-authored the reports: To Err is Human and Crossing the Quality Chasm, chaired the Committee on Access to Insurance for Children, and co-chaired the Committee on Patient Safety Data Standards. Dr. Coye is Chair of the Board of Directors of PATH. She is also a member of the Board of Directors of Aetna, Inc., and served for five years on the Board of Trustees of the American Hospital Association. Dr. Coye was also a founding board member of The California Endowment, the largest private health care philanthropy in California, and served for eight years as a member of the Board of Directors of the China Medical Board.

Arthur H. Rubenstein M.B.B.Ch.
Thursday, November 10th • 12:00 pm - 1:15 pm • Commonwealth Ballroom
Professor, Department of Medicine, Division of Endocrinology
Raymond and Ruth Perelman School of Medicine, University of Pennsylvania

Dr. Rubenstein was formally the Executive Vice President of the University of Pennsylvania for the Health System and Dean of the Raymond and Ruth Perelman School of Medicine.

Before joining Penn, Dr. Rubenstein served as Dean of Mount Sinai School of Medicine and Gustave L. Levy Distinguished Professor. Earlier, he was the Lowell T. Coggeshall Distinguished Service Professor of Medical Sciences and Chairman of the Department of Medicine at the University of Chicago Pritzker School of Medicine.

Dr. Rubenstein is an internationally-prominent endocrinologist recognized for clinical expertise and groundbreaking research in diabetes and author of more than 350 publications.

Dr. Rubenstein is the recipient of many awards and prizes, including the highest honor from the Association of Professors of Medicine, the Robert H. Williams Distinguished Chair of Medicine Award. In 2009, Dr. Rubenstein was awarded the prestigious Abraham Flexner Award for Distinguished Service to Medical Education from the Association of American Medical Colleges.

Born in South Africa, Dr. Rubenstein received his medical degree from the University of the Witwatersrand in Johannesburg. In 2001, he was honored by his alma mater when an honorary degree, Doctor of Science in Medicine, was conferred upon him. He is a Fellow of the College of Medicine of South Africa and of the Royal College of Physicians of London; a Master of the American College of Physicians; American Academy of Arts and Sciences; and a member of the Institute of Medicine of the National Academy of Sciences.
This panel will examine the many trends in health policy affecting the supply, training, deployment, and demand for various health professionals. Innovations around teaching health centers, interprofessional education, community health teams and the shortage of primary care providers will all be discussed.

**Moderator:**

Lisa Simpson M.B., B.Ch.,
M.P.H., F.A.A.P.

RWJF Clinical Scholars National Advisory Committee

Dr. Simpson is the president and CEO of AcademyHealth, and its advocacy arm, the Coalition for Health Services Research. Previously, she was director of the Child Policy Research Center at Cincinnati Children’s Hospital Medical Center and professor of pediatrics in the Division of Health Policy and Clinical Effectiveness, Department of Pediatrics, University of Cincinnati. She served as the Deputy Director of the Agency for Healthcare Research and Quality. Dr. Simpson previously served on the Institute of Medicine’s Committee on Comparative Effectiveness Research Priorities and the Committee on Highly Effective Clinical Services, as a National Policy Advisor for the National Initiative for Children’s Healthcare Quality, on a national advisory committee to the Agency for Healthcare Research and Quality and on the board of directors for the Academic Pediatric Association. Dr. Simpson is a member of the American Academy of Pediatrics Obesity Leadership Workgroup, the Robert Wood Johnson Clinical Scholars Program National Advisory Council, and the AHRQ HCUP Steering Committee. She is the recipient of numerous awards, including the Excellence in Public Service Award from the American Academy of Pediatrics, the Senior Executive Service Meritorious Presidential Rank Award, the Department of Health and Human Services Secretary’s Distinguished Service Award, the 2007 Health Policy Researcher of the Year award from the Health Policy Institute of Ohio, and the 2010 Public Policy and Advocacy award from the Academic Pediatrics Association. Dr. Simpson earned her undergraduate and medical degrees at Trinity College (Dublin, Ireland), a master’s in public health at the University of Hawaii, and completed a post-doctoral fellowship in health services research and health policy at the University of California, San Francisco.

**Frederick Chen M.D., M.P.H.**

(Washington 99-01) is Associate Professor in the Department of Family Medicine at the University of Washington and Chief of Family Medicine at Harborview Medical Center. Dr. Chen received his medical degree from the University of California, San Francisco, and completed his M.P.H in epidemiology at UC Berkeley. After training in family medicine at the University of Washington he completed a fellowship as a Robert Wood Johnson Clinical Scholar. Dr. Chen was the Kerr White Visiting Scholar in the Center for Primary Care Research at AHRQ and an Atlantic Fellow at the Public Health Policy Unit of the University College London. At the University of Washington, he has been the lead faculty for the WWAMI Underserved Pathway, medical director for the Washington State Patient-Centered Medical Home Collaborative, and a researcher in the Rural Health Research Center. He serves as senior advisor to HRSA’s Bureau of Health Professions for the Teaching Health Center program.

**Linda Cronenwett Ph.D., R.N., F.A.A.N.** is the Co-Director of the Robert Wood Johnson Foundation’s Executive Nurse Fellows program. She is also the Beerstecher Blackwell Term Professor and former dean of the School of Nursing, University of North Carolina at Chapel Hill. Prior to her appointment as Dean, she was the Sarah Frances Russell Distinguished Professor of Nursing Systems at UNC-Chapel Hill. In addition to her role in the RWJF ENF program, Dr. Cronenwett is the principal investigator of a national initiative, Quality and Safety Education for Nurses, currently in its third phase of funding from the Robert Wood Johnson Foundation. She also serves as a member of the Board of Directors of the Josiah Macy Jr. Foundation and the North Carolina Institute of Medicine, and is Chair of the North Carolina Center for Hospital Quality and Patient Safety. In addition, she is an appointed member of the Special Medical
Panel 1: continued from previous page

Advisory Group on Veterans Affairs. Dr. Cronenwett is an elected fellow of the American Academy of Nursing and the North Carolina Institute of Medicine. Her past service includes terms of office on the National Advisory Council for Nursing Research at the National Institutes of Health, editorial advisory boards of Applied Nursing Research, Online Journal of Knowledge Synthesis for Nursing, Journal of Nursing Measurement, and the Joint Commission Journal of Quality Improvement, and numerous offices in professional associations. She earned her master’s degree in parent-child nursing from the University of Washington and her undergraduate and doctoral degrees in nursing from the University of Michigan.

Mark S. Johnson M.D., M.P.H. (UNC 82-84) is the Dean of the College of Medicine at Howard University. He is a graduate of Coe College is Cedar Rapids, Iowa where he earned an interdisciplinary degree in Black Literature. He went to medical school at UMD-New Jersey Medical School (NJMS.) He did his residency training at the University of South Alabama Medical Center in Mobile. He was a Robert Wood Johnson Clinical Scholar at UNC-Chapel Hill, where he also earned an MPH in Epidemiology. Prior to his current position Dr Johnson was Professor and Chair of the Department of Family Medicine at NJMS, Dr. Johnson had previously been on the faculty at both Meharry and South Alabama. He has been listed in Best Doctors in America and America’s Best Family Physicians. He was a member of the United States Preventive Services Task Force from 2001 to 2004. He was President of the Association of Departments of Family Medicine from 2003 to 2005. He served on the New Jersey Task Force for Prevention of Obesity from 2004 to 2008. Currently, he is a member of the editorial board of the Journal for the American Board of Family Medicine.

PANEL 2

Integration of Health Services Research and Operations Management—U.S. Department of Veterans Affairs

Wednesday, November 9, 2011 | 1:00 PM - 2:15 PM
Location Crystal Ballroom Salon AB

The Veterans Health Administration (VA) provides comprehensive health care to 8.3 million Americans. In order to fulfill that mission, VA is a major payer and provider of health professions education (including a longstanding partnership with the Robert Wood Johnson Foundation’s Clinical Scholars program) and medical and health services research. In this session Drs. Robert Jesse and Eve Kerr will discuss the intersection of improvement science and health services research and their strategic importance in the future of healthcare for VA and the Nation.

Mark S. Johnson M.D., M.P.H.

Moderator:
Malcolm Cox M.D.

Robert Wood Johnson Foundation
Clinical Scholars

RWJF Clinical Scholars National Advisory Committee

Malcolm Cox, M.D. is the Chief Academic Affiliations Officer for the Veterans Health Administration, U.S. Department of Veterans Affairs, in Washington DC. Dr. Cox received his undergraduate education at the University of the Witwatersrand and his M.D. from Harvard Medical School. Previously he served as Associate Chief of Staff for Research and Chief of the Medical Service at the Philadelphia VA Medical Center; and Vice Chair of the Department of Medicine, Associate Dean for Network & Primary Care Education and Associate Dean for Clinical Education at the University of Pennsylvania School of Medicine. In 2003, Dr. Cox returned to Harvard Medical School as Dean for Medical Education. He was appointed the Carl W. Walter Distinguished Professor of Medicine at Harvard Medical School. In 2006, Dr. Cox returned to the Department of Veterans Affairs, where he has led a major expansion of VA’s medical, nursing and psychology training programs. Dr. Cox was the first Robert G. Petersdorf Scholar in Residence at the Association of American Medical Colleges in 1994-95. Currently, he serves on the National Leadership Board of the Veterans Health Administration, the National Board of Medical

continued on next page
Robert Wood Johnson Foundation
Clinical Scholars

Panel 2: continued from previous page

Examiners, and the National Advisory Committee of the Robert Wood Johnson Clinical Scholars Program. Dr. Cox is a member of many professional and scientific societies and the recipient of numerous honors and teaching awards. He has been the Principal Investigator or Co-Investigator of grants from the American Heart Association, the National Institutes of Health, the Department of Veterans Affairs, the Robert Wood Johnson Foundation and the Josiah Macy Jr. Foundation.

Robert L. Jesse M.D., Ph.D. was appointed as the Principal Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs (VA) Central Office, Washington DC, on July 4, 2010. Prior to his current assignment, he served as the Acting Principal Deputy Under Secretary for Health.

Dr. Jesse’s previous position was the Chief Consultant for Medical Surgical Services in the Office of Patient Care Services, and the National Program Director for Cardiology. He implemented broad reforms in the delivery of specialty, sub-specialty and emergency care that have significantly improved the quality of care provided across the VA healthcare system.

Dr. Jesse graduated with a Bachelor of Science degree in Biochemistry from the University of New Hampshire and then worked as a research associate at the Harvard School of Public Health. He earned a Ph.D. in Biophysics and M.D. at the Medical College of Virginia. He joined the faculty at Virginia Commonwealth University Health System as the Director of the Acute Cardiac Care Program, and the Chief of the Cardiology Section at the Richmond VA Medical Center. He holds the rank of tenured Professor of Internal Medicine/Cardiology at Virginia Commonwealth University Health System.

Dr. Jesse is a diplomat of the American Board of Internal Medicine with specialty boards in Cardiovascular Medicine. He is a Fellow of the American College of Cardiology, and has served as a Governor for the College. He is a Fellow of the American Heart Association and is currently the President of the Richmond Metro Chapter of the American Heart Association.

Eve A. Kerr M.D., M.P.H. (UCLA 92-94) is a Professor of Internal Medicine at the University of Michigan, Director of the Center for Clinical Management Research, a VA Health Services Research and Development Center of Excellence, and Research Director of the VA Quality Enhancement Research Initiative for Diabetes Mellitus. Dr. Kerr received her medical degree from the University of California, San Francisco and completed her internship and residency in general medicine at University of California, Center for the Health Sciences, Los Angeles, California. She subsequently completed the Robert Wood Johnson’s Clinical Scholar’s Program and received a Masters of Public Health from UCLA. In 1996, she joined the faculty of the University of Michigan Department of Internal Medicine and the Ann Arbor VA Center for Clinical Management Research. Dr. Kerr is a nationally recognized expert in research on performance measurement and quality improvement. She was elected to the American Society of Clinical Investigation in 2009.
Innovations in Delivery and Payment to Improve Health Care Quality

Thursday, November 10, 2011 | 9:10 AM - 10:25 AM
Location Crystal Ballroom Salon AB

The panelists — Dr. Robert Berenson, Dr. Jeff Brenner and Dr. Elliott Fisher — have spent many years on the front lines battling for transformational health system change. Each has taken his own approach toward game-changing innovations that will align incentives for controlling costs, improving quality, and caring for the sickest and most socially disadvantaged populations. But each has experienced challenges to his efforts — ranging from political forces to methodological inadequacies. In this panel, each will briefly share his story and then engage each other and the audience in discussing how to overcome barriers to change and fundamentally reshape health care delivery systems.

Moderator:
Lisa I. Iezzoni, M.D., M.Sc.
RWJF Clinical Scholars National Advisory Committee

Lisa I. Iezzoni is Professor of Medicine at Harvard Medical School and Director of the Mongan Institute for Health Policy at the Massachusetts General Hospital. She received degrees in medicine and health policy and management from Harvard University.

Dr. Iezzoni has conducted numerous studies for the Agency for Healthcare Research and Quality, the Medicare agency, and private foundations on a variety of topics, including evaluating methods for predicting costs, clinical outcomes, and substandard quality of care. She has published and spoken widely on risk adjustment and has edited a textbook, now in its third edition (2003), on risk adjustment for measuring health care outcomes. Dr. Iezzoni has conducted numerous studies for the Agency for Healthcare Research and Quality, the Medicare agency, and private foundations on a variety of topics, including evaluating methods for predicting costs, clinical outcomes, and substandard quality of care. She has published and spoken widely on risk adjustment and has edited a textbook on risk adjustment for measuring health care outcomes; its fourth edition will appear in 2012. A 1996 recipient of the Investigator Award in Health Policy Research from The Robert Wood Johnson Foundation, she is studying health policy issues relating to persons with disabilities. A 1996 recipient of the Investigator Award in Health Policy Research from The Robert Wood Johnson Foundation, she is studying health policy issues relating to persons with disabilities.

Dr. Iezzoni is a member of the Institute of Medicine in the National Academy of Sciences, serves on the editorial boards of major medical and health services research journals. Her book When Walking Fails was published in 2003 and another book, More than Ramps: A guide to improving health care quality and access, coauthored with Bonnie O’Day, appeared in 2006.

Robert Berenson M.D., (George Washington University 77-79) is an Institute Fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, with experience practicing medicine, serving in senior positions in two Administrations, and helping organize and manage a successful preferred provider organization. From 1998-2000, he was in charge of Medicare payment policy and private health plan contracting in the Centers for Medicare and Medicaid Services. Previously, he served as an Assistant Director of the Carter White House Domestic Policy Staff and recently was a member of the Obama transition team. Effective July 2009, Dr. Berenson became a Commissioner of the Medicare Payment Advisory Commission (MedPAC). In July 2010, he became vice chair of MedPAC.

Dr. Berenson is a board-certified internist who practiced for twenty years, the last twelve in a Washington, D.C. group practice, and is Fellow of the American College of Physicians. He helped organize and manage a successful preferred provider organization serving the Washington, D.C. metropolitan area. He was co-author, with Walter Zelman, of The Managed Care Blues & How to Cure Them, published in 1998, and, with Rick Mayes, Medicare Payment Policy and the Shaping of U.S. Health Care in 2006. He is a graduate of the Mount Sinai School of Medicine and on the faculty at the George Washington University Schools of Medicine and Public Health and the Fuqua School of Business at Duke. Dr. Berenson was a Robert Wood Johnson Foundation Clinical Scholar in the George Washington University program from 1977-1979.

continued on next page
Dr. Jeffrey Brenner M.D. is a family physician that has worked in Camden, NJ for the past twelve years. Dr. Brenner owned and operated a solo-practice, urban family medicine office that provided full-spectrum family health services to a largely Hispanic, Medicaid population including delivering babies, caring for children and adults, and doing home visits. He attended Robert Wood Johnson Medical School and completed a Family Medicine residency at the Swedish Health Center in Seattle, Washington.

Dr. Brenner is the Director of the Institute of Urban Health at Cooper Hospital where he has spearheaded innovative solutions for improving the health of urban, underserved communities. Recognizing the need for a new way for hospitals, providers, and residents to collaborate he founded and has run the Camden Coalition of Healthcare Providers since 2003.

The Camden Coalition is a non-profit organization, committed to improving the quality, capacity, and accessibility of the healthcare delivery system in Camden. Dr. Brenner’s work is dependent on building complex collaborations amongst three highly competitive hospitals, two local FQHC’s, and small private offices in Camden. Through the Camden Coalition, local stakeholders are working to build an integrated, health delivery model to provide better care for Camden City residents.

His life’s goal is ensure that all families who live in urban, underserved communities receive high quality, culturally competent, personalized family health care.

Elliott S. Fisher M.D., M.P.H. (Washington 83-85) is the James W. Squires, MD Professor at Dartmouth Medical School and Director for Population Health and Policy at The Dartmouth Institute for Health Policy and Clinical Practice. He received his undergraduate and medical degrees from Harvard University and completed his internal medicine residency and public health training at the University of Washington. He is the director of the Dartmouth Atlas of Health Care and a member of the Institute of Medicine of the National Academy of Sciences.

His research has focused on exploring the causes of the two-fold differences in spending observed across U.S. regions and health care systems, on understanding the consequences of these variations for health and health care, and on the development and testing of approaches to performance measurement and payment reform that can support improvement. The research revealed that most of the differences in spending are due not to differences in health status, preferences, prices or poverty, but rather to greater use of discretionary services, such as the use of the hospital as a site of care and specialist referrals or diagnostic tests that would not have been ordered in lower spending regions. The findings that per-capita spending—on these services—is essentially uncorrelated with either quality or health outcomes highlighted the potential opportunity to improve the efficiency of U.S. health care.

His current policy work has focused on advancing the concept of “accountable care organizations” (ACOs) and includes co-directing, with Mark McClellan, a joint Brookings- Dartmouth program to advance ACOs through research, coordination of public and private initiatives and the creation of a learning collaborative that includes several pilot ACO sites across the U.S.
PANEL 4

Engaging with Communities to Create Sustainable Change: How Can Communities Beat Depression? The Evolution of a Community-Partnered Learning Collaborative

Friday, November 11, 2011 | 8:30 AM - 9:45 AM
Location Crystal Ballroom Salon AB

This panel describes the development of an ongoing community-partnered, participatory research effort to reduce the burden of depression on under-resourced communities of color in Los Angeles. To address this issue, faculty, fellows and community partners of the UCLA Clinical Scholars Program developed a multi-stage learning collaborative based on the principles and structure of Community-Partnered Participatory Research (CPPR). This approach emphasizes equal power sharing, instilling trust and respect, and developing scientific and community capacity. The panel will discuss the challenges faced, solutions developed, lessons learned and promises ahead from initiating the idea to developing the infrastructure and implementing the research at scale.

Moderator:
Lawrence W. Green Dr.P.H.
RWJF Clinical Scholars National Advisory Committee

Lawrence W. Green is Adjunct Professor of Epidemiology and Biostatistics and Director of the Social and Behavioral Sciences Program at the University of California at San Francisco Hellen Diller Comprehensive Cancer Center. He joined CDC in 1999 as Distinguished Fellow-Visiting. He served as Director of CDC’s World Health Organization Collaborating Center on Global Tobacco Control and as Acting Director of the Office on Smoking and Health. He then served as the Director of CDC’s Office of Science and Extramural Research and as Associate Director for Prevention Research and Academic Partnerships in the Public Health Practice Program Office. Previously, Dr. Green was the Director of the Institute of Health Promotion Research and Professor and Head of the Division of Preventive Medicine and Health Promotion, Department of Health Care and Epidemiology, at the University of British Columbia in Canada. He served as the first Director of the U.S. Office of Health Information and Health Promotion in the Office of the Assistant Secretary for Health under the Carter Administration, and as Vice President of the Kaiser Family Foundation. Dr. Green is a past President and Distinguished Fellow of the Society for Public Health Education and recipient of the American Public Health Association’s highest awards, the Distinguished Career Award and Award of Excellence, and the American Academy of Health Behavior first Research Laureate Medal. He received an Honorary Doctor of Science Degree from the University of Waterloo in Canada. He currently serves on the Editorial Boards of the American Journal of Preventive Medicine, the American Journal of Health Behavior and 12 other journals in his field and is Associate Editor of the Annual Review of Public Health.

Bowen Chung M.D., M.S.H.S. (UCLA 03-05) is a child and adolescent psychiatrist and currently an Assistant Professor-in-Residence within the Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA, an adjunct scientist at the RAND Corporation, and an investigator at the LA Biomed Research Institute. He is primarily based at a public hospital, Harbor –UCLA Medical Center and has an affiliation with NIMH funded, Partnered Research Center for Quality Care. Dr. Chung has been supported through a diversity supplement to examine outcomes for transitional age youth with depression in an R01 in Community Partners in Care. In addition, he was recently funded as the PI by the National Library of Medicine to develop patient and provider online training and education resources for depression care; is a co-PI on an ARRA funded supplement from NICHD to examine minority father’s perspectives on biomedical research participation in a study examining the impact of stress during pregnancy on child developmental outcomes; and is a co-investigator within the Community Engagement core at the UCLA Clinical Translational Research Institute.

continued on next page
Kenneth Wells M.D., M.P.H., (UCLA 77-80) is a Professor of Psychiatry and Biobehavioral Sciences at UCLA David Geffen School of Medicine, a Professor of Health Services in the UCLA School of Public Health, and Affiliated Adjunct at RAND. His joint appointment across UCLA and RAND is supported by a UCLA-RAND Memorandum of Understanding that promotes research across these institutions. He is the Director of the Center for Health Services and Society at the UCLA Semel Institute and is Co-Director of the UCLA Robert Wood Johnson Clinical Scholars Program, which supports health services research training for physicians in all clinical specialties. Dr. Wells received the American Psychiatric Association’s 2006 Research Prize for lifetime achievement in research and previously received the Senior Investigator Award of Academy Health. He is a member of the Institute of Medicine and for four years chaired its Neuroscience and Behavioral Health Board. He has been Chair of the Community Health Improvement Collaborative (CHIC), a coalition of community and academic partners from four NIH-funded Centers in Los Angeles, that are seeking to improve infrastructure and methods for community-academic partnered participatory research in health. He is currently PI of the Partnered Research Center for Quality Care (PRCQC) and Community Partners in Care (CPIC) R01.

Loretta Jones, M.A. is the founder and Executive Director of Healthy African American Families (HAAF) II. As a “Community Gatekeeper,” Loretta Jones has dedicated her entire life towards the hope and healing of community and society-at-large. Her career as a civil rights activist, health policy advocate, and social architect has spanned more than 30 years. In an effort to level the playing field for all people, Ms. Jones continues her unyielding commitment as a change agent against disparities in human health, development, and opportunity. She is a member of the Advisory Council planning NICHD’s longitudinal child health study and chairs its Social Justice committee. She is a co-investigator of the NIMH UCLA/RAND Center for Research on Quality in Managed Care, the NIA UCLA Center for Health Improvement in Minority Elderly (CHIME), and the NIH Drew/UCLA Project EXPORT, as well as a recipient of numerous CDC grants and contracts. She is a member of the UCLA Institutional Review Board (IRB) for protection of human subjects. Ms. Jones was recently honored by the CDC as their first recipient of an award for public leadership in overcoming health disparities. She first-authored a recent article in JAMA on the framework for Community Partnered Participatory Research. She is the co-PI with Dr. Wells of Community Partners in Care, and has co-authored a number of journal articles on the findings of that study, as well as on adapting principles of ethical clinical research to the context of community-based participatory research.

PURPOSE: Creutzfeldt-Jakob disease (CJD) is a rare, rapidly progressive dementia, primarily occurring in those over 55 years of age. This prion disease may be transmitted through iatrogenic means (iCJD), as evidenced epidemiologically by case clustering around a common surgical exposure. In this context, veterans of the armed forces represent an older population at particular risk of requiring chronic surgical treatment due to injuries sustained during military service. Therefore, we wondered whether CJD could have been transmitted iatrogenically within the Veterans Health Administration (VHA) system, which provides care nationally for American veterans with service-connected disabilities. As a starting point for further investigation, we aimed to identify a “spike” in the incidence of CJD diagnoses in the VHA following activation of the ICD-9 code (International Classification of Diseases, Ninth Revision) for the disorder at the beginning of fiscal year (FY) 1997.

METHODS: VHA Medical SAS Datasets were analyzed for all incident CJD diagnoses, defined as those associated with an ICD-9 code for CJD (FY 1997-2008: 046.1, FY 2009-2010: 046.11 and 046.19) that could not be excluded following electronic medical record review (EMR, VISTA Web). Diagnostic standards were based on 2009 CJD criteria. CJD diagnoses with insufficient data available for inclusion or exclusion by these criteria were included for analysis as “suspect” diagnoses. Given the greater likelihood that a one-year elevation in incidence was due to chance, the incidence of CJD diagnoses from all categories was calculated over each consecutive two-year period, using the sum of unique patients seen under VHA care during each FY of the two-year interval as denominator. To provide context for these findings outside the VHA, the mortality. Consequently, the Veterans Health Administration (VHA) provides housing, job training, and health care assistance to homeless and at-risk Veterans through specialized homeless services programs. The risk of using a VHA homeless services program among returning Iraq/Afghanistan Veterans, a Veteran cohort with the largest proportion of women to serve and to be exposed to combat, has not been well characterized. Therefore, we sought 1) to determine the risk of using a VHA homeless services program among Iraq/Afghanistan Veterans, a Veteran cohort with the largest proportion of women to serve and to be exposed to combat, has not been well characterized. Therefore, we sought 1) to determine the risk of using a VHA homeless services program among Iraq/Afghanistan Veterans, a Veteran cohort with the largest proportion of women to serve and to be exposed to combat, has not been well characterized.
Veterans in VHA care, 2) whether this risk differs between female and male Veterans, and 3) to compare the characteristics of homeless female and male Veterans.

METHODS: Using the Operation Enduring Freedom/Operation Iraqi Freedom Roster, a database of Iraq/Afghanistan military service personnel enrolled in VHA care, we identified Veterans with at least one inpatient or outpatient VHA visit between October 1, 2001 and September 30, 2009. The study’s primary outcome, time to first use of a VHA homeless services program, was defined as the time from the date of military separation to first use of a VHA homeless services program. Cox proportional hazards regression was used to estimate the relative risk of using a VHA homeless services program, adjusting for relevant socio-demographic and clinical variables such as mental health conditions. We used chi-square and Wilcoxon rank-sum tests to compare the characteristics of homeless female and male Veterans.

RESULTS: Of 445,319 Veterans, 7,431 (1.7%) used a VHA homeless services program, 961 women (1.8%) and 6,470 men (1.7%), during a median duration of study follow-up of 1172 days (interquartile range, 636-1651). Women were as likely as men to use a VHA homeless services program (adjusted hazard ratio, 1.02, 95% confidence interval, 0.95-1.09). Median time to first use was similar for female and male Veterans (685 days vs. 687 days, respectively, p = 0.53). A larger proportion of homeless female Veterans were Black (46.9% vs. 25.6%, p<0.001), unmarried (73.4% vs. 66.4%, p<0.001), and had more than a high school education (14.2% vs. 9.0%, p<0.001) compared to homeless male Veterans. While a greater percentage of homeless women had a diagnosis of major depression (20.4% vs. 14.0%, p<0.001), homeless women had lower rates of alcohol use disorder (14.9% vs. 27.7%, p<0.001), substance use disorder (10.9% vs. 21.2%, p<0.001), PTSD (35.7% vs. 42.6%, p<0.001), and schizophrenia (0.9% vs. 1.9%, p=0.03) than homeless men.

CONCLUSIONS: About 1.7% of Iraq/Afghanistan Veterans in VHA care used a VHA homeless services program during the study follow-up period. Overall, there was no substantial difference in the risk of using a VHA homeless services program between women and men. However, homeless female and male Veterans differed significantly with respect to socio-demographic and clinical characteristics. In light of our study findings, we recommend health care providers, homeless services programs, and homelessness prevention efforts address the unique and shared needs of female and male Iraq/Afghanistan Veterans.

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MEDELL BRIGGS-MALONSON
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Hospitals at Risk? Race and Socioeconomic Predictors of Hospital Readmissions in California

BACKGROUND: The Patient Protection and Affordable Care Act aims to decrease preventable hospital readmissions by reducing Medicare payments for excess 30-day readmissions following discharge for heart failure (HF), acute myocardial infarction (MI), and pneumonia (PNA). However, there is growing concern among health policy and health care system leaders that the legislation may result in unintended financial consequences for hospitals that serve vulnerable populations.

PURPOSE: The purpose of this study is to identify the hospital-level racial and socioeconomic characteristics that are associated with all cause 30-day hospital readmissions for HF, MI, and PNA. We propose that hospitals that serve higher proportions of black or low-income patients will have higher rates of readmissions.

METHODS: The primary data source was the 2007 California Office of Statewide Health Planning and Development (OSH-PD) patient discharge data set. The primary outcome was risk-adjusted odds of all cause 30-day readmissions. The primary predictors were facility-level summaries of the race and household income of hospital visitors. We examined all adult 30-day readmissions following a hospital discharge for HF, MI, and PNA. We categorized hospitals into deciles based on the proportion of black patients served and average household income. Hierarchical regression and prediction models were performed to examine the influence of hospital-level race and income on early readmissions, adjusting for patient characteristics and hospital structural factors.

RESULTS: Hospitals that served high proportions of black and low-income patients were associated with higher odds of 30-day readmissions. Patients discharged from minority-serving hospitals had 5-7% higher odds of readmission for HF, AMI, and PNA [HF: OR 1.05 95%CI (1.02-1.07); AMI: OR 1.07 95%C1 (1.03-1.12); PNA: OR 1.04 95% CI (1.02-1.07)]. Patients discharged from low-income serving hospitals had 3-4% higher odds of an early readmission for the three conditions [HF: OR 0.967 95%CI (0.944-0.990); AMI: OR 0.964 95% CI (0.928-1.00); PNA: OR 0.960 95% CI (0.937-0.985)]. Adjusting for patient race and income decreased the odds of readmission by up to 2% for HF and PNA patients discharged from
After adjusting for patient race and income, minority-serving hospitals; however, these patients were still more likely to be readmitted. Patients discharged from low-income hospitals were no longer more likely to be readmitted after adjusting for patient race and income.

CONCLUSION: Patients discharged from hospitals that serve high proportions of black and low-income patients have significantly higher odds of 30-day readmissions for heart failure, acute myocardial infarction, and pneumonia. These hospitals are at risk of being financially penalized by future Medicare payment reform policies. However, these “at risk” hospitals may be disciplined for unaccounted facility and patient factors that extend beyond the hospitals’ control. Readmission-related measures of care, hospital financial resources, patient health beliefs and behaviors, and community social determinants of health are important aspects of health care utilization that should be considered by federal and private payers when developing readmission reduction strategies. Only then can policies and programs be developed that successfully address the multifactorial origins of hospital readmissions and associated health disparities.

KEY WORDS: readmissions race income hierarchical model

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Does MRI Utilization Reduce Recurrent Stroke?

PURPOSE: Magnetic Resonance Imaging (MRI) is an increasingly common part of the acute stroke evaluation and may improve selection of secondary prevention therapies. However, the impact of MRI on clinical outcomes is unknown. We sought to determine whether receiving an MRI during acute stroke hospitalization reduces the risk of recurrent stroke.

METHODS: We identified all hospital discharges with a primary ICD-9-CM discharge diagnosis of ischemic stroke (433.x1, 434.x1, 436) or transient ischemic attack (TIA) (435) admitted through the Emergency Department in 6 states (NY, FL, NE, NC, AZ, WA). Data was drawn from the State Inpatient Databases (SID) between 2003-2009. MRI utilization was identified using the SID Magnetic Resonance Technology (MRT) definition relying on UB-92 revenue codes (MRI 610-619) and ICD-9-CM procedure codes.

Our primary outcomes were recurrent stroke at 90 days and one year, defined as any rehospitalization with a primary ischemic stroke ICD-9-CM diagnosis code. Two analytic approaches were used to estimate the effect of MRI on recurrent stroke risk. In our primary analysis, we used an instrumental variable (IV) approach with regional MRI practice patterns as an instrument (number of MRIs per 1000 hospital discharges aggregated at the hospital referral region (HRR)). A 2-stage probit model was used to estimate the IV effect, adjusting for patient and hospital-level variables. In a secondary analysis, we used propensity score (PS) matching after deriving the propensity for receiving MRI from the same covariates as in the IV analysis. We then used one-to-one matching within a specified caliper to derive MRI and non-MRI cohorts. Rates of recurrent stroke were then compared between the propensity matched groups.

RESULTS: The index population was 362,003 ischemic stroke or TIA discharges. Mean age was 72 (SD 14) and 56% of the study population was female. Recurrent stroke was identified in 3.8% of discharges by 90 days and 5.1% of discharges by one year.

Our instrument met statistical criteria for validity: regional and individual MRI utilization were strongly associated and qualitatively, covariates were evenly distributed among regional MRI utilization quintiles. IV analysis demonstrated no difference in the rate of recurrent stroke at 90 days among patients with a higher probability of receiving MRI compared to those with a lower probability of receiving MRI. Patients in the highest utilizing quintile had a predicted 90-day stroke recurrence rate of 3.4% (95% CI 1.9% - 5.0%) compared to 2.3% (95% CI 1.9%-2.7%) in the lowest utilizing quintile. Similar results were obtained at one year. However, PS analysis demonstrated a lower risk of recurrent stroke in individuals who received MRI than in those who did not at 90 days (3.7% vs. 4.3%, p < 0.001), but no difference at one year (5.9% vs. 5.9%, p=0.83).

CONCLUSIONS: Different estimates of MRI’s effect on stroke recurrence were obtained with IV and PS analyses: IV analysis revealed no effect of MRI on recurrence stroke while PS analysis found a significant reduction in recurrent stroke with MRI. Methods for resolving such differences and obtaining reliable estimates of causal effect in such scenarios are needed.

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Incidence of Genital Warts Among Adolescents and Young Adults Prior to the Introduction of the Human Papillomavirus (HPV) Vaccine

Few studies have examined the epidemiology of genital warts (GW) in adolescents and young adults in the United States. The aim of this study was to describe the incidence of GW in this population prior to the introduction of the HPV vaccine in order to provide baseline data for future studies of vaccine impact. We also sought to describe the anatomical location of GW cases.

The study population included 11-30 year old members of the Northern California Kaiser Permanente health plan. We identified all cases of GW among female (n=96,790) and male (n=84,474) members continuously enrolled from 7/1/00 to 6/30/05, by combining wart-related ICD-9-CM codes (078.10, 078.11, and 078.19) with a specific location qualifier in the electronic medical record. The qualifier describes the anatomical location of the wart (genital, anal, vulvar, etc.) and was recorded by the provider at the time of visit. We calculated GW incidence rates by age and sex and also characterized the anatomical site of disease. Among those with GW, additional incident cases of GW were identified if a new diagnosis was recorded after a 12-month disease-free interval.

We identified a total of 1,684 cases of GW among 181,264 continuously enrolled members. The incidence of GW was highest among 25-29 year old females (5.59 cases/1,000 person-years) and males (3.78/1,000 person-years). The incidence of GW was higher among females than males in all age groups. Among females, 63.3% of the 1,238 incident GW cases were coded to a vulvar location and 21.1% were coded to the cervix. Among males, 91.6% of the 444 GW cases were coded as genital, but the exact anatomical location was not recorded.

Incidence of GW was highest in 25-29 year old females and males, unlike previous studies that found a peak incidence for females 20-24 years of age. This is one of the only studies to describe anatomical location of GW; among females, most occurred on the vulva. Incidence of GW prior to HPV vaccine introduction provides baseline data that can be used in future evaluations of vaccine impact. In addition, data on incidence of GW can inform assessments of cost and burden of this preventable disease.

KEY WORDS: Genital Warts, Epidemiology, Vaccine Preventable Diseases

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nism for reporting on health information when covering health issues for their Latino audience, 2) identify Latino journalists’ perceptions and reporting practices along the continuum of cancer, as a model for stories reflecting issues across the health care system, and 3) examine Latino media’s perceived role and perceptions of the Latino audience, and how these impressions influence the production and angle of health information stories.

**METHODS:** Using a community-based-participatory-research approach, we partnered with the California Medical Association Foundation (CMAF) and New America Media (NAM). The CMAF is part of a national Cervical Cancer-Free Campaign; addressing disparities among Latinas is the focus of California’s campaign, and Los Angeles is the demonstration site. NAM is the country’s first and largest national collaboration and advocate of 2000 ethnic news organizations. This multi-stakeholder, multi-venue media case study uses a purposive sampling technique to conduct individual in-depth structured telephone interviews with 10-15 Los Angeles Latino media reporters and 10-15 editors. With the aid of NAM’s Los Angeles contacts, we invited 73 journalists (reporters and editors) from multiple mediums (Print, Internet, TV, Radio) by invitation letter/e-mail. Criteria for interview-participation were self-identification as a journalist who published a health information story in a Latino-focused venue within the last year. So far, 24 eligible journalists have responded (33% response rate).

**RESULTS:** Currently 22 interviews are complete (including 3 trial interviews); ten are editors and twelve are reporters. We will use a multi-stage exploratory analysis plan. Firstly, we will describe the main themes covered in our interview script domains: (1) process/factors of Latino health stories of New Jersey disseminated a toolkit to systematically improve the accuracy and reliability of race/ethnicity data collected in New Jersey hospitals. The New Jersey initiative to improve race/ethnicity data collection provides a unique opportunity to study the effect of these changes on the identification of healthcare disparities among ethnic minorities using administrative data sources.

**PURPOSE:** The purpose of this project was to evaluate the effect of the New Jersey initiative on hospitalization rates for acute myocardial infarction (AMI) among Asian-American subgroups.

**METHODS:** Using the New Jersey State Inpatient Databases (SID), we compared hospitalization rates for AMI among Asian Americans before (2005-2006) and after (2008-2009) the statewide initiative. Rates were compared for Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese sub-
Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on Pay-For-Performance Measures?

**PURPOSE.** To examine whether physician organizations (POs)—independent practice associations and medical groups—located in lower socioeconomic status (SES) areas score lower in the largest, non-governmental, multi-stakeholder pay-for-performance (P4P) program in the United States.

**METHODS.** Cross-sectional study of the 160 POs participating in the 2009 year of Integrated Healthcare Association (IHA)’s P4P Program. Our main predictor was the PO AREA SES measure, an indicator that reflected the SES of the census tract of the 11,718 practice sites within the 160 POs. We calculated PO AREA SES using established methods for characterizing the SES of census tracts and geo-coding techniques; values for this measure were standardized according to the mean values across the entire state of CA and oriented so that positive numbers represent higher SES while negative numbers represent lower SES. Our main outcome measure was IHA’s P4P Performance score, which was the score used to determine whether POs would receive a P4P bonus payment. This measure was a composite of measures representing clinical quality, but also included several measures related to:

**RESULTS:** Table 1: Age-Adjusted AMI Hospitalization Rate per 100,000 by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Age-Adjusted Rate (95% CI) Before (2005-2006)</th>
<th>Age-Adjusted Rate (95% CI) After (2008-2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH White*</td>
<td>429.35 (424.51-434.24)</td>
<td>381.36 (376.84-385.92)</td>
</tr>
<tr>
<td>NH Black</td>
<td>363.91 (351.81-376.32)</td>
<td>359.13 (347.46-371.08)</td>
</tr>
<tr>
<td>Asian/Pacific Islander*</td>
<td>158.76 (146.81-171.36)</td>
<td>227.76 (214.51-241.56)</td>
</tr>
<tr>
<td>Asian Indian*</td>
<td>140.91 (120.45-163.54)</td>
<td>213.53 (192.02-236.64)</td>
</tr>
<tr>
<td>Chinese*</td>
<td>58.29 (44.60-74.63)</td>
<td>97.91 (77.79-121.16)</td>
</tr>
<tr>
<td>Filipino*</td>
<td>144.60 (121.59-170.49)</td>
<td>174.30 (151.35-199.71)</td>
</tr>
<tr>
<td>Japanese*</td>
<td>131.13 (69.02-221.51)</td>
<td>290.56 (207.33-394.52)</td>
</tr>
<tr>
<td>Korean*</td>
<td>73.09 (50.71-100.00)</td>
<td>164.07 (132.37-200.49)</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>158.88 (88.37-256.72)</td>
<td>125.78 (81.37-184.57)</td>
</tr>
</tbody>
</table>

*Denotes statistically significant differences in hospitalization rates between the 2 study periods.

**KEY WORDS:** Healthcare Disparities, Data Collection, Asian Americans, Myocardial Infarction

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the patient experience, and to information technology and diabetes registry use. We first examined the bivariate relationship between PO AREA SES and IHA P4P Performance, and then used multivariate logistic regression to examine the strength of this association after adjusting for PO size, type and percent annual revenue from Medicaid. RESULTS. In 2009, the PO AREA SES measure ranged from negative 11 to positive 11 (mean 0, SD 5). PO performance scores ranged between 23 and 86 (mean 69, SD 15; possible range 0-100). In bivariate analysis, there was a significant association between PO AREA SES and IHA P4P Performance. In multivariate analysis, a one standard deviation increase in PO SES nearly tripled (odds ratio 2.76, 95%CI 1.68-4.54) the likelihood of a PO being ranked in the top two quintiles of performance (p<0.001), even after adjusting for PO size, type and percent annual revenue from Medicaid.

CONCLUSIONS. In summary, in a well-established P4P program (using commonly used measures and a commonly used bonus structure), large POs located in lower SES areas are less likely to earn P4P rewards than those based in higher SES areas. Our study substantiates the concern about whether providers are competing on a level playing field, and whether P4P may increase resource gaps between POs in higher and lower SES areas and widen disparities in care. Given the growing reliance on P4P strategies to represent quality incentives in alternative quality contracts or accountable care organizations, stakeholders may want to consider ways of using P4P in a manner that recognizes that the playing field may not be level and that disparities may be widened as a result.

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Evaluation of a Conceptual Model for Adolescent Substance Use Prevention

BACKGROUND: While strong evidence-based substance use prevention curricula exist for middle school students, few programs target older adolescents and fewer reduce alcohol and marijuana use. Given the lack of an effective existing curriculum for high school populations, a new model is required. We developed a conceptual model for substance use prevention curricula based on the literature. We tested our conceptual model on 9th grade students attending a large multi-ethnic public high school.

PURPOSE: To develop and test a conceptual model for substance use prevention education. We evaluate whether observed relationships between peer influence, coping skills, refusal self-efficacy, self-concept and substance use are consistent with the conceptual model.

CONCEPTUAL MODEL: The model is based on both the Social Influence Theory, which recognizes the importance of peer influence on substance use, and the Theory of Problem Behavior, which places substance use in the context of global functioning. The model integrates for the first time three known predictors of substance use (coping skills, self-concept, and peer influence) in a way that might inform comprehensive prevention curricula. In the model, poor coping skills are thought to decrease self-efficacy to refuse substances. Meanwhile, the relationship between self-concept (i.e., sense of identity) and substance use is thought to vary by domain, with high social self-concept, low behavioral self-concept and low global self-concept being risk factors. Finally, self-concept interacts with peer influence such that high-risk self-concepts potentiate peer influence’s effect on substance use. While peer influence, coping skills and self-concept have been studied independently, this is the first study to investigate the relationships among these factors.


CONCLUSION: Results suggest four key pathways that predict adolescent substance use: having pro-drug attitudes, pro-drug perceived peer norms, high risk self-concepts and a combination of maladaptive coping skills and low refusal self-efficacy. Comprehensively targeting each of these pathways may be important for adolescent substance use prevention. No known existing program currently does this. Results from this study inform the development of a substance use prevention curriculum targeting coping skills, peer influence and self-concept.

KEY WORDS: Substance Use, Adolescents, Coping, Self-concept, Peer Influence

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Project C.O.A.C.H.: Counseling Others About Contacts and exposures with HIV

PURPOSE: To determine a comprehensive understanding of facilitators and barriers to effectively conducting partner notification with men who have sex with men.

BACKGROUND: Estimates suggest that approximately 21% of HIV infected individuals are unaware of their status. This impacts the individual, who fails to receive the benefits of antiretroviral therapy, and society, as individuals unaware of their status may engage in ongoing risk behaviors, potentially transmitting the virus to others. Efforts to address this problem include national guidelines for opt-out universal HIV testing in clinical settings; in addition, routine partner notification for patients newly diagnosed with HIV is also recommended. Partner notification, or contact tracing, is the strategy whereby partners are notified of a potential exposure to a particular disease, including HIV. Partner notification is often conducted by public health department specialists, yet there is a lack of referrals to the program by health care providers and medical case managers; additionally, the public health department specialists have limited success in eliciting partner names and contact information from men who have sex with men (MSM).

METHODS: We will perform a mixed-methods study, guided by principles of community-based participatory research, to ascertain the knowledge, attitudes and experiences with partner notification among New Haven-based medical case managers, public health department specialists and men who have sex with men. We will conduct in-person in-depth interviews (with MSM and public health department specialists) and focus groups (with medical case managers). We will digitally record and professionally transcribe each interview and focus group. Employing a multidisciplinary team and guided by grounded theory, we will use the constant comparison method for analysis. We will use Atlas.ti software to facilitate organization of the data. We will elicit participant confirmation through several strategies, including attending pre-existing meetings and posting preliminary findings on a website with an invitation for anonymous electronic feedback.

ANTICIPATED RESULTS: We will identify knowledge gaps about how to optimize partner notification for men who have sex with men.

CONCLUSIONS: Collaborations with members of the Department of Public Health and a community-based HIV/AIDS service organization are essential for conducting pertinent research to inform the process of partner notification with men who have sex with men. Particular knowledge gaps can be identified, which may be targeted in future interventions, including education and media campaigns.

KEY TERMS: HIV, partner notification/contact tracing, qualitative research, community-based participatory research additional

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C L A R A F I L I C E
CSP 2010-2012 / YALE UNIVERSITY

Pandemic Planning In Pediatric Emergency Departments: Surge Experiences During the 2009 H1N1 Influenza Pandemic

PURPOSE: In the United States, terrorist attacks, natural disasters, and pandemics of the past decade have prompted hospitals to better plan and prepare for large scale public health emergencies. A central goal in preparing for all major medical events is to optimize medical surge capacity—the ability to evaluate and care for a markedly increased volume of patients. Recently, pediatric emergency departments (EDs) experienced medical surge during the 2009 H1N1 influenza pandemic. Little is known about how pandemic planning efforts prepared pediatric EDs to manage medical surge in this context.

OBJECTIVE: The objective of this study is to characterize pediatric ED providers’ experiences with pandemic planning and implementation during the 2009 H1N1 pandemic. From May through August 2011, the authors are conducting a qualitative study consisting of in-depth phone interviews with pediatric ED medical directors or designated respondents with expertise in ED pandemic planning. Purposive sampling is being used to select participants from institutions with pandemic emergency medicine training programs across the United States representing a range of geographic regions, hospital types and annual ED volumes. Data are being collected through use of a standardized interview guide. Prompts explore respondents’ experiences with development and implementation of their respective institution’s pandemic plan, challenges faced and solutions adopted in response to medical surge, and communi-
Police officers in our community carry a substantial burden of medical and mental health conditions which are often untreated despite access to health insurance. These conditions contribute to on-the-job difficulty and productivity loss. Results of this study have been disseminated to the local Police Union, Police Department, EAP and occupational health programs, as well as city representatives. At the bequest of the Police Chief, directed by local police officers, and partnered with the Yale RWJF Clinical Scholars program, a formal Police Health Committee has been formed with the mission of studying current health issues among officers, developing interventions, and analyzing subsequent outcomes to improve the health of officers in our community.

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**RESULTS:** Surveys were completed by 137 officers (response rate=39%), with respondents being similar to the overall department in terms of sex, race, and years of service. The majority of respondents were male (75%), white (60%), had over 10 years of police experience (64%), primarily served as uniformed patrol officers (75%), and had a mean age of 39.4 ± 8.4 years. Overall, the mean body mass index was 28.9 ± 4.8 kg/m², with 40.2% of male and 24.1% of female officers being obese (BMI>30 kg/m²). A self-reported diagnosis of hyperlipidemia (25.8%), hypertension (21.3%), arthritis (10.7%), and depression (9.0%) was common. In the previous 1 month, PTSD symptoms were present in 54.1% of respondents, with 27.1% of all respondents screening positive for PTSD. The mean productivity loss among all respondents was 5.6%. Compared to those without a diagnosis, productivity loss was significantly higher for those with a diagnosis of depression (11.1% vs. 5.1%, p=0.002), PTSD (9.5% vs. 3.9%, p<0.001), and arthritis (9.0% vs. 5.0%, p=0.02).

**CONCLUSIONS:** Police officers in our community carry a substantial burden of medical and mental health conditions which are often untreated despite access to health insurance. These conditions contribute to on-the-job difficulty and productivity loss. Results of this study have been disseminated to the local Police Union, Police Department, EAP and occupational health programs, as well as city representatives. At the bequest of the Police Chief, directed by local police officers, and partnered with the Yale RWJF Clinical Scholars program, a formal Police Health Committee has been formed with the mission of studying current health issues among officers, developing interventions, and analyzing subsequent outcomes to improve the health of officers in our community.
Association Between Active Transport and Cardiovascular Disease Risk Factors

PURPOSE: Most US adults do not achieve the Department of Health and Human Services’ recommended target of 150 minutes/week of moderate physical activity (PA). New strategies to help individuals obtain sufficient PA are urgently needed. Active transport (biking and walking for transportation) incorporates PA into individuals’ existing daily routines. However, it is unclear if active transport confers the same health benefits as other forms of PA. Thus, we are investigating the relationship between active transport and cardiovascular disease risk factors.

METHODS: This study will use cross-sectional data from the 2007-2008 National Health and Nutrition Examination Survey (NHANES). Adults aged ≥20 years without impaired mobility will be classified by amount of active transport per week. Multivariable regression analyses will be performed to examine the association between level of active transport and a broad range of cardiovascular risk factors, including body mass index (BMI), abdominal waist circumference, blood pressure, blood glucose, triglycerides, high density lipoprotein (HDL), and metabolic syndrome. Stratified analyses will be performed to assess the relationship between active transport and cardiovascular risk among those who do and do not meet PA guidelines through recreational PA. Analyses will be weighted to account for the complex survey design and adjusted for sociodemographic characteristics, smoking status, self reported diet, and minutes/week of recreational PA.

RESULTS: Adults aged ≥20 years who did not meet PA guidelines through non-active transport (N = 2,068) were categorized according to level of active transport per week: none (79.4%), 1-149 min (10.0%), and ≥150 min (11.0%). In unadjusted analyses, significant inverse associations were found between level of active transport and both BMI (p<0.05) and waist circumference (p<0.05). Individuals who engaged in no active transport were significantly more likely than those who engaged in ≥150 min/week of active transport to have metabolic syndrome (38.6% vs. 27.1%, p<0.05). Similar trends were observed for hypertension and diabetes although differences did not achieve statistical significance. There was no association between level of active transport and HDL or triglycerides.

CONCLUSION: Preliminary analyses of data from the 2007-2008 NHANES indicate that active transport is associated with lower BMI, lower waist circumference, and lower prevalence of metabolic syndrome in adults who do not meet PA recommendations through recreational and work-related physical activity. Multivariable analysis is planned. Should associations remain significant after adjustment, efforts should be made to develop policies and infrastructure that promote the use of active transport.

KEY WORDS: Active transport, non-motorized transport, physical activity

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interviewed 14 people living around the intervention vacant lots and 15 people living around the control vacant lots. The interview consisted of a qualitative in-home portion to assess perceptions of neighborhood physical and social disorder, experiences with violence, and the health effects of these experiences. This was followed by a walking interview along a predetermined route that took participants into contact with the study vacant lots. During the walk we measured heart rate with a GPS connected device. After baseline interviews were complete, the greening intervention was performed. We conducted follow up interviews with 72% of participants 2 months after the greening, to assess changes in perceptions of safety and violence after the greening. Additionally, we will analyze police crime data, including homicide, assault, robbery, and rape, from around the two sites before and after the greening.

RESULTS: 59% of participants were male and 97% were Black. 28% did not have a high school diploma, while 41% had a high school diploma or GED equivalent. 52% of participants had a household income less than $25,000. Initial results from baseline interviews indicate that violence plays a significant role in the lives of many participants, and issues of safety regularly affect decisions made about daily life. Vacant land was identified as a significant safety and well-being problem for many residents. Vacant lots were thought to attract illegal activity, increase the amount of trash in the neighborhood, and attract mice, possums, and other rodents. Further results, including heart rate and crime data, will be analyzed in the Fall of 2011.

CONCLUSIONS: We show the feasibility of randomly selecting vacant lots for greening, partnering with PHS for the greening intervention, and evaluating violence-related outcomes. Physical disorder, such as vacant lots and abandoned homes, represent safety and health concerns for people living in areas of blight. They also prohibit the development of a sense of community in these neighborhoods. Vacant lot greening may contribute to violence reduction and increased community collective efficacy. Larger prospective trials are needed to investigate the possible relationship between vacant lot greening and violence related outcomes.

KEY WORDS: Vacant lot, Greening, Violence, Safety, Physical disorder

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Are Longer Resuscitation Efforts Associated with Improved Survival During In-Hospital Arrest?

BACKGROUND: Approximately 200,000 hospitalized patients suffer cardiac arrest each year. One of the most challenging decisions facing clinicians who care for these patients is determining when to terminate resuscitation efforts. Clinicians are frequently reluctant to continue efforts when return of spontaneous circulation (ROSC) has not occurred early on during cardiac arrest, given the overall poor prognosis for such patients. Prior recommendations suggest it is reasonable to terminate efforts from anywhere between 10 and 30 minutes. Given such broad recommendations and a lack of direct empirical evidence, it is likely that the duration of resuscitation attempts prior to termination of efforts varies across hospitals. The extent of this variation and its relationship with survival has not been previously explored. We hypothesized that the duration of resuscitation attempts varies across hospitals, and that patients at hospitals with longer attempts have better survival.

METHODS AND RESULTS: Between 2000 and 2008, we identified 64,349 patients with cardiac arrests at 435 hospitals within a large national registry. For each hospital, we determined the median duration of resuscitation attempts prior to the termination of efforts among its non-survivors. We specifically focused on non-survivors given that the duration of attempts in this group would reflect a facility’s overall propensity for longer efforts. After stratifying hospitals into quartiles based on their median duration, we determined the association between longer attempts and risk-adjusted survival using multivariable hierarchical models. The overall proportion of patients achieving ROSC was 48.5%. The median duration of resuscitation attempts among non-survivors at hospitals was 20 minutes (interquartile range, 17-23 minutes). Compared with patients at hospitals in the quartile with the shortest median duration of resuscitation attempts, patients at hospitals with the longest median duration had a 14% higher likelihood of ROSC (adjusted risk-ratio 1.14, [95% CI: 1.09-1.20]; p=0.001). This corresponded to a 7% increase in the adjusted rate of ROSC (42.2% to 49.3%) with increasing median duration of resuscitation. Importantly, an 11% higher likelihood survival to discharge (adjusted risk-ratio adjusted risk-ratio 1.11, [95% CI: 1.01-1.21]; p=0.024), corresponding to a 1.7% increase in the adjusted rate of survival to discharge (10.0% to 11.7%) with increasing median duration of resuscitation (Table). These findings were largely isolated to cardiac arrests due to asystole and pulseless electrical activity (p for interaction, 0.004).

CONCLUSIONS: We found significant variation in resuscitation duration prior to the termination of efforts across hos-
Perspectives of Adolescents In the Juvenile Justice System Regarding Recidivism

PURPOSE: Youth entering the juvenile justice system are one of the most at-risk subpopulations of adolescents both in regards to morbidity and mortality. Their time of adjudication represents an opportunity for interventions that could potentially alter the course of their lives. There is a growing body of literature that at-risk adolescents have insight into their own needs and effective strategies to address these needs. However, no studies have asked the youth themselves about their opinions regarding interventions aimed at recidivism. The purpose of our study is to identify youth’s own perceptions of positive and negative influences on future arrests.

METHODS: We conducted a qualitative study based on teen-centered interviews of recently adjudicated youth on probation between the ages of 13 and 18 years old. The interview script consisted of open-ended semi-structured questions based on the theory of planned behavior constructs as well as an exploration of constructive interventions. The interview questions used open-ended techniques to explore the youth’s perceptions of the factors that led to their arrest as well as interventions and resources they believe would decrease their chances of being involved in activities that led to their arrest. At the end of the interview, subjects were asked to rank interventions that have been validated in the literature as well as elaborate on their attitudes regarding these interventions. Raw data consisted of narrative responses to the semi-structured recorded interviews.

RESULTS: Thirty interviews were required for saturation. Mean participant age was 16.2 years; 60% of participants were males and 40% were females. Several major themes were noted for each of the constructs. Most youth regret their arrest and identify lack of family support and peer pressure as factors involved with their arrest. Family attitude is an influential deterrence to future arrests but the stigma of having been arrested is not a factor. A large majority of female youth actually considered their arrest as a turning point in their lives but a majority of male youth did not. At the same time, all of those interviewed hope to never be arrested again. The programs ranked as most influential to preventing future arrests include job training, mentorship, and family therapy. Those that focused on community service and peer mediation were not ranked as effective.

CONCLUSION: Our study provides insight to the risk factors leading to and preventing arrests through the eyes of the adjudicated youth themselves. This perspective will be crucial in identifying youth preferences in order to design more effective and appropriate interventions aimed at decreasing recidivism.

KEY WORDS: at-risk adolescents, adjudication, recidivism, intervention, qualitative

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YALE 2009-2011

Improving Transitions in Care from Hospital to Shelter in New Haven: Implementing Systems Change from Community-Based Participatory Research Findings

PURPOSE: Coordinating transitions in hospital care for patients experiencing homelessness is challenging and community-based, patient-centered data are needed to guide strategies for improvement both at hospitals and shelters. Our objectives were to understand the experience of patients with transitions from acute hospital care to a community shelter and to determine aspects of these experiences that may influence the quality of these transitions.

METHODS: Using a Community-Based Participatory Research approach, we collected quantitative and qualitative data about transitions in care from the hospital emergency room and inpatient discharges to the shelter from interviews with shelter clients who reported an episode of hospital care within the preceding 12 months. We performed frequency analysis and multivariable logistic regression with quantitative data and analyzed qualitative data using the constant comparative method.

RESULTS: Ninety-eight homeless individuals participated in our study. Qualitative themes revealed concerns about post-discharge housing, discharge timing, transportation, and coordination with the shelter. In frequency analysis, 56% reported that their housing status was not assessed by any hospital staff, 27% reported being discharged after dark, and 61% reported having no plan for safe post-discharge transportation. After discharge, 68% of participants reported going to a shelter the first night, 21% reported staying with friends, family, or other arrangement and 11% reported staying on the streets with no shelter whatsoever. In multivariable analysis, discharge after dark was significantly associated with staying on the streets vs. staying in a shelter (OR 6.6; 95% CI 1.3-33.2). One participant summed up the views of many: “sometimes miscommunication between the hospital and shelter is a problem - the hospital sends you there, but then you can’t get in.” These results have sparked a new dialogue between the shelter and our major teaching hospital (Yale-New Haven Hospital) to explore mechanisms for enhanced collaboration in the care of these vulnerable patients. Presently, a pilot program to identify and track transitions in care from hospital to shelter for chronically homeless is being finalized between the hospital and shelter. Additionally, high-level stakeholder meetings with City and State Legislators and Executive Leadership from the Hospital, Shelter, FQHC and area Foundations are ongoing. The purpose of these meetings is to discuss the creation of new infrastructure (including possible creation of homeless respite care facility) to create and sustain meaningful changes in care for this population that is in line with City, State, and Federal plans to prevent and end chronic homelessness. The current status of implementation for these community-based system changes will be the highlight of this presentation.

CONCLUSIONS: Assessment of housing status, discharge timing and transportation are important factors of discharge quality for homeless patients. Improved communication and coordination between shelter and hospital can result in systems change within the community to improve transitions from acute care for homeless patients.

KEYWORDS: Homelessness, Transitions in Care, CBPR, Quality of Care, Systems Change

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ADRIANNE HAGGINS
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When Coverage Expands, What Happens to Utilization of Health Care Services? CHIP as a Natural Experiment

PURPOSE: Expansion of insurance coverage is conceptually designed to improve access to primary care and reduce utilization of emergency services. Determining whether expanding coverage achieves this goal is of paramount importance as the United States prepares for marked expansion of coverage through the Affordable Care Act. We examined patterns of health care utilization after coverage expanded through the Children’s Health Insurance Program (CHIP), focusing on adolescents (a major target group for CHIP) versus young adults (not targeted in CHIP).

METHODS: Secondary data analyses were performed using the National Ambulatory Medical Care Survey (NAMCS)
For the ED setting, there was no statistically significant change in OP visits over the same time period. For young adults, there was no statistically significant increase in visits per 1000 persons over the years 1999-2008 (95% CI, 125-457). The number of OP adolescent visits increased by 290 visits per 1000 persons over the baseline visit rate measured in the pre-CHIP period (95% CI, 24-62).

The OP-to-ED utilization ratio for adolescents increased by 1.1 in comparison to the pre-CHIP ratio (95% CI, 0.6-1.6), while the ratio for young adults decreased by 0.49 during the CHIP time period compared with the pre-CHIP era (95% CI, -0.83- -0.14).

CONCLUSIONS: Since the implementation of CHIP, adolescent visits in non-ED outpatient settings have increased while ED visit rates have remained relatively flat. Concurrent comparisons with young adults suggest that expanding insurance coverage to adolescents improved access to health care services and shifted utilization to non-ED settings. These findings have implications for expansions of insurance coverage to broader groups through the Affordable Care Act of 2010.

KEY WORDS: CHIP, Medicaid, ED utilization, health reform, adolescents

AUTHORS: Adrianne Haggins, MD, Matthew M. Davis, MD, MAPP

and the National Hospital Ambulatory Medical Care Survey (NHAMCS)—annual cross-sectional surveys using nationally representative probability samples of physician visits to non-federal clinics and short-stay hospitals. Analysis of years 1992-1996 established a baseline utilization trend prior to CHIP and was then compared with utilization patterns in 1999-2008, after the launch of CHIP in 1997-98. Primary outcomes were population-adjusted annual visits to emergency departments (ED) versus non-emergency outpatient settings (OP) (defined as physician offices, community health centers and hospital-based outpatient departments). Adolescents were persons 11-18 years old and young adults 19-29 years old. Interrupted time-series analyses were performed on annual utilization rates to ED and OP between adolescents and young adults in the pre-CHIP and CHIP periods. In addition, OP-to-ED utilization ratios were calculated and compared for the pre-CHIP versus CHIP periods, among adolescents and young adults.

RESULTS: Compared with the pre-CHIP period, the mean number of OP adolescent visits increased by 290 visits per 1000 persons over the years 1999-2008 (95% CI, 125-457). For young adults, there was no statistically significant increase in OP visits over the same time period.

For the ED setting, there was no statistically significant change in the mean number of adolescent visits during the CHIP period compared with the pre-CHIP time period. In contrast, for young adults from 1999-2008 there was an increase of 43 visits per 1000 persons over the baseline visit rate measured in the pre-CHIP period (95% CI, 24-62).

The OP-to-ED utilization ratio for adolescents increased by 1.1 in comparison to the pre-CHIP ratio (95% CI, 0.6-1.6), while the ratio for young adults decreased by 0.49 during the CHIP time period compared with the pre-CHIP era (95% CI, -0.83- -0.14).

CONCLUSIONS: Since the implementation of CHIP, adolescent visits in non-ED outpatient settings have increased while ED visit rates have remained relatively flat. Concurrent comparisons with young adults suggest that expanding insurance coverage to adolescents improved access to health care services and shifted utilization to non-ED settings. These findings have implications for expansions of insurance coverage to broader groups through the Affordable Care Act of 2010.

KEY WORDS: CHIP, Medicaid, ED utilization, health reform, adolescents

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Discussions about Pain are Associated with Heightened Patient Affect During Primary Care Visits in An Urban Clinic

PURPOSE: Patients frequently report that talking about their pain with their primary care physicians is frustrating. Findings from basic communication science suggest that this frustration may manifest as observable changes in affect (i.e., displayed emotion) during primary care visits. Our study investigated whether patient affect differs during discussions about pain compared to discussions about other topics in primary care visits.

METHODS: We identified all primary care visits that included discussions about pain (n equals 92) from an archive of previously video-recorded primary care visits collected at an urban clinic serving primarily black, low-income patients (n equals 133). We used a structured coding system to identify all segments of the visits in which pain was discussed. We then excerpted three 30-second “thin slices” from the beginning, middle, and end of each visit. One to two slices per visit included discussions about pain; the remaining slices from that visit included discussion about other topics; the total was 132 pain-related and 121 non-pain-related slices. After a brief training, four raters independently viewed each slice and rated patients from low to high on six affective dimensions using six-point scales: warm/friendly, engaged/attentive, tense/anxious, disagreeable/antagonistic, upset/distressed, and sad/depressed. Factor analysis was used to evaluate groupings among these dimensions. We used hierarchical linear regression to compare the mean ratings for pain-related vs. non-pain-related slices, controlling for patient specific heterogeneity (fixed effect).

RESULTS: Based on the results of factor analysis, we constructed two composite variables for our primary analysis: “positive affect” (warm/friendly and engaged/attentive) and “negative affect” (upset/distressed and tense/anxious). Estimated reliability for mean positive and negative affect ratings was 0.82 and 0.71, respectively. Within visits, mean ratings of patients’ affect were 0.36 points higher (95%CI 0.18 to 0.54) for negative affect and 0.16 points higher (95% CI 0.03 to 0.28) for positive affect when they were discussing pain than when they were discussing other topics. Differences between ratings of pain and non-pain slices were statistically significant for both negative (p less than 0.001) and positive (p equals 0.014) affect.
CONCLUSIONS: Ratings of patients’ positive and negative affect were significantly higher during discussions about pain compared to discussions about other topics in primary care visits. These results suggest that discussions about pain are associated with heightened patient emotions during primary care visits. Further studies should investigate whether these heightened emotions are related to patients’ frustration with discussing pain and with better or worse pain management. Use of “thin slices” is a novel but effective method for identifying variation in patient affect during patient-physician interactions.

KEYWORDS: patient-physician communication, pain, affect, thin slices, primary care

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Michael Hochman
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Implementation and Evaluation of a Patient-Centered Primary Care Intervention Involving Telephone Triage, Urgent Care Access, and Expanded Case Management at a Safety-Net Clinic

BACKGROUND: In Los Angeles County as well as nationally, patients in low income communities frequently are unable to access timely primary care services, potentially leading to low satisfaction with care, poor health outcomes, and overuse of already overcrowded emergency rooms.

PURPOSE: In collaboration with the Los Angeles Department of Health Services, we are in the process of implementing and evaluating a program to improve access to and the quality of services offered at a public safety-net resident internal medicine clinic. Specifically, our aims are to improve patient satisfaction, to improve resident satisfaction, to prevent unnecessary emergency room and hospital visits, and to improve the quality of care.

METHODS: Using grant funding, we have developed and implemented a program offering several new services to patients, specifically: 1) telephone triage during business hours by resident physicians; 2) off-hours telephone access to a resident physician for emergencies; 3) same-day visits for patients with acute care needs (as judged by the residents conducting the telephone triage); and 4) expanded case management services from two care coordinators (e.g., visiting hospitalized patients to ensure a smooth transition back to the ambulatory setting, facilitating urgent appointments, tests, and studies, etc.). We are planning a 12-month controlled evaluation of the program to monitor its impact on: 1) patient satisfaction with access to care using a modified version of the Consumer Assessment of Health Providers and Systems (CAHPS) survey; 2) resident satisfaction with their ambulatory experience using a validated resident satisfaction survey; 3) emergency and hospital visit rates among patients; and 4) hemoglobin A1C and LDL control among patients with diabetes. Two resident clinics within the same health system with a similar patient population will serve as controls.

RESULTS: Focus groups and interviews with patients, staff, and residents prior to program implementation indicated that patients commonly seek urgent care in the emergency room because they are unable to access timely urgent care services from the clinic. In addition, patients report that they would enthusiastically utilize a telephone triage system and same-day appointments rather than seeking urgent care in the emergency room. The program began on July 11, 2011, and has thus far received high ratings from patients, clinic staff, and resident physicians on feedback surveys (satisfaction scores in all groups have been > 4 on a scale of 1-5). As of mid-September, the call center was receiving approximately 10 patient calls a day and 5-7 case management requests. At baseline, there was an average of 79 emergency room and hospital visits per 1,000 patients in the intervention and control clinics. In the first two months since program implementation, there has been an average of 68 emergency room and hospital visits per 1,000 patients in the intervention clinic vs. 91 in the control clinics (P=0.11). Conclusions: If our intervention continues to be successful throughout the 12-month evaluation period, it could serve as a model for other resident primary care clinics in underserved communities.

KEY WORDS: access to primary care, telephone triage, case management

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**ERI C  H O D G S O N**
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Understanding the Knowledge, Attitudes and Beliefs Regarding Contraception Use Among Adult, African American Women at Risk for Undesired Pregnancy

PURPOSE: Over half of pregnancies in the US are unplanned. Within this group of women who are experiencing unplanned pregnancies, there are significant racial and ethnic and inequalities, particularly among poor women. Prior research regarding the cross-cultural and socioeconomic differences in contraception use and adherence has focused on adolescents. However, less is known about the role of these factors in contraceptive decision making among adult African American women at risk for undesired pregnancy.

METHODS: Focus groups of economically disadvantaged, non-pregnant African-American women, aged 16-49, residing in Connecticut during 2011 were performed. To date, four groups with a total of 25 women have participated. Data were collected using a standardized discussion guide, augmented by prompts for clarification. Audio taped sessions were transcribed and are being independently coded by investigators and crosschecked to enhance coding validity. Data are being coded using the constant comparative method, and analyzed in ATLAS TI software to facilitate the reporting of recurrent themes, supporting quotations, and links among the themes. An audit trail will be maintained to document analytic decisions during data analysis and interpretation.

RESULTS: We will elucidate major themes regarding ways that adult African American women learn about, choose, use, and adhere to a contraceptive method.

CONCLUSIONS: Using the major themes underlying the knowledge, beliefs, attitudes and contraceptive decision making process of African American women, we intend to create a decision support tool that can help users understand and prioritize the essential elements of an optimal contraception choice.

KEY WORDS: contraception, decision making, African American, women, focus groups

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Quality and Safety of Care for Hospitalized Adolescents and Young Adults with Inflammatory Bowel Disease

PURPOSE: Adolescents and young adults with chronic disease, including inflammatory bowel disease (IBD), are hospitalized in both children’s (CH) and non-children’s hospitals (NCH) and care for by physicians trained in pediatrics and adult-oriented specialties. It is unknown, however, if quality of care is associated with hospital type or physician specialty.

OBJECTIVE: To determine the effect of hospital type and physician specialty on quality of care for hospitalized adolescents and young adults with IBD.

METHODS: This retrospective cohort study used the Premier Perspective Database to identify 11,619 inpatients ages 16 to 25 years with IBD discharged from 416 U.S. hospitals from 1/1/2007 through 12/31/2009. Independent variables abstracted from the database included hospital characteristics; attending physician specialty; and patient sociodemographic and clinical characteristics. The main outcome measures are rates of death, abdominal surgery, post-operative complications, AHRQ-defined patient safety indicators (PSI), and length of stay (LOS).

RESULTS: Of the 11,619 inpatients comprising the study sample, 1,260 (10.8%) were at CH and 10,359 (89.2%) were at NCH. Compared to NCH, there were higher death rates among CH compared to NCH (0.4% vs. 0.1%, P=0.009), which did not reach significance after adjustment of hospital characteristics, patient demographic and clinical characteristics. There were similar death rates among pediatric compared to non-pediatric attending physicians (0.1% vs. 0.2%; P=0.461). Compared to NCH, CH had similar rates of surgery (10.5% vs. 10.9%; P=0.686). Compared to non-pediatric attending physicians, pediatric attending physicians had lower rates of surgery (6.1% vs. 11.6%; P<0.001), but these differences did not reach significance after adjustment. Among those patients undergoing surgery, CH had similar rates of post-operative compli-
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Understanding Barriers to Evaluation for Early Intervention Services

PURPOSE: To explore barriers to evaluation for and enrollment in early intervention services for urban families of children with developmental delay aged 0 to 3 and to identify possible strategies to overcome these barriers. METHODS A qualitative study featuring semi-structured interviews. Participants for parent interviews will be drawn from the CDC funded Translating Evidence-Based Developmental Screening (TEDS) into Pediatric Primary Care Study which studied implementation of developmental screening guidelines in four urban practices. We will recruit up to 30 parents of children who were referred to early intervention but not evaluated and up to 30 parents of children, who were referred to early intervention and were evaluated as a comparison group. We will interview the parent primarily involved in the child’s care and continue interviewing until we reach thematic saturation. Parents of children with multiple congenital anomalies/genetic disorders and children with identified developmental delay prior to the TEDS study are excluded.

RESULTS: Pending

CONCLUSIONS: Pending

KEY WORDS: Care Coordination, Developmental Delay, Policy


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The Patient-Centered Transition (Pact) Project: Improving the Transition from Hospital to Primary Care for Socioeconomically Vulnerable Patients

BACKGROUND: A patient’s transition from hospital to ambulatory care is fraught with challenges which can lead to dissatisfaction, morbidity and high cost. While still recovering from an acute illness, patients must assume responsibility for new health care behaviors. Uninsured and Medicaid patients are particularly vulnerable to socioeconomic factors which can impede the ability to successfully perform these crucial health behaviors. They are more likely than the privately insured to lack timely primary care provider (PCP) follow-up, to return to the ED following hospital discharge, and to be readmitted to the hospital. Yet, there have been no published transition interventions that target the socioeconomically vulnerable patient population. A program which offers support to socioeconomically vulnerable patients during the transition from hospital to home is more likely to be effective if it stems from people who are socially similar to the patients and who have experience! d
similar stressors.

PURPOSE: Our primary aim is to evaluate whether The PaCT Project is more effective than usual discharge planning at increasing completion of post-discharge follow-up care with a PCP

METHODS: We are conducting a randomized controlled trial of a Patient-Centered Transition (PaCT) intervention in which trained Community Health Workers (CHWs) will act as PaCT Partners for uninsured/Medicaid patients who are being discharged from the General Medicine services of Penn Medicine Hospitals. PaCT Partners will provide patients with social support and help patients to overcome the challenges of transition, including arranging primary care provider (PCP) follow-up, filling medication prescriptions and obtaining referrals to community-based social services. As our primary outcome, we will examine the effect of the PaCT intervention on proportion of patients who complete primary care follow-up within two weeks post-discharge. We will also examine the effect of PaCT on secondary outcome variables including patients’ satisfaction with the experience of transition, medication adherence, self-rated health, and ED revisit or inpatient readmission within 30 days after discharge.

RESULTS: We will recruit a total of 384 patients which will allow us to detect a 15% increase in timely primary care follow-up and a 13% difference in proportion of patients experiencing the key secondary outcome of acute care reutilization within 30 days of discharge. Interim results for the first 128 participants of the PaCT Project will be available by Fall 2011.

CONCLUSION: PaCT is a community-based, patient-centered intervention that is designed to improve post-hospital outcomes for socioeconomically vulnerable patients. If successful, PaCT will: 1) Increase patient safety during the transition by reducing medical errors; 2) Improve patient satisfaction with the transition process and 3) Provide cost-effective care to a high-risk patient population.

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The Impact of a Dedicated Pediatric Trauma Center: A Prospective Study

PURPOSE: The delivery of high quality, timely trauma care for injured children is paramount. Consequently, pediatric trauma centers (PTCs) have been established to address the specialized needs of injured children. However, due to geographic disparities, the vast majority of children live many miles from the nearest PTC. This results in delayed treatment and resuscitation for many injured children. In Los Angeles County, Northridge Medical Center recently received accreditation to become a level 2 PTC. Northridge Medical Center serves the San Fernando Valley, an area home to over one half million children. This provides a unique opportunity to take advantage of a natural experiment occurring in the San Fernando Valley. In this study, we will explore the effect of establishing a PTC in a community previously without local access to pediatric trauma care.

METHODS: This study will employ a pretest/posttest study design to evaluate Northridge’s PTC accreditation at a natural experiment. Demographic and clinical variables of historical controls abstracted from the California Patient Discharge Database and the Los Angeles County Pre-hospital Emergency Medical Systems Database from 2005-2007 will be compared alongside data prospectively collected after Northridge Medical Center received PTC accreditation. The control group will be composed of children ages ≤14 years from the San Fernando Valley who sustained moderate to severe injury treated at any hospital in Los Angeles County from January 2005-December 2007. The experimental group will consist of children ages ≤14 years from the San Fernando Valley who sustained moderate to severe injury treated at Northridge Medical Center from January 2011-December 2011. Primary outcome measures include medical and surgical complications, length of hospitalization and readmission.

RESULTS: Since accreditation began in October 2010, 97 injured children have received trauma care at Northridge hospital, with 64 (66%) children requiring hospital admission after injury. Of those admitted, 12 (19%) required operative intervention, 42 (66%) required pediatric intensive care for injury stabilization and resuscitation and 10 (15%) were admitted for general inpatient pediatric care. Overall mortality was approximately 5%, with all 3 deaths determined to be non-preventable. The injury severity distribution at Northridge is
CONCLUSIONS: Injured children are a particularly vulnerable population whose care and resource allocation is the subject of ardent academic and political discussion. Ours is the first prospective study to examine how the presence of a local pediatric trauma center changes the quality of the pediatric emergency care delivered. Specifically, we anticipate a significant decrease in complication rates, hospitalization and readmissions due to shortened EMS transport times. Our results will contribute evidence to current pediatric emergency care debates and may serve to guide future trauma healthcare policy in California and nationally.

KEYWORDS: prospective pediatric trauma pediatric trauma center clinical outcomes

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RESULTS: We studied 464 primary care physicians, with 74,490 unique patients contributing quality data. Of the physicians, 203 (44%) had adopted EHRs and 261 (56%) were using paper. The median practice size was 4 physicians. Physicians with EHRs provided high quality care on 59.6% of the measures, compared to 47.2% for physicians using paper (unadjusted p = 0.001). Those with EHRs were independently more likely to provide high quality care [adjusted odds ratio (OR) 1.43; 95% confidence interval (CI) 1.07, 1.92]. This overall finding persisted when we considered the subset of measures that were expected to be directly affected by EHRs and that are part of the federal meaningful use program (adjusted OR 1.59; 95% CI 1.17, 2.17). However, there was no difference in quality between EHRs and paper for those measures not expected to be directly affected by EHRs (adjusted OR 0.85; 95% CI 0.25, 2.86).

CONCLUSIONS: This is one of the first studies to find a positive association between electronic health records and ambulatory quality in a community-based setting. In contrast to several recent national and statewide studies, which found no effects of EHRs, this study’s finding is consistent with national efforts to promote meaningful use of EHRs.

KEYWORDS: health information technology, electronic health records, ambulatory care, primary care, quality of care

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A Randomized Controlled Trial of Financial Incentives to Promote Weight Loss among Obese Employees

PURPOSE: Obesity is a leading cause of chronic disease, resulting in not only significant patient morbidity and mortality, but also substantial economic costs in the workplace. Consequently there is growing employer interest in novel approaches to reduce the prevalence of obesity among workers. The Patient Protection and Affordable Care Act permits employers to offer greater financial incentives for employees to meet biometric targets like body mass index (BMI), but there is little evidence on how incentives can most effectively promote weight loss in this setting. The purpose of this study is to test whether two novel financial incentive approaches can promote and sustain weight loss among obese employees.

METHODS: We developed a research partnership with the Children’s Hospital of Philadelphia Division of Human Resources to recruit 105 employees with a BMI between 30 and 40 kg/m² who were interested in losing weight. Participants were each given a weight loss goal of 1 pound per week for 24 weeks, provided with access to a website to track their progress, and randomized to one of 3 groups: (1) monthly weigh-ins alone, (2) $100 for being at or below their monthly target weight, or (3) $100 to $500 (contingent on the performance of 4 other anonymous participants) for being at or below their monthly target weight. Participants were recruited in March and April 2011, and will be followed through January 2012 to determine whether weight changes at the end of the 24 week intervention period are sustained in the subsequent 12 weeks. The primary outcome is weight change at 24 weeks; secondary outcomes include net weight change over the full 36 week study period, changes in physical activity and dietary habits, and participation in employer-sponsored wellness programs. We report here the baseline characteristics of study participants and will report interim outcome results in November 2011.

RESULTS: Participants have a mean BMI of 34.6 kg/m² [standard deviation (SD) 2.7], a mean age of 45.4 years (SD 10.2) and a mean household income of $94,952 (SD $38,317). Most are White (65.7%) or African American (30.5%) and have at least a college education (61%). While the majority of participants (74.3%) were already trying to lose weight at baseline, they only engaged in moderate physical activity an average of 1.4 days (SD 1.9) per week and vigorous physical activity an average of 1.1 days (SD 1.6) per week. Most reported binge eating when not feeling hungry (57.1%), eating when feeling anxious (68.9%), and overeating when feeling blue (64.8%). Prior to the study few participants were using employer-sponsored personal health coaches offered at no cost to employees (21.0%) or had taken advantage of their employer’s fitness center membership reimbursement benefit (11.4%).

CONCLUSIONS: Participants in an employer-based weight loss study reported high levels of interest in losing weight but low baseline levels of physical activity and high rates of overeating. The results of this study will provide valuable information to employers on how incentives for weight loss affect BMI, health behaviors, and participation in workplace wellness programs.

KEY WORDS: obesity, financial incentives, health behaviors, workplace wellness

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An Alternative Approach for Quantifying Hospital Resource Utilization: Implications of “Standard Costs” for Hospital Value Improvement, Performance Measurement, and Comparative Effectiveness Research

PURPOSE: Hospitals seeking to reduce costs need to understand the relationship between measured costs and actual utilization because the knowledge leads to very different approaches towards value improvement. Hospitals with high utilization would focus improvement methods on reducing treatment intensity, while hospitals with lower utilization but higher fixed costs would focus improvement methods on reducing the cost of labor, overhead, and contracting. In this study, we employed a novel method to distinguish utilization from fixed costs: standard dollar values (SDVs).
METHODS: We used a voluntary, fee-supported database containing an itemized, date-stamped log of all items and services charged to the patient or insurer, including medications, laboratory tests, diagnostic and therapeutic services, and cost of each service item (derived from each hospital’s cost accounting software). In a sample of adult patients, we calculated the median cost of each service item in the database and assigned the median value as the SDV of that item at every hospital. Once standard costs were assigned for all items, we summed all SDVs assigned to each patient and calculated the average standard cost of a hospitalization per patient at each hospital, adjusting for differences in initial patient severity. We calculated predicted total patient-level costs (based on patient-prescribing severity) using a hierarchical mixed-effect linear regression model. We defined the expected costs for each hospital as the average of patient-level model-predicted costs. We then defined hospitals as “at expected,” “below expected,” and “above expected” for both cost and utilization.

RESULTS: At the individual item level, application of SDVs led to changes in the distribution of costs and the ranking of hospitals. Using the example of chest films, the mean cost (in dollars) per patient, per hospital was $93, with a standard deviation of $38 and an interquartile range from $71-$111. After applying the median cost to all chest films in the database, the mean cost (in SDVs) per patient, per hospital was $84, with a standard deviation of $31 and an interquartile range from $75-$88. Although results from hospitals’ expected to observed values for cost and SDVs are pending, we did compare hospital rankings for cost and utilization of chest films. Only one hospital that was among the top 10 highest cost hospitals was also one of the top 10 utilizers. Similarly, only one hospital that was among the 10 lowest cost hospitals was one of the 10 lowest utilizers.

CONCLUSIONS: Standard costs are a novel method for measuring utilization in hospitals. By comparing standard costs to costs derived from internal hospital accounting systems, it will be possible to determine whether high costs are due to greater utilization or differences in fixed costs. SDVs will be a useful diagnostic tool for hospitals attempting to reduce costs as well as for policymakers interested in identifying and comparing the practices of efficient providers of hospital care.

KEYWORDS: costs of hospital care, utilization, efficiency, performance measurement, comparative effectiveness

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Readmission Following Surgical Procedures: Implications for Quality Improvement and Cost Savings

PURPOSE: Policymakers are increasingly targeting readmission for quality improvement and cost savings. Our objective was to characterize readmission following surgical procedures and estimate cost savings if readmissions are reduced.

METHODS: Eligible patient-level records from the National Surgical Quality Improvement Program (NSQIP), years 2005-2008, were linked to Medicare inpatient claims data using indirect patient identifiers. Risk factors, indication for surgery (ICD9 code), and 30-day postoperative adverse events (PAE) were determined from NSQIP while 30-day readmission and costs were determined from Medicare. PAE included surgical site infections as well as cardiac, pulmonary, neurologic and renal complications Poisson models were developed to determine incident rates of readmission, accounting for mortality. The number of surgical procedures performed per year was determined from the Nationwide Inpatient Sample (2008). Results: Of the 114,288 patients in the linked database who were discharged alive, 16,541 were readmitted within 30-days of surgery. The incident rate of readmission, accounting for mortality, was 15.7%. Indications for surgery most frequently associated with later readmission were arterial aneurysms, atherosclerosis, arterial occlusion, colon cancer and abdominal hernia. Procedures most frequently associated with readmission were open colectomy, carotid artery procedures, and lower extremity (LE) bypass. The PAE rates for these three procedures were 28.0%, 5.6% and 20.9%, respectively. Incident rates of readmission were higher for patients who had a PAE compared to those who did not (35.1% vs. 11.3% for colostomy, 65.2% vs. 9.3% for carotid, and 60.6% vs. 14.6% for LE bypass). Similarly, the mean cost of the readmission was higher for patients who also had a PAE ($11,682 vs. $8,171 for colectomy, $12,556 vs. $10,865 for carotid, and $11,399 vs. $7,927 for LE bypass).

RESULTS: The incident rate of readmission per year was determined from the Nationwide Inpatient Sample (2008). Results: Of the 114,288 patients in the linked database who were discharged alive, 16,541 were readmitted within 30-days of surgery. The incident rate of readmission, accounting for mortality, was 15.7%. Indications for surgery most frequently associated with later readmission were arterial aneurysms, atherosclerosis, arterial occlusion, colon cancer and abdominal hernia. Procedures most frequently associated with readmission were open colectomy, carotid artery procedures, and lower extremity (LE) bypass. The PAE rates for these three procedures were 28.0%, 5.6% and 20.9%, respectively. Incident rates of readmission were higher for patients who had a PAE compared to those who did not (35.1% vs. 11.3% for colostomy, 65.2% vs. 9.3% for carotid, and 60.6% vs. 14.6% for LE bypass). Similarly, the mean cost of the readmission was higher for patients who also had a PAE ($11,682 vs. $8,171 for colectomy, $12,556 vs. $10,865 for carotid, and $11,399 vs. $7,927 for LE bypass).

CONCLUSIONS: Standard costs are a novel method for measuring utilization in hospitals. By comparing standard costs to costs derived from internal hospital accounting systems, it will be possible to determine whether high costs are due to greater utilization or differences in fixed costs. SDVs will be a useful diagnostic tool for hospitals attempting to reduce costs as well as for policymakers interested in identifying and comparing the practices of efficient providers of hospital care.

KEYWORDS: costs of hospital care, utilization, efficiency, performance measurement, comparative effectiveness

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Patients’ willingness to Provide a Biospecimen for Genetic research at Screening Mammogram

PURPOSE: To characterize patients’ willingness to provide a biospecimen for genetic research at routine screening mammogram visits.

METHODS: Preliminarily, 1,498 female patients completed a health survey at screening mammogram at two facilities over the initial three months of enrollment. All were given the option to provide a biospecimen (blood and/or saliva) as part of a breast screening registry. The motivations for and barriers to providing a biospecimen were surveyed. Multivariate analysis examined associations between specific motivators and barriers and patient-related characteristics. After a planned final quantitative analysis at six months of enrollment, semi-structured telephone interviews of minority patients will be conducted to further understand motivators and barriers to participation.

RESULTS: Preliminarily, of 1,498 women, 65% consented to the longitudinal breast registry, 58% were willing to be contacted again, and 46% were willing to provide a biospecimen. Of those who were willing to provide a sample, 62% wanted to help future breast cancer patients, 53% wished to advance scientific knowledge, 29% hoped to help themselves if they were to develop breast cancer, and 24% wished to help an affected family member. In regards to barriers, 38% were concerned by privacy issues, 30% did not see a benefit for themselves, 18% felt that the time commitment was too great, and 12% did not want a needlestick. In multivariate analysis, women were more likely to contribute a sample if they were Hispanic (OR 1.63±0.31, p<0.01), had a personal history of breast cancer (OR 1.99±0.44, p<0.003), had current breast symptoms (OR 1.37±0.21, p<0.04), or were older (OR 1.02±0.005, p<0.001). Asian-Americans were less likely to contribute a biospecimen (OR 0.42±0.07, p<0.001) compared to Caucasians. African-Americans (OR 0.15±0.11, p<0.01) and Asians (OR 0.51±0.16, p<0.04) were less likely to donate due to lost time compared to Caucasians. African-American (OR 2.43±0.79, p<0.01) and college-educated (OR 1.85±0.40, p<0.01) women were less likely to donate due to privacy concerns.

CONCLUSION: A large proportion of women being screened are willing to provide a biospecimen for future genetic research. Willingness to provide a biospecimen differs based on a number of patient-specific characteristics, including race/ethnicity. Particular minority groups appear to have unique concerns and motivators. Addressing these specific concerns and understanding unique motivators of minority subpopulations is critical to encourage diverse enrollment in biospecimen banks so that all racial/ethnic groups may benefit from potential future genetic-based discoveries.

KEYWORDS: health disparities, genomics, biospecimen bank, breast cancer screening

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Robert Wood Johnson Foundation Clinical Scholars

$10,345 for LE bypass). Reducing the PAE rate for these three procedures by a relative 5% each would result in an estimated reduction of 3.3, 1.6 and 4.8 readmissions per 1000 patients undergoing colectomy, carotid procedures and LE bypass, respectively. This reduction in readmissions among all Medicare patients aged 65 or older would result in an estimated savings of $9.1 million per year ($5.8 million for colectomy, $1.5 million for carotid, and $1.8 million for LE bypass). Extrapolating to the overall US population, this reduction could result in a savings of $19.1 million per year to the healthcare system for these three procedures alone.

CONCLUSION: Readmission following surgical procedures is common and represents an opportunity for quality improvement and cost savings.

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C H R I S T O P H L E E
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Patients’ Willingness to Provide a Biospecimen for Genetic Research at Screening Mammogram

PURPOSE: To characterize patients’ willingness to provide a biospecimen for genetic research at routine screening mammogram visits.

METHODS: Preliminarily, 1,498 female patients completed a health survey at screening mammogram at two facilities over the initial three months of enrollment. All were given the option to provide a biospecimen (blood and/or saliva) as part of a breast screening registry. The motivations for and barriers to providing a biospecimen were surveyed. Multivariate analysis examined associations between specific motivators and barriers and patient-related characteristics. After a planned final quantitative analysis at six months of enrollment, semi-structured telephone interviews of minority patients will be conducted to further understand motivators and barriers to participation.

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**Rating Fast Food by Calories Purchased: Is Subway Healthier Than McDonald’s?**

**BACKGROUND:** Rating systems are intended to guide customer choices. Several researchers developed the Nutrition Environment Measures Scale for Restaurants (NEMS-R) to rate restaurants on health. The scale is intended to determine objectively in which restaurants customer are likely to obtain a healthier meal. Restaurants’ primary contribution to unhealthy diets is associated with large portions, so calories purchased may be one good indicator of a healthy meal. According to the NEMS criteria, sandwiches should contain < 10% saturated fat, and no more than 650 calories.

**PURPOSE:** This project will determine if the NEMS-R scale that evaluates the “healthiness” of a restaurant is correlated with the calorie content of the food customers order when they patronize the restaurants. The study will assess whether adolescents purchasing food at a restaurant marketed as “healthy” (Subway) (NEMS-R scale score is 41 out of a maximum healthy score of 63) purchase fewer calories than at a competing chain (McDonald’s, whose NEMS-R score is 22).

**METHODS:** In partnership with a youth group in South Los Angeles, we recruited 97 adolescents who purchased a meal at both restaurants on different days. The students purchased an after-school meal at the restaurant and provided us with their receipt. We then confirmed the items they ordered. From the receipt data we will calculate the amount of calories each participant purchased, and potentially consumed. We will then compare calories obtained from each of the two restaurants using a paired t-test.

**RESULTS:** Initial qualitative observations reveal that participants purchased more sweetened drinks at McDonald’s compared to Subway, due to the lower cost of the meal. Many youth who have $4 to $5 to spend for an afternoon meal purchase from the dollar menu, where a burger is 390 calories and a small fries is 380 calories. This leaves youth the needed money to purchase a drink, typically sweetened tea which has 180-200 calories. In contrast, sandwiches at Subway are 650 calories and cost $4 to $6, and youth typically cannot afford to order a drink. With our data collection now finished, complete results will be available for presentation at the national meeting.

**CONCLUSION:** In comparison to other studies, which do not use subjects as their own control, we will be able to conclude if youths aged 12-21 purchase fewer calories at a healthier restaurant as rated by NEMS-R. We will also be able to conclude whether the NEMS-R score is a valid predictor in terms of the number of calories consumed at a meal.

**KEY WORDS:** Obesity, Nutrition, Fast Food, Adolescents

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**ANISH P. MAHAJAN**  
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**Routine Opt-Out HIV Screening and Patient Acceptability in Safety-Net Clinics**

**PURPOSE:** Fewer than half of all Americans have ever been tested for HIV, and 20% of those infected are unaware of their positive status. To increase testing offers and patient acceptance of screening, the CDC recommends routine ‘opt-out’ HIV screening, in which patients are told they will undergo testing unless they decline.

**PURPOSE:** To determine whether non-targeted opt-out HIV screening in urban ambulatory care is associated with greater testing offers, test acceptance, and patient satisfaction than non-targeted opt-in HIV screening and risk-based testing.

**METHODS:** At 2 Los Angeles safety-net clinics, participatory research methods were used to create 4 rapid HIV testing interventions: a) risk-based testing according to USPSTF guidelines (standard of care), b) physician-initiated opt-out screening, c) nurse-initiated opt-out screening, and d) nurse-initiated opt-in screening. Using a quasi-experimental time samples design, each screening intervention was implemented in each clinic for a 2-month interval. All 19,006 presenting patients ages 18-64 were eligible for screening. Multivariate logistic regression was used to assess associations between acceptance of screening and type of intervention and other patient characteristics, with Taylor series linearization methods to adjust for clinic level clustering.

**RESULTS:** Relative to standard risk-based testing, all of the screening interventions significantly increased offer rate (11% vs 27%; p < 0.05) and actual testing rate (8% vs 16%; p < 0.05). Physician-initiated opt-out screening resulted in greater offer, acceptance, and testing rates than either nurse-initiated opt-in or opt-out screening (p < 0.05). In multivariate regres-
sion adjusting for clinic site, type of screening intervention, and previous history of testing, increasing age, female sex, and African-American ethnicity was associated with decreased odds of test acceptance (p < 0.05).

CONCLUSIONS: Routine HIV screening in safety-net clinics is feasible, and resulted in a 2-fold increase in the percentage of clinic patients offered and undergoing screening. Physician-rather than nurse-initiated HIV screening resulted in the higher offer, acceptance, and screening rates. Even in the context of a partnered quality improvement program directed at improving HIV detection, an opt-out screening strategy does not assure universal offering of HIV testing. In addition, opt-out HIV screening may not sufficiently increase testing rates for some groups with high prevalence of undiagnosed infection.

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The Association Between Local Food Environment and Obesity And Diabetes in California Adults

BACKGROUND: The consumption of high fat and high caloric “fast foods,” and lower rates of eating fruits and vegetables are associated with a higher prevalence of both obesity and diabetes. Access to healthier foods and the opportunity to make choices in the “built environment” are important components in the battle against these epidemics. However, the most accurate way to represent the effect of the built environment on individuals and their health status has not yet been established. The objectives of this study are: 1) to investigate the relative availability of less nutritious food vendors versus more nutritious food vendors around people’s homes as a ratio (the Retail Food Environment Index – RFEI), 2) to assess whether variation in the levels of the RFEI are associated with obesity and diabetes among adults in California, and 3) to assess how these measures of food availability vary by race/ethnicity and income.

METHODS: Data from the adult respondents of the 2007 California Health Interview Survey (CHIS 2007), a statewide population health survey, was geocoded with GIS software and linked with the 2007 InfoUSA Business File, a geographic listing of food retailers. We will calculate the RFEI, a ratio of the number of less nutritious food vendors (e.g., fast-food restaurants, convenience stores, pharmacies) to the number of more nutritious food vendors (e.g., supermarkets, warehouse stores, fruit/vegetable stores, farmers’ markets), for varying “buffers” (1 mile, 2 miles, 5 miles) around adult CHIS respondents’ homes based on their level of urbanicity. We defined RFEI scores of <4 as indicating areas with greater availability of healthy food choices, and scores of 8 and greater as indicating areas with less availability of healthy food choices. We are using bivariate analyses and multivariate logistic regression modeling to assess the association of RFEI with obesity and diabetes, as well as with race/ethnicity and income.

RESULTS: Among California adults, 22.5% are obese and nearly 8% have been diagnosed with diabetes. Lower income, minority race/ethnicity and obesity are associated with living in areas that have a higher RFEI. Over 36% of lower income adults (0-199% FPL) compared to 32.1% of higher income adults (>400% FPL) live in areas of the highest RFEI (>8) [p<0.05]. Almost two-fifths (39.2%) of African-Americans and 36.3% of Latinos, compared to 32.1% of whites, live in these least healthy food environments [p<0.05]. Additionally, 24.6% of people who live in areas of the highest RFEI (>8) are obese, while in areas with the lowest RFEI (<4), 20.6% of adults are obese [p<0.05]. We are currently constructing and conducting multivariate logistic regression modeling to assess the association of RFEI with obesity and diabetes, as well as with race/ethnicity and income.

CONCLUSION: Californians who live in areas with more healthy food vendors as compared to unhealthy food vendors, are less likely to be obese. Although this cross-sectional analysis cannot confirm causality, efforts to increase food choice may represent one approach to slow the growing obesity epidemic. Partnership with multiple community stakeholders will be key to effective change in food environment policy.

KEY WORDS: Nutrition, Built Environment, Food Environment, Obesity, Diabetes
Super Utilizers: A Cross-Sectional Interview Study. Who are the Highest Utilizers of our Health Care System?

BACKGROUND: Of the population of 79,000 in Camden, NJ, a small proportion of the population accounts for a large proportion of the health care expenditures. One percent of Camden’s 79,000 residents spend 30% of its health care dollars. Thirteen percent are responsible for 80%, and only 20% of residents spend 90% of the health care expenditures of this struggling city (Green et al, 2010). Dr. Jeffrey Brenner noted this disparity and set out to target this minority of patients, the Super Utilizers. He has created an innovative model, reaching out to patients who are the highest utilizers of health care to try to provide the care they need. The objectives of his team are to help them improve their health and use of outpatient and community health care services, such that they may be able to stay out of the hospital, with the added benefit of decreasing their utilization and overall health care costs. For a cohort of 36 super utilizers, impacts of Brenner’s team included a decrease in monthly costs of 56% (Green et al, 2010). Efforts to create and refine interventions to help these patients achieve higher levels of health and quality of life are ongoing. This proposal aims to give voice to the patient perspective as well as their outreach care team providers using in-depth interviews, eliciting ideas from these patients themselves about their health and health care, program effectiveness and potential solutions.

PURPOSE: This study will characterize high utilizer patients and their biopsychosocial contexts using patient interviews and interviews of High Utilizer Outreach Team members. We will offer additional clinical relevance with case summaries from chart review.

METHODS: Development of the interview script was informed by videotaped interviews of residents of the community in which the High Utilizers reside, and by observation of the Outreach Team by the principal investigator. Interview topics include descriptions of patients’ health and experiences with the health care system and with the outreach program. Patients will be selected using purposive sampling. Open-ended, in-depth, semi-structured interviews will be conducted with patients (n=30) and Outreach Team providers (n=5) by two trained interviewers, lasting 30-45 minutes each. All interviews will be audio recorded. Transcripts will be coded following a grounded theory approach. We will use NVivo 9 to facilitate qualitative analysis. A brief summary of the medical case for each patient will be abstracted from charts kept by the Outreach Team.

RESULTS: We anticipate presentation of a case series of individuals and their perceptions, followed by qualitative analysis of the interview data as a whole.

CONCLUSIONS: This study will provide insight into patient and field provider perspectives on access, health care and the outreach programming, contextualized by summaries of the patients’ clinical cases. This will inform program development and improve understanding of “super-utilizer” patient populations.

KEYWORDS: patient perspectives, descriptive, qualitative, interview, health care utilization, cost

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The Role of Caregivers in the Emergency Department and their Relationship with Patient Satisfaction, Disposition and Follow-up

PURPOSE: For older adults, both inpatient and outpatient care involves not only the patient and physician, but often a family member or informal caregiver (also termed care partner). They can assist in medical decision making and in performing the patient’s activities of daily living. To date, multiple outpatient studies have examined the positive roles family members play during the physician visit, however, there is very limited information on the involvement of the care partner in the emergency department (ED) and their relationship with
OBJECTIVE: We examined the relationship between FMAP and children’s Medicaid/CHIP enrollment over the past decade, and estimated the potential changes in children’s coverage with the FMAP decrease in 2011.

METHODS: We utilized publicly available data from the Current Population Survey for insurance coverage and child poverty trends. FMAP levels were obtained from the Federal Register for each state from 1999-2009. Several economic variables were evaluated as potential confounders in Medicaid/CHIP (public program) enrollment—such as unemployment, state tax revenue and state gross domestic product—but these were not associated with children’s coverage and results are not shown. We employed multivariable regression analyses to adjust for potential economic covariates; we used a hierarchical model to control for unobservable state fixed effects over time. Using best-fit models, we estimated the potential impact of the 2011 FMAP decrease on public program enrollment among children.

RESULTS: From 1999 to 2009, public program enrollment rose 13 percent while uninsurance decreased by 3 percent nationwide. The proportion of children living in poverty increased by 4 percent. In analyses adjusted for child poverty, we found on average that every 5 percentage-point increase in FMAP was associated with a 1.3 percentage-point increase (p<0.001) in public program enrollment, and with a decrease of 0.3 percentage points in the child uninsurance rate (p=0.057). Based upon these models, we estimate that the decrease in FMAP set to occur in June 2011 will be associated with a decrease in enrollment of 2.7 percent, or more than 700,000 children.

CONCLUSIONS: Medicaid and CHIP have been a safety net for children over the last decade, providing broader coverage for children as number of children living in poverty has increased. Our findings demonstrate increased FMAP is associated with increased enrollment in public programs. The scheduled decrease in FMAP in 2011 may result in the first decrease in Medicaid/CHIP enrollment in over a decade.

Key words: Medicaid, Children’s Health Insurance Program,
Implications of Neonatal Abstinence Syndrome for Health Care Utilization and Expenditures

BACKGROUND: Neonatal abstinence syndrome (NAS), a withdrawal from narcotics after birth, results in substantial morbidity. Yet, the predominant clinical features of NAS have not been previously described in a national sample. Furthermore, the impact of NAS on our nation’s health care system and public programs like Medicaid has not been previously described.

PURPOSE: To determine (1) clinical features, (2) health care utilization and charges associated with neonatal abstinence syndrome in a recent national sample of US births.

METHODS: We utilized data from the Agency for Healthcare Research and Quality’s Healthcare Cost and Utilization Project Kids’ Inpatient Database (KID) for the year 2009 (most recent year available). Our analysis was limited to newborns on the basis of diagnosis related group codes from hospital discharge data. We examined the frequency and characteristics of newborns diagnosed with NAS, and other newborn diagnoses were identified using ICD-9 diagnosis codes; patient and hospital characteristics and hospital charges were provided in the KID. Hospital charges were converted to costs using cost-to-charge ratios provided by AHRQ; where missing, data were imputed to inform aggregate statistics. Chi-square and multivariable logistic regression analyses were conducted and are reported with nationally weighted data to permit national inferences.

RESULTS: In 2009, approximately 4.2 million discharges met criteria for study inclusion; 13,758 newborns (3.3 per 1000 discharges) were diagnosed with NAS. Compared to newborns without NAS, those with NAS were significantly more likely to be low birthweight (OR=3.2; 95% CI: 3.0-3.5) and to have seizures (OR=10.3; 8.7-12.2) or a respiratory complication (e.g., respiratory distress syndrome or transient tachypnea of the newborn; OR=3.1; 2.8-3.4). The majority of newborns with NAS were discharged from urban (89%), non-children’s hospitals (81%) and teaching hospitals (54%). Infants diagnosed with NAS accrued mean hospital costs of $19,200 (95% CI: $18,000-$20,400), compared to $996 ($970-$1,022) for uncomplicated term infants. Compared with private insurance, Medicaid coverage (OR=5.1; 4.6-5.7) or lack of insurance (OR=3.6; 3.1-4.1) were strongly associated with the diagnosis of NAS, even after controlling for family income. Aggregate national hospital costs for all newborns diagnosed with NAS were $288 million ($258M-$318M) in 2009, including $225 million ($198M-$251M) as Medicaid expenditures, (78% of the total, despite the fact that newborns on Medicaid comprise only 46% of all newborn discharges).

CONCLUSIONS: In this national sample, newborns with NAS differ significantly from other neonates in their comorbid diagnoses and health care utilization. Hospital expenditures for NAS care are borne disproportionately by state Medicaid programs. Initiatives to prevent NAS and improve care for NAS may lead to reduced morbidity and corresponding savings for the health care system—particularly for public payers.

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Implementing a Primary Care-Based Teleretinal Screening Protocol for the Los Angeles County Safety Net

BACKGROUND: Diabetic retinopathy is a leading cause of blindness in US adults, affecting over 5.3 million Americans over age 18. However, severe vision loss from diabetic retinopathy can be reduced up to 94% by timely treatment with laser photoagulation. Implementation of teleretinal screening with fundus cameras in primary care settings has the
potential to address the current long-standing wait times of 6-9 months for diabetic retinopathy screening examinations in the Los Angeles County (LAC) safety net by eliminating the need for referral to eye care specialists for those patients without evidence of retinopathy on the fundus photograph.

**PURPOSE:** The purpose of implementing teleretinal screening in the LAC safety net is to increase the proportion of patients screened and to improve timely access to ophthalmic care for those who need further evaluation, treatment, or close monitoring for diabetic retinopathy.

**METHODS:** This project will examine the impact of implementing a primary care based teleretinal screening program on number of diabetics screened and time to definitive diagnosis and treatment for those with evidence of retinopathy. Phase one includes: assessing clinic access to fundus cameras; implementing an 8hr training program for fundus photographers (LVN/MA level) and recruiting as needed; selecting and refining the software platform for transmitting teleretinal images; developing a protocol for image evaluation including title/status of readers and reimbursement; and establishing triage mechanisms for abnormal screening photographs integrated with the LAC specialist referral system. The primary endpoint for phase two, evaluation, will be change in wait time from referral to definitive treatment for diabetic retinopathy before and after implementation of teleretinal screening. After implementation, wait times will be stratified by diagnosis for severity of retinopathy and compared to suggested time to treatment in the American Academy of Ophthalmology Preferred Practice Pattern. In preparation for implementing this program, we are conducting a pilot project at six candidate clinics in South Los Angeles to better estimate the proportion of patients screened with fundus photos meeting criteria for specialty care.

Results from this pilot, described below, inform the next phases of implementation and evaluation outlined above.

**RESULTS:** In 6 months of our pilot study, 231 of 1028 patients (22.5%) screened needed an ophthalmic referral and 58 (6%) were in need of possible treatment for diabetic retinopathy. Therefore, 797 of 1028 (77.5%) had normal exams and were removed from the queue waiting for ophthalmology appointments, while those 6% with severe, treatable disease were flagged for expedited referral.

**CONCLUSIONS:** The initial results of our pilot study suggest that integrating teleretinal screening into the primary care visit is likely to eliminate the need for separate visits to eye care providers for those with normal fundus photos, which will preserve this scarce resource for those who need care and are currently facing long wait times. We expect that primary care-based teleretinal screening will increase the quality, efficiency, and scope of diabetic eye care in the LAC safety net and ultimately enable more timely access to treatment for those in need.

**KEY WORDS:** diabetes, retinopathy, telemedicine

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bivariate analyses, subscribers text-messaged more frequently and were more sexually active than non-subscribers.

Intention-to-treat analyses did not reveal outcome differences between the groups, likely due to limited uptake of the Hookup within the intervention group. However, in multivariate treatment-received analyses controlling for known baseline differences, students who subscribed to the Hookup had significantly greater increases in overall sexual health knowledge based on eight true-false items related to selected weekly text messages. In addition, overall self-efficacy increased significantly more among subscribers than non-subscribers. Among the components of the self-efficacy scale, subscribers gained more confidence in getting condoms if needed, tended towards having more confidence in discussing the decision to have sex with a partner, but were not more likely to feel that they would be able to use condoms every time if they were going to have sex. Among students who were sexually active, subscribers and non-subscribers did not differ in use of condoms at last sex or intention to get screened for STIs after the intervention. Changes in intentions to have sex among non-sexually active students were proportionally the same in both groups, increasing about 50%.

CONCLUSIONS: This study demonstrated that a simple sexual health text-messaging service may have a positive impact on teens’ sexual health knowledge and self-efficacy, though changing ultimate behaviors may be more challenging. Examining and addressing barriers to uptake of the Hookup, lengthening the intervention period, and limiting cross-over effects between study groups may improve future studies of the Hookup’s impact and might increase observed effects. Furthermore, determining the potentially different utilities of a preventive sexual health tool for adolescents with varying levels of sexual experience may be important.

KEYWORDS: adolescents, sexual health, text-messaging

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Tough Choices: Exploring Decision-Making for Pregnancy Prevention Among Girls in the Juvenile Justice System

PURPOSE: An estimated 2.18 million juveniles are arrested annually in the U.S., 29% of whom are female. Correctional medicine has long overlooked the reproductive health needs of incarcerated women. A 2003 survey of incarcerated adolescent females found that, although 94% were sexually active, only 37% had used a reliable contraceptive method in the month prior. Little is known about the pregnancy prevention decision-making of this group. We conducted qualitative research in partnership with GirlsGangs, a community organization which provides programs for girls in the juvenile justice system both during time served in juvenile camps and on probation in the community. We investigated the factors that influence these teens’ decisions to either prevent pregnancy or become pregnant. These data will guide intervention development for gender-specific programming in juvenile re-entry services.

METHODS: 20 adolescent females were recruited from Girls Gangs programs for girls re-entering the community. Stratified purposive sampling was used to achieve a balance of Hispanic and African-American adolescents who have and have not been pregnant. In-depth 60-minute semi-structured interviews were used to gather data in order to generate hypotheses regarding decision-making for pregnancy prevention. Iterative analysis during data collection was used to identify themes and assess for saturation. Preliminary findings are reported from analysis of notes and audiotapes taken during the interviews.

RESULTS: Participants described a strong sense of personal agency, self-reliance, and decision-making capacity regarding intimate relationships and sexual behaviors. They also identified motivations to prevent pregnancy, including the poor economic climate and expectations of both a loss of freedom and a life of hardship which would result from motherhood. At the same time, however, participants expressed a sense of fatalism and lack of control with respect to pregnancy and childbirth. They described an absence of trusted adults and social networks with which to discuss pregnancy prevention and life planning. Finally, they described influences of male partners, whose lack of respect, inadequate emotional and economic readiness, and coercive behavior made pregnancy both less desirable and more likely. Personal agency regarding sexual behaviors often co-existed with fatalism regarding pregnancy; and both emerged as part of the discussion low levels of contraceptive use, suggesting a possible causal link.

CONCLUSIONS: Girls in the juvenile justice system have high
rates of sexual activity, and several factors may exacerbate challenges to healthy sexual behaviors. Social isolation is pervasive and may be worsened by high rates of recidivism and lack of adult role models. This insecurity may also contribute to their fatalism and perceived lack of control. Male partners may coerce teens into making child-bearing decisions that contradict their own interests and life plans. We also identified, however, strengths upon which interventions might build. Most participants were able to identify multiple motivators for pregnancy prevention, including personal agency and self-reliance with respect to sexual behaviors. These may represent opportunities for empowerment-focused programming aimed at extending agency beyond sexual behaviors to include decisions about pregnancy, relationships, and broader life goals.

KEYWORDS: community-partnered research, adolescent health, sexual health, contraception

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PURPOSE: Optimal timing of the first operative debridement for open tibial fracture (OTF) to avoid limb amputation has not been determined. We used national data to characterize patterns of timing of first operative debridement in patients with OTF and examined whether there is a relationship between timing of first operative debridement and amputation.

METHODS: Data were analyzed from the Nationwide Inpatient Sample, 2003–2008, which are stratified probability samples of 20% of all non-federal hospital admissions from the majority of states. Patients were included if they had an ICD-9-CM diagnosis code for OTF. Patients were excluded if age < 18 years, if they were transferred from or to another hospital, if more than one amputation was performed, if debridement timing was unspecified, or if patients were treated at a facility that did not perform any amputations in the sample. We evaluated the association between timing of the first operative debridement and the outcome of amputation using a multiple logistic regression model, adjusted for clustering by hospital. We controlled for hospital characteristics, patient characteristics, and clinical risk factors for amputation including comorbidities, overall injury severity score, mechanism of injury, and associated lower extremity injuries (artery, nerve, complex wound, dislocation, and need for fasciotomy).

RESULTS: Of 7,108 patients with OTF at 188 hospitals, 3.9 percent (n equals 278 patients) underwent amputation during their hospitalization. The majority of patients (56.0%) underwent first operative debridement on hospital day 0 or 1. A smaller proportion of patients underwent first debridement between hospital day 2–7 (14.8%) and beyond 1 week after admission (4.5%). Nearly one-quarter of the patients (24.8%) did not have debridement coded, aside from an amputation (if performed). In analyses adjusted for patient and hospital characteristics as well as clinical risk factors, timing of first operative debridement on hospital day 4 or later is associated with more than three times greater odds of amputation (days 4–5 odds ratio [OR] 3.5, 95% CI 1.80–6.72, days 6–7 OR 3.6, 95% CI 1.65–7.77, and >1 week OR 8.2, 95% CI 4.87–13.70). Having no debridement coded was also associated with higher odds of amputation (OR 3.0, 95% CI 2.04–4.38). When the analysis was repeated excluding 101 patients having amputation on the day of admission, delaying the first debridement more than 24 hours after admission had significantly higher odds of amputation for each day that debridement is delayed.

CONCLUSIONS: Delay of first operative debridement is associated with a significantly increased probability of amputation in patients with OTF. If the decision to perform an amputation is not made soon after admission in patients with severe lower extremity trauma, early operative debridement appears to be associated with limb preservation. A future study of practice patterns of debridement at the hospital level is needed to determine if delay of debridement is associated with contextual clinical factors.

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Fall Related Disability in Previously Non-Disabled Older Adults Aged 65-69 in the United States: A 10-Year Longitudinal Analysis

BACKGROUND: Recent evidence suggests that the declining disability trend in older adults may be reversing, particularly among the “young elderly” (60-69 years old). More information about fall related disability in this group could help clinicians and healthcare systems prioritize and target fall prevention efforts.

PURPOSE: The purpose of this study was to examine falls and disability over a 10-year period (1998-2008) in a nationally representative cohort of previously non-disabled community dwelling older adults (aged 65-69 at baseline). We hypothesized that multiple falls without injury, and falling with injury would be independently associated with subsequent disability.

METHODS: A nationally representative cohort of non-disabled community dwelling older adults aged 65-69 at baseline was followed biennially for 10 years. The primary disability outcome was defined as at least one limitation in 11 activities of daily living (ADL) or instrumental activities of daily living (IADL). Respondents were categorized into four fall status categories at the beginning of each 2-year survey period: no falls in the prior 2 years, one fall without injury in the prior 2 years, at least 2 falls without injury in the prior 2 years, and at least one fall with injury in the prior 2 years. We specified a repeated measures clustered logistic regression model with time-varying covariates to evaluate the impact of fall status on subsequent disability for each 2-year period. We used the results of this model to simulate a hypothetical fall prevention program.

RESULTS: Experiencing one fall with injury in the prior 2 years (OR=1.41, p<0.05), at least 2 falls without injury in the prior 2 years (OR=2.25, p<0.001), or at least 2 falls with at least one injury in the prior 2 years (OR=3.82, p<0.001) were independently associated with higher rates of subsequent disability after adjustment for socio-demographic, clinical, and functional covariates. In the simulation analyses, we found that reducing fall frequency among all individuals with at least 2 falls without injury or at least 2 falls with at least one injury during the prior 2 years was associated with a potential reduction in disability of 9% and 15%, respectively (p<0.001). When assuming program effectiveness of 13% (RRR=0.87), the corresponding reduction in disability was 1.2% (NNT=83) and 2% (NNT=50).

CONCLUSIONS: Falling, both with and without injury, is an important risk factor for disability among older adults aged 65-69. Since falls are common and preventable, fall prevention programs targeting the young elderly may be an important strategy for preventing disability in this group.

KEYWORDS: Falls, older adults, disability, prevention

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Prenatal Care Utilization Patterns Among Refugee Women

PURPOSE: To partner with the only clinic in the United States that exclusively focuses on the reproductive health needs of refugee women. In order to provide data to inform this clinic’s outreach strategies, we intend to: 1) examine patients’ prenatal care utilization patterns; 2) identify potential patient characteristics associated with inadequate utilization; and, 3) explore potential cultural issues, facilitators, and barriers affecting when refugee women seek care.

BACKGROUND: A growing proportion of refugees are entering the United States, many of whom are women of reproductive-age. Evidence suggests that refugee women are at higher risk for inadequate prenatal care utilization and poor obstetric outcomes. The Refugee Women’s Health Clinic (RWHC) was founded in 2008, by a former RWJF Clinical Scholar, Dr. Crista Johnson, to address the disparities in reproductive health outcomes among the growing refugee population in Phoenix, AZ. The clinic has identified inadequate prenatal care utilization among their patients as an area of concern they wish to address. In line with using evidence-based quality improvement (EBQI) techniques, additional data is needed to further define this problem as a foundation for formulating optimal strategies to address it.

METHODS: Our overall approach will be a partnered design and analysis, using mixed methods, with emerging findings guiding subsequent waves of data collection and program de-
Development. To examine prenatal care utilization patterns and identify patient characteristics associated with inadequate utilization, we will review the medical records of all adult clinic patients seen since 2008. The primary outcome variable will be prenatal care utilization as measured by the Adequacy of Prenatal Care Utilization (APNCU) Index, which assesses prenatal care utilization using month of initiation of care and total number of visits, adjusted for gestational age. We will assess for associations between the APNCU Index categories and such categories as: patient age, race/ethnicity, marital status, use of transportation services, involvement in the Women, Infants, and Children’s (WIC) program, and insurance status. We will conduct focus groups with the largest ethnic groups served by the RWHC (refugee women from Burundi, Burma, and Somalia) to gain cultural insights into the facilitators and barriers influencing women’s prenatal care utilization.

PRELIMINARY RESULTS: One hundred and thirty-six refugee women presented to the clinic for care between December 12, 2008 and January 1, 2011. The majority of women were from Somalia [28(20.6%)], Burma [25(18.4%)], and Burundi [18(13.2%)]. The remaining women were from other countries in Africa [38(27.9%)], the Middle East [11(8.1%)], South Asia [13(9.6%)], and Southeast Asia [3(2.2%)]. Further preliminary results, from both the chart review and the focus groups, will be available in November 2011.

CONCLUSIONS: We have been able to develop a partnered research and EBQI project with a unique clinic serving refugee women. We have successfully engaged both community and clinic stakeholders to identify an issue they want to address and formulate a research plan to further delineate this issue. This constitutes a unique, partnered EBQI and case study resource for women’s health in refugee communities and is expected to lead to further research and program development.

KEY WORDS: refugee, pregnancy, prenatal care utilization, APNCU Index


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Emergency Department Information System Use and Support of Meaningful Use Criteria

PURPOSE: The Centers for Medicare and Medicaid Services created “meaningful use” objectives describing specific functionality hospital information systems must include to qualify for federal incentives. Since emergency department information systems (EDIS) help meet the requirements for meaningful use, we sought to describe the latest EDIS adoption rates across U.S. emergency departments (EDs) and their support for six core meaningful use criteria.

METHODS: We conducted a secondary data analysis of the 2005-2008 National Hospital Ambulatory Medical Care Survey (NHAMCS), the most recently available with EDIS data. NHAMCS provides a nationally representative sample of all U.S. ED visits. EDIS usage data were collected by interviews with hospital administrators. EDIS adoption rates were determined by a question asking whether the ED had a complete (all electronic), partial (part electronic and part paper-based), or no EDIS. Respondents are also asked about specific EDIS features, including six that are required for meaningful use: patient demographics, computerized physician order entry (CPOE), drug interaction checks, intervention reminders, public health reporting, and problem lists. Descriptive statistics were calculated using survey weights to produce unbiased, national estimates. We will also perform a trends analysis of EDIS adoption along with a multivariate model examining the influence of urban and teaching status. This is yet to be completed.

RESULTS: As of 2008, 72% of U.S. EDs had some type of EDIS in place. However, less than 25% reported completely electronic systems and 28% reported no EDIS. In EDs, support for meaningful use components, included patient demographics (92%), problem lists (41%), CPOE (47%), public health reporting (30%), drug interaction checks (34%), and intervention reminders (32%). Only 7.5% of EDs supported all six core “meaningful use” features surveyed by NHAMCS.

CONCLUSION: In 2008 over a quarter of EDs did not have any EDIS and most reported incomplete systems. A minority of EDIS contain key meaningful use features. Results support the need for more alignment between hospitals and EDs to increase EDIS functionality and careful monitoring of the effect of this rapid transition on quality of care.

KEY WORDS: Health Information Technology, Technology Adoption, Meaningful Use, Emergency Department a

AUTHORS: Anand R Shah, MD, Philadelphia VA Medical Center, University of Pennsylvania; Adam Landman, MD, MS, Brigham and Women’s Hospital; Joshua P Metlay, MD, PhD, University of Pennsylvania; Karin Rhodes, MD, MS, University of Pennsylvania
Which Terminally Ill Patients and Their Caregivers Value High-Cost, but Modestly Effective Therapies? Preferences for Riluzole use in Amyotrophic Lateral Sclerosis (ALS)

BACKGROUND: Understanding what therapies patients with terminal illness and their families find most valuable may allow insurers to customize coverage and ensure resources are used for maximal benefit. Riluzole, the sole drug approved for treatment of ALS, provides on average, an additional 3 months of life and costs $1000/month. Despite the high cost, little is known regarding how ALS patients/caregivers value riluzole compared to supportive therapies for ALS.

PURPOSE: In this study, we evaluated patient and caregiver perceptions of the relative importance of riluzole compared to 4 other major categories of supportive therapy: durable medical equipment (DME), home services, home modifications and medications for symptom management.

DESIGN: We surveyed ALS patients and their caregivers receiving care at the Penn Comprehensive Neuroscience Center. Information was collected regarding riluzole use, out-of-pocket costs, financial strain, quality of life, disease severity and, for patients not taking riluzole, reasons for forgoing the medication. Patient and caregiver preferences were measured in two ways: first, participants were asked to order categories of therapy according to importance (from 1-5, with 1 = most important) using cards representing each different category and second, participants were asked to distribute 15 poker chips among the categories according to importance.

RESULTS: We surveyed 98 patients and 71 caregivers. Among patients, 61% were male, 93% were white, and 70% of patients were taking riluzole. Doubts about efficacy (32%) and side effects (24%) were the most common reasons given for not taking riluzole.

Preferences regarding riluzole’s importance were polarized. For patients, 30% ranked riluzole as most important, while 33% ranked it as least important. Similarly, 25% of caregivers ranked riluzole as most important, while 35% ranked it least important. Patient-caregiver concordance was highest for riluzole ranking (weighted $\kappa = 0.55, p < 0.001$) and only fair-poor for other kinds of treatments ($< 0.41$). Overall, patients ranked DME as most important (mean rank= 2.33), followed by home modifications, riluzole, home services and other medications (mean rank=3.52). Latent class modeling revealed 2 classes of patients: one group preferred riluzole to all other therapies (with hazard ratios (HR) 0.10-0.22 for other therapies); in contrast, a second group preferred DME as most valuable (HR 15.2, $p < 0.001$ compared to riluzole). Multivariate logistic regression revealed that women and patients with private insurance were more likely to prefer riluzole, while patients with impaired ambulation were likely to prefer DME (AOR 0.15, CI 0.04-0.54, $p = 0.003$), over riluzole.

CONCLUSIONS: A majority of surveyed patients (70%) were using riluzole, but opinion regarding its importance relative to other supportive therapies for ALS was sharply divided in both patients and caregivers. Overall, patients and caregivers preferred durable medical equipment over other therapies, including riluzole. Our findings suggest certain patients may receive little value from riluzole and may prefer improved coverage for other therapies such as durable medical equipment.

AUTHORS: Amy Y. Tsou M.D., Judith Long M.D., Leo McCluskey M.D., Lauren Elman M.D., Katelin Hoskins B.S.N., Mark Cary Ph.D., Jason Karlawish M.D.
note and content of the conversation. JW duplicated extraction of initial 50 observations and then a random sample of 10% of remaining extractions. JW and PICU staff member (BB) independently reviewed all extracted PGOC conversations, with agreement of 87.5% regarding whether the documented content reflected PGOC intent. JW performed additional extraction of any observations to resolve disagreements. Using Feudtner’s ICD9 criteria for “complex chronic conditions” (CCC), JW determined if patients met criteria for CCC on admission. Using multivariate logistic regression, we determined if patient characteristics were associated with PGOC conversations. We performed multivariate linear regression controlling for physician heterogeneity (fixed effects) and time-to-event analyses among patients with documented PGOC conversations to determine if patient characteristics were associated with time from admission to PGOC conversation. With each additional day in the PICU, there was a significant increase in the likelihood of having a PGOC conversation documented (OR = 1.06; 95% CI 1.04-1.09). Nearly one-half (43%) of PGOC conversations overall and 48% of conversations in patients with CCC (n=48) were documented by PICU physicians; other subspecialties with more than 5 PGOC conversations in CCC patients included oncology (n=9), nephrology (n=9) and neurosurgery (n=6).

CONCLUSIONS: Only one-third of the most severely ill patients admitted to pediatric critical care had documented prognostic goals-of-care conversations. Even if PGOC conversations occurred but were not documented, lack of documentation limits the team’s knowledge of communication between health care providers and families. Although patients with CCC status are more likely to have an established relationship with a subspecialty provider, PGOC conversations are as likely or more likely to be addressed by PICU staff as by their primary subspecialty service.

KEY WORDS: pediatric intensive care, goals of care, complex chronic condition

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KAREN WANG
CSP 2010-2012 / YALE UNIVERSITY

Perspectives on Community-Based Participatory Research: Experiences of Community and University Researchers

BACKGROUND: The value of community-based participatory research (CBPR) to understand health inequities and create sustainable interventions is well known. In spite of several decades of using this approach, the diffusion and acceptance of CBPR has been slow in certain university-community contexts.

METHODOLOGICAL: In order to better understand the barriers to adoption of CBPR in a small, urban community in New England with existing university-community tension and whose university-community engagement in CBPR is relatively young, we are systematically assessing the experiences of community-based organization (CBO) personnel and university researchers involved in research relationships. The two lead co-researchers, one from a CBO and the other university-based, are using purposeful snowball sampling to recruit participants and perform key informant interviews of CBO personnel and university researchers in this urban community. The CBO co-researcher is interviewing CBO personnel, and the university co-researcher is interviewing university researchers with the intent to capture higher quality data. Interviews explore (1) the decision process to engage in a partnership, (2) the advantages and disadvantages for each party in the collaboration, and (3) skills and attitudes participants feel are needed for collaboration. Interviews are being audio-taped and professionally transcribed. Atlas.ti will be used to organize interview narratives. Our multidisciplinary team, including experts in organizational behavior, CBPR, and community organizations, will perform analyses of the interviews using the constant comparative method. Concurrently, the two lead co-researchers are meeting with the organizational psychologist on the team to reflect on their working relationship, since
we expect the relationship between the two co-researchers to mirror many of the characteristics of the relationship between the university and CBO.

**POTENTIAL CONTRIBUTIONS:** We hope to identify perceptions and experiences of CBOs and university researchers that will improve understanding of the elements of mutually satisfying CBPR relationships.

**AUTHORS:** Karen Wang, Natasha Ray, David Berg, Amy Carroll-Scott, Georgina Lucas, Marjorie S. Rosenthal

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**KATHERINE WATKINS**  
UNIVERSITY OF CALIFORNIA, LOS ANGELES 1996-1998

The Quality and Cost of Care for Veterans with Mental and Substance-Use Disorders

**SPECIAL REPORT:** U.S. veterans have elevated rates of serious mental health and substance-use disorders. In 2006, the VA commissioned a comprehensive evaluation of its mental and substance-use treatment system. The study addressed the following questions: (1) What is the cost and quality of mental health care received by veterans? (2) How does the quality compare with that delivered in the private sector? (3) How does quality vary across geographic regions of the United States and for different groups of veterans? To address these questions, we analyzed VA administrative data and conducted a 7,069 medical record reviews for veterans with one or more of five diagnoses (schizophrenia, bipolar disorder, PTSD, major depression, and substance-use disorders). We found the following: (1) Veterans in the Study Population Account for a Disproportionately Large Share of VA Service Use and Costs. Despite representing only 15% of the population, these veterans accounted for one third of all VA medical costs. (2) The Quality of VA Mental Health Care Is Generally as Good as or Better than Care Delivered by Private Plan. We compared VA performance with that of private providers serving a comparable civilian population. In nearly every case the VA had higher levels of performance. (3) Despite Comparing well to Private Providers, the VA did not Always Meet the Implicit Expectations Specified in its Own Performance Guidelines. Documented receipt of evidence-based practices (EBP) was well below reported capacity. No EBP was received by more than one third of eligible veterans. (4) The Quality of Care Varies Across Regions and Populations. We found variations across all the performance measures we examined, sometimes by as much as 25 percentage points. Implications Given the complexity and costs associated with these disorders, identifying ways to increase efficiency while improving quality is paramount. Moreover, even though the VA performed as well as or better than the private sector, the variations in care suggest that performance can improve.

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**KATHERINE YUN**  
YALE UNIVERSITY 2009-2011

Prevalence of Noncommunicable Chronic Conditions Among a Primary Care-Based Sample of Adult Refugees

**PURPOSE:** Data on the prevalence of noncommunicable chronic conditions among refugees are limited, as refugee health care has historically focused upon infectious disease screening and treatment. Refugee resettlement agencies and health care providers need additional information about chronic disease prevalence in order to design appropriate health promotion, clinical and case management services. In partnership with a refugee resettlement agency, we sought to determine the prevalence of chronic conditions among adult refugees seen at a hospital-based primary care center.

**METHODS:** Study aims and design were developed in consultation with our community partner, using principles of community-based participatory research. We conducted a retrospective medical record review for refugees seen at a hospital-based primary care center between January, 2006 and October, 2010. Patients were included if they were age 18 year or older at the time of arrival in the US and if they had at least one primary care visit during the study period (n = 180). Records from clinical sites outside of the hospital and clinic were not included. Consistent with other research, chronic conditions were defined as any disease that typically lasts for a year or more and requires ongoing medical attention and/or limits activities of daily living. Communicable conditions were excluded. We documented the proportion of refugees diagnosed with or treated for any chronic condition during the first eight months in the United States (the duration of federal refugee health insurance), as well as the number of chronic conditions per person. We also documented the proportion of refugees with risk factors for chronic disease: overweight, obesity, and tobacco use.
RESULTS: The median age of refugees in this sample was 31 years (range 25-40) and 53.4% were from Iraq. The prevalence of any noncommunicable chronic condition was 51.7%. The most common conditions were behavioral health problems (16.7%) and hypertension (12.2%). Among refugees with any chronic condition, 18.3% had three or more diagnoses. There was no difference in chronic disease prevalence by gender. One-third of the refugees in this sample were overweight (32.4%), 22.7% were obese, and 28.9% reported tobacco use. Women were more likely than men to be obese (33.3% vs. 15.2%, P<0.001) and men were more likely to report tobacco use (44% vs. 11.4%, P<0.001). Nearly two-thirds (61.1%) of the refugees in this sample were adults without dependent children, a cohort who are largely excluded from means-tested public benefit programs.

CONCLUSIONS: Despite being a young population, adult refugees seen at this primary care center have a high burden of noncommunicable chronic conditions. Risk factors for poor health are also prevalent. Weight management and tobacco cessation are important targets for clinical services and community-based health promotion. Clinical services should include routine screening for behavioral health conditions, as well as resources for ongoing behavioral health care. Programs are needed to ensure that refugees with chronic conditions maintain access to health care subsequent to the expiration of federal refugee health insurance.

ADDITIONAL AUTHORS: Katherine Yun, MD, Yale School of Medicine; Kelly Hebrank, IRIS - Integrated Refugee Immigrant Services; Lauren Graber, Yale School of Medicine; Mary-Christine Sullivan, MSN, MPH, Yale School of Nursing; Irene Chen, Yale School of Public Health; Jhumka Gupta, ScD, MPH, Yale School of Public Health
Common Interest Sessions

Thursday, November 10 • 1:45 pm - 2:45 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.

1. Health Care Challenges Related to Robotic Surgery
   Charlene Hooper (Yale)
   The purpose of this group will be to discuss the expansion of robotic surgery in the United States and its impact on health care costs, delivery, surgeon training and patient outcomes. Participants can exchange ideas for areas of needed research, professional standards and quality assurance in this field.

2. School-based Interventions and Partnerships
   Ray Perry (UCLA), Deepa Camenga (Yale)
   Rebecca Dudovitz (UCLA)
   Many scholars, alumni and faculty work with schools through their work as researchers, community leaders, advocates and clinicians. During this session, we will share our experiences as physicians partnered with schools, and discuss strategies for strengthening our relationships with them. Additionally, we will discuss the benefits and the challenges of intertwining research into the school setting.

3. HIV and Substance Abuse Interest Group
   Oni Blackstock (Yale), Deepa Camenga (Yale)
   Jen Edelman (Yale), Karen Wang (Yale)
   The goals of the interest group would be to provide Scholars the opportunity to share with one another ongoing research and project ideas related to HIV, substance abuse, or the intersection of these closely aligned fields, as well as to potentially collaborate on future projects and discuss career pathways. Possible discussion topics for this session include the medical home/co-location of primary care and substance abuse treatment services for HIV-infected patients.

4. Nudging People To Eat Less and Be More Active
   Lenny Lesser (UCLA), Jeff Kullgren (Penn)
   Individuals’ home and work environments promote sedentary behaviors and consumption of excess calories. This session will discuss novel policy approaches to promote a healthier energy balance. Topics will include pricing incentives, advertising policy, default options, restaurant/food grading, calorie labeling, and other behavioral economic approaches.

5. How to Use Popular Culture and Media to Improve Health
   Tammy Chang (Michigan)
   If McDonald’s, Starbucks, and the NBA can do it, why can’t we? This session will focus on methods to influence popular culture and media to improve health, including what has been tried, how to measure outcomes, and what kind of funding might exist to do this type of work.

6. Off-Site Policy Experiences
   Anand Shah (Penn), Clara Filice (Yale)
   Gregg Furie (Yale)
   This session will focus on discussing opportunities available to scholars interested in pursuing off-site policy experiences during or after their fellowship.
7. RWJF CSP Global Health Interest Group: How Does a Global Perspective Help us Solve Domestic Health Issues? Sidney Coupet (Michigan), Nurit Harari (Yale)

This session will allow scholars and mentors to explore domestic health issues in a global context by using lessons learned through international health experiences.

8. Health Reform and the Underserved: Will We Be Ready? Robin Clarke (UCLA), Michael Hochman (UCLA) Katherine Neuhausen (UCLA), Yoshi Laing (UCLA)

In 2014, many millions of Americans from lower-income tiers who currently are uninsured will receive health insurance coverage through the Affordable Care Act. Many of these will covered by an expansion of Medicaid. Many questions remain about how the system will adjust to provide care to these previously underserved. How do we expand capacity to cover these patients? Is the Medicaid reimbursement hike sufficient to induce providers to take care of them? What is the role of previous safety net providers like community health centers and public facilities? How do we educate patients about their new level of choice?

9. The Doctor Will See You Now: A Discussion on Access to Care Adam Sharp (Michigan), Alan Teo (Michigan) Kathy Auger (Michigan)

Potential Topics for Discussion:
• Defining access
• Research approaches to evaluate access
• Disparities and inequities
• Barriers to care
• Potential health care reform implications
• Examples of efficient systems
• Comparison of access by treatment setting (i.e., Inpatient, outpatient, ED…)
• Workforce effects on access (i.e., physician vs non-physician providers and their roles)
• Cost effectiveness in providing appropriate access

10. Linking Community Settings with Hospitals and Institutions to Improve Outcomes Nishant K. Sekaran (Michigan)

This session will focus on better structuring policies to link the hospital/institutional and community environments to improve functional outcomes for older adults.
## Community-Based Approaches to Improving Health

1. **Eugenia Garvin**  
   (Penn 10-12)  
   A Pilot Randomized Controlled Trial of Vacant Lot Greening and Violence Related Outcomes

2. **Lenard Lesser**  
   (UCLA 09-12)  
   Rating Fast Food by Calories Purchased: Is Subway Healthier than McDonald’s?

3. **Karen Wang**  
   (Yale 10-12)  
   Perspectives on Community-Based Participatory Research: Experiences of Community and University Researchers in Partnerships

## Screening and Prevention

1. **Rebecca Dudovitz**  
   (UCLA 09-12)  
   Evaluation of a Conceptual Model for Substance Use Prevention

2. **E. Jennifer Edelman**  
   VA Scholar (Yale 09-12)  
   Project C.O.A.C.H.: Counseling Others About Contacts and Exposures with HIV

3. **Gregg Furie**  
   VA Scholar (Yale 10-12)  
   Association Between Active Transport and Cardiovascular Disease Risk Factors

4. **Manny Jimenez**  
   (Penn 10-12)  
   Understanding Barriers to Evaluation for Early Intervention Services

5. **Christoph Lee**  
   (UCLA 10-12)  
   Patients’ Willingness to Provide a Bio Specimen for Genetic Research at Screening Mammogram

## Health Care Disparities

1. **Medell Briggs-Malonson**  
   (UCLA 09-12)  
   Hospitals at Risk? Race and Socioeconomic Predictors of Hospital Readmissions in California

2. **Rosette Chakkalakal**  
   (Yale 10-12)  
   Do Improvements in Race/Ethnicity Data Collection Affect Knowledge of Healthcare Disparities? The Case of Asian Americans and Acute Myocardial Infarction

3. **Shreya Kangovi**  
   VA Scholar (Upenn 10-12)  
   The Patient-Centered Transition (PACT) Project: Improving the Transition from Hospital to Primary Care for Socioeconomically Vulnerable Patients

## Vulnerable Populations

1. **Mana Golzari**  
   (Penn 10-12)  
   Perspectives of Adolescents in the Juvenile Justice System Regarding Recidivism

2. **Eric Hodgson**  
   (Yale 10-12)  
   Understanding the Knowledge, Attitudes, and Beliefs Regarding Contraception Use Among Adult, African American Women at Risk for Undesired Pregnancy

3. **Erin Saleeby**  
   (UCLA 10-12)  
   Tough Choices: Exploring Decision-Making for Pregnancy Prevention Among Girls in the Juvenile Justice System

4. **Luwam Semere**  
   (UCLA 10-12)  
   Prenatal Care Utilization Patterns Among Refugee Women
**Second & Third Year Poster Presentations: Session B**

**WEDNESDAY, NOVEMBER 9TH  |  5:00 PM – 6:00 PM**

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<th>ROOM</th>
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| ➊ Jed Barash  | VA Scholar (Yale 10-12)  
Elevated Incidence of Diagnosed Creutzfeldt-Jakob Disease: Veterans Health Administration System, Fiscal Years 1997-1998 | ➊ Robin Clarke | (UCLA 10-12)  
Medical Home Recognition and Diabetes Quality of Care in Community Health Centers |
| ➋ Deepa Camenga | (Yale 09-12)  
Incidence of Genital Warts Among Adolescents and Young Adults Prior to the Introduction of the Human Papillomavirus (HPV) Vaccine | ➋ Clara Filice | (Yale 10-12)  
Pandemic Planning in Pediatric Emergency Departments: Surge Experiences During the 2009 H1N1 Influenza Pandemic |
| ➌ Zachary Goldberger | (Michigan 10-12)  
Are Longer Resuscitation Efforts Associated with Improved Survival During In-Hospital Arrest? | ➌ Michael Hochman | VA Scholar (UCLA 10-12)  
Implementation and Evaluation of a Patient-Centered Primary Care Intervention Involving Telephone Triage, Urgent Care Access, and Expanded Case Management at a Safety-Net Clinic |
| ➍ Kalpana Narayan | (Penn 10-12)  
The Role of Caregivers in the Emergency Department and their Relationship with Patient Satisfaction, Disposition and Follow-up | ➍ Dawn Mautner | (Penn 10-12)  
Super Utilizers: A Cross-sectional Interview Study Who are the Highest Utilizers of our Health Care System? |
| ➋ Erika Sears | VA Scholar (Michigan 10-12)  
Relationship Between Debridement Timing and Amputation in Patients with Open Tibial Fracture: A National Study | ➋ Stephen Patrick | (Michigan 10-12)  
Federal Medical Assistance Percentage Policy and Medicaid/Chip Enrollment for Children |
| ➋ Nishant Sekaran | (Michigan 10-12)  
The Effect of Falling on Disability in Previously Non-Disabled Community Dwelling Older Adults Aged 65-69: A 10 Year Longitudinal Analysis | ➋ Stephen Patrick | (Michigan 10-12)  
Implications of Neonatal Abstinence Syndrome for Health Care Utilization and Expenditures |
| ➋ Jennifer Walter | (Michigan 10-12)  
Factors Associated with Prognostic Goals-Of-Care Conversations for Critically Ill Children | ➋ Anand Shah | VA Scholar (Penn 10-12)  
Emergency Department Information System Use and Support of Meaningful Use Criteria |
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.

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The National Advisory Committee of the Robert Wood Johnson Foundation 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.

A special thanks to Drs. Britt, Fuentes-Afflick, Green and Saha for their time and energy as NAC members. Their teams are ending this December, but we know they will remain in the Clinical Scholars family.
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Participating Universities & Community Partners

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.

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  - UCLA Robert Wood Johnson Foundation Clinical Scholars program

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- Michele Heisler, MD, MPH
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- Matthew M. Davis, MD, MAPP
  - Co-Director
  - Michigan Robert Wood Johnson Foundation Clinical Scholars Program

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- Loretta Jones
  - CEO of Healthy African-American Families

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- Zachary Rowe
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Joshua Metlay, MD, PhD
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Detective,  
New Haven Police Department
The Robert Wood Johnson Foundation

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 M.D., M.P.H., Director Human Capital and Clinical Scholars Senior Program Officer
- John Lumpkin M.D., M.P.H., 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.

IN ATTENDANCE

David Krol M.D., M.P.H.
Director Human Capital and Clinical Scholars
Senior Program Officer

Risa Lavizzo-Mourey M.D., M.B.A.
CEO and President

Willard D. “Bill” Nielsen
RWJF Trustee

Christine Phares
Grants Administrator

For more information, visit: www.rwjf.org

You can sign up to receive e-mail alerts on upcoming Foundation Calls for Proposals at:

www.rwjf.org/services
Medell Briggs-Malonson  
VA Scholar  
University of California Los Angeles  
**Research Interests:** Racial and socioeconomic health disparities, community health program development, and emergency health services accessibility. Develop a community-based health program to decrease preventable heart failure related emergency department visits and hospitalizations among African-Americans.

Deepa Camenga  
Yale University  
**Research Interests:** Adolescent smoking cessation; adolescent vaccination; experiences of low income adolescents and young adults as they transition from pediatric to adult care.

Alejandra Casillas  
University of California Los Angeles  
**Research Interests:** The health of Latino immigrants—primarily women’s health issues (breast and cervical cancer screening; STD education) and exploring the trauma and stigma of immigration to the US and how this impacts health care utilization and perceived health needs. She is also interested in studying the use of Spanish-speaking media to develop educational tools on prevalent chronic medical problems in the Latino population.

Rebecca Dudovitz  
University of California Los Angeles  
**Research Interests:** Improving academic performance in school age children. Academic success is associated with positive health outcomes and improving high school graduation rates can have a large impact on our children’s futures. She is interested in better understanding this relationship between health and education and on finding ways to improve educational outcomes for students in high-risk populations.

E. Jennifer Edelman  
VA Scholar / Yale University  
**Research Interests:** Primary and secondary HIV prevention, including the intersection with substance abuse.

Stephen Henry  
VA Scholar / University of Michigan  
**Research Interests:** Understanding and improving face-to-face communication in health care. Improving communication about pain in primary care, including efforts to reduce racial disparities and improving quality in pain management.

Sophia Jan  
University of Pennsylvania  
**Research Interests:** 1. Healthcare transition for adolescents and young adults with chronic illness; 2. Improving quality of care and safety across pediatric and adult institutions; 3. Improving quality of care for children with complex medical condition.
Robert Wood Johnson Foundation
Clinical Scholars

3RD YEAR CLINICAL SCHOLARS | 2009-2012 Cohort

Jeffrey Kullgren
VA Scholar
University of Pennsylvania
Research Interests: Access to care, health incentives, insurance benefit design, health behaviors.

Elise Lawson
VA Scholar
University of California Los Angeles
Research Interests: Methods of surgical quality measurement, use of quality improvement methodologies (six sigma, lean, etc) in a surgical setting, and improving shared decision making between surgeons and patients through the use of appropriateness criteria.

Lenard Lesser
University of California Los Angeles
Research Interests: Behavioral economic interventions that nudge people to eat less; effects of marketing on obesity; quantifying the food marketing environment; conflicts of interest in nutrition research and policy; sugary beverages and health; insurance coverage for preventive services.

Demetria Malloy
VA Scholar
University of California Los Angeles
Research Interests: Racial and socioeconomic health disparities, provider-patient communication and medical adherence issues. She is investigating the impact food environment has on the burden of chronic disease. She is also constructing and testing a community-based feasibility pilot of a medication adherence program for African-American veterans.

Raymond Perry
University of California Los Angeles
Research Interests: Adolescent sexual health, use of new media resources for health promotion, racial and gender disparities in adolescent health outcomes and healthcare utilization, school health programs.

Amy Tsou
VA Scholar
University of Pennsylvania
Research Interests: Improving patient provider communication, impact of cultural, religious and economic factors on end of life care, influence of media on healthcare utilization.
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<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Research Interests</th>
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<tbody>
<tr>
<td>Jed Barash</td>
<td>VA Scholar / Yale University</td>
<td>Prion diseases, particularly Creutzfeldt-Jakob disease.</td>
</tr>
<tr>
<td>Oni Blackstock</td>
<td>VA Scholar / Yale University</td>
<td>HIV prevention and treatment among communities of color, particularly women of color, as well as assessing health care needs and improving health outcomes for women from vulnerable populations (HIV+ and at-risk women, female Veterans, and women of color).</td>
</tr>
<tr>
<td>James Burke</td>
<td>VA Scholar / University of Michigan</td>
<td>How physicians use diagnostic test information—the relationship between diagnostic test utilization and outcomes.</td>
</tr>
<tr>
<td>Rosette Chakkalak</td>
<td>Yale University</td>
<td>Immigrant health and exploring limitations of data collection as they relate to knowledge and awareness of the health of minority populations.</td>
</tr>
<tr>
<td>Robin Clarke</td>
<td>University of California Los Angeles</td>
<td>Developing standardized evaluations of primary care practices that encourage more satisfactory and higher value care. He is testing whether the existing practice assessments accurately and appropriately evaluate the care delivered by community health centers. He hopes to describe what practice components best define a patient-centered medical home within the safety net.</td>
</tr>
<tr>
<td>Clara Filice</td>
<td>Yale University</td>
<td>Health policy, the built environment and injury prevention, pediatric access to care, insurance coverage.</td>
</tr>
<tr>
<td>Justin Fox</td>
<td>Yale University</td>
<td>Improving care among surgical oncology patients and how research can inform health policy.</td>
</tr>
<tr>
<td>Gregg Furie</td>
<td>VA Scholar / Yale University</td>
<td>The impact of the built environment on disease risk.</td>
</tr>
</tbody>
</table>
Eugenia Garvin  
University of Pennsylvania  
**Research Interests:** Violent crime prevention in urban American. Specifically, in understanding how modifications to the built environment, such as urban greening initiatives, can reduce crime and increase perceptions of safety. Also interested in how emergency department based violence prevention programs can reduce the impact of violence of victims lives, as well as reduce the overall burden of violence in a community.

Zachary Goldberger  
University of Michigan  
**Research Interests:** Understanding attitudes and experiences of patients receiving implantable cardioverter-defibrillators (ICDs), and shared decision-making for patients receiving ICDs for primary prevention of sudden cardiac death. In addition, he is examining patterns of care in resuscitation during in-hospital cardiac arrest. His teaching interests center upon improving ECG literacy and cardiac physical examination skills in trainees.

Mana Golzari  
University of Pennsylvania  
**Research Interests:** Healthcare reform for incarcerated youth and upon reentry as well as community and educational interventions targeting youth violence.

Adrienne Haggins  
University of Michigan  
**Research Interests:** Access to care and improving long term health outcomes for inner city African-American populations with chronic diseases that utilize the emergency department.

Michael Hochman  
VA Scholar  
University of California Los Angeles  
**Research Interests:** Strategies for providing primary care, particularly in underserved communities. Can ‘medical homes’ lead to more efficient and effective care? If so, what elements of a ‘medical home’ are most important? Comparative effectiveness research, including the dissemination of comparative effectiveness research results to the physician (and patient) community.

Eric Hodgson  
Yale University  
**Research Interests:** Medical decision making, in particular around contraception.

Manny Jimenez  
University of Pennsylvania  
**Research Interests:** Exploring patient centeredness, shared decision making and care coordination for children with developmental disabilities and/or chronic illness.
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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Shreya Kangovi</td>
<td>University of Pennsylvania</td>
<td>Community health workers, healthcare transitions, access to care.</td>
</tr>
<tr>
<td>Lorraine Kelley-Quon*</td>
<td>University of California Los Angeles</td>
<td>Clinical outcomes in children requiring surgical intervention. She is also interested in assessing the current state of trauma care for children in the San Fernando Valley and work towards creating recommendations for the establishment of a quality pediatric trauma care system. *will not be in attendance</td>
</tr>
<tr>
<td>Christoph Lee</td>
<td>University of California Los Angeles</td>
<td>The intersection between the utilization of medical imaging and cost-effective patient care, comparative effectiveness of non-invasive imaging procedures versus conventional treatments, radiation dose exposure and patient safety, patient access to advanced medical imaging, and quality measurements in radiology.</td>
</tr>
<tr>
<td>Dawn Mautner</td>
<td>University of Pennsylvania</td>
<td>Health care access and quality in vulnerable and underserved patient populations. Specifically, pipeline and mentoring programs and how they support disadvantaged youth’s pursuit of higher education and entry to the health care work force. Costs of care and mechanisms for improving quality and access while decreasing costs.</td>
</tr>
<tr>
<td>Kalpana Narayan</td>
<td>University of Pennsylvania</td>
<td>Explore geriatric capacity building within the hospital setting, more specifically in the emergency department and assess its role with cost and quality of care.</td>
</tr>
<tr>
<td>Stephen Patrick</td>
<td>University of Michigan</td>
<td>Healthcare financing and delivery/social determinants of health: 1) prenatally 2) in the intensive care unit 3) after discharge. Initial interests—long-term outcomes of neonatal ICU graduates. In particular how insurance status and social determinates of health might have an effect on clinical outcomes.</td>
</tr>
<tr>
<td>Name</td>
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</table>
| Lauren Patty*       | VA Scholar University of California Los Angeles | **Research Interests:** Quantify undiagnosed eye diseases in adult Latinos within the US and improving access to ophthalmic care, such as screening for glaucoma and diabetic retinopathy, for underserved populations.  
*will not be in attendance*                                                                                                                                                                                                 |
<p>| Erin Saleebey       | University of California Los Angeles | <strong>Research Interests:</strong> Investigate the decision-making of adolescents regarding pregnancy prevention and to design and evaluate programs for enhanced contraceptive service provision for at-risk youth.                                                                                                                                                                               |
| Erika Sears         | VA Scholar University of Michigan  | <strong>Research Interests:</strong> Decision-making in the surgical specialties, including both patient and provider factors, with specific interest in studying patient expectations and using decision analysis to evaluate competing treatment strategies.                                                                                                                                 |
| Nishant Sekaran     | University of Michigan             | <strong>Research Interests:</strong> (1) Safely improving mobility among hospitalized patients at risk for functional decline; (2) The clinical factors and social policies that influence the expression of disability among high-risk individuals.                                                                                                                                 |
| Luwam Semere        | University of California Los Angeles | <strong>Research Interests:</strong> Investigate birth outcomes of immigrant populations, particularly among African refugees. She is also interested in determining health disparities that exist among these populations as compared to their U.S.-born counterparts and using community-based participatory research to develop strategies to eliminate the disparities which exist. |
| Anand Shah          | VA Scholar University of Pennsylvania | <strong>Research Interests:</strong> Health care redesign and investigating the ability of health information technology to improve quality of care and efficiency.                                                                                                                                                                                                                           |
| Jennifer Walter     | University of Michigan             | <strong>Research Interests:</strong> Research interests: Improving communication between health care providers and patients with a particular focus on chronically and critically ill children. She is also investigating concerns in research ethics, including the influence of compensation on vulnerable populations’ willingness to participate in clinical research. |
| Karen Wang          | Yale University                    | <strong>Research Interests:</strong> Geographic and neighborhood barriers to care among patients with HIV in the US.                                                                                                                                                                                                                                                                                                  |</p>
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<tbody>
<tr>
<td>Oluseyi Aliu</td>
<td>VA Scholar University of Michigan</td>
<td>Healthcare workforce, technical surgical education, health literacy and communications/information technology.</td>
</tr>
<tr>
<td>Katherine Auger</td>
<td>University of Michigan</td>
<td>Factors that impact outcomes in hospitalized children such as the role of hospitalists and the role of inpatient/outpatient transitions.</td>
</tr>
<tr>
<td>Dustyn Baker</td>
<td>University of California Los Angeles</td>
<td>Long-term interest in translating racial disparity research into policy. Research interests are related to evaluation of policies that may lead to racial and ethnic disparities within the Medicare Part D appeals process.</td>
</tr>
<tr>
<td>Jonathan Bergman</td>
<td>VA Scholar University of California Los Angeles</td>
<td>Quality of end of life care in urology, and to form community partnerships to improve the understanding of the end of life process among both healthcare providers and patients.</td>
</tr>
<tr>
<td>Nicole Brown</td>
<td>Yale University</td>
<td>Coordination of clinical and community interventions for high-risk children and adolescents.</td>
</tr>
<tr>
<td>Roberta Capp</td>
<td>Yale University</td>
<td>Healthcare processes and quality of care, specifically sepsis, death and dying in the emergency department, avoidable ED visits and access to emergency services.</td>
</tr>
<tr>
<td>Tammy Chang</td>
<td>University of Michigan</td>
<td>Using popular culture and media to improve health; Health Policy focusing on the social determinants of health.</td>
</tr>
<tr>
<td>Sidney Coupet</td>
<td>University of Michigan</td>
<td>Defining the impacts of global health on American Physicians, quality care and its relevance to America’s Healthcare system.</td>
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<tr>
<td>Name</td>
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<tr>
<td>Nathaniel DeNicola</td>
<td>VA Scholar, University of Pennsylvania</td>
<td>Decision modeling for elective induction of labor and cesarean delivery, including physician and patient perspectives; Antenatal corticosteroids for late preterm births; Social media as a tool for improving physicians’ political action.</td>
</tr>
<tr>
<td>Kelly Doran</td>
<td>VA Scholar, Yale University</td>
<td>Emergency department and community-based interventions to address socioeconomic barriers to health among underserved urban populations.</td>
</tr>
<tr>
<td>Brandi Freeman</td>
<td>University of Pennsylvania</td>
<td>Health disparities, the use of technology to improve communication between physicians and vulnerable patient populations, physician workforce diversity and pipeline programs.</td>
</tr>
<tr>
<td>Nurit Harari</td>
<td>Yale University</td>
<td>Infant nutrition and studying the contributing factors to early infant weight gain among minority communities and community interventions, especially with respect to the obesity epidemic.</td>
</tr>
<tr>
<td>Charlene Hooper Collier</td>
<td>Yale University</td>
<td>Disparities in preterm birth, particularly understanding the impact of maternal stress, support networks, and education on preterm birth; outcomes and cost-effectiveness research in robotic surgery in gynecology.</td>
</tr>
<tr>
<td>Nathan Irvin</td>
<td>University of Pennsylvania</td>
<td>Violence prevention, bullying, hospital based violence prevention plans, social emergency medicine.</td>
</tr>
<tr>
<td>Lindsay Jubelt</td>
<td>VA Scholar, University of Pennsylvania</td>
<td>Innovations in health care delivery systems and cost containment strategies for these systems.</td>
</tr>
<tr>
<td>Chen Kenyon</td>
<td>University of Pennsylvania</td>
<td>Quality of care with specific interest on poor and vulnerable populations, unique models of care for high risk populations.</td>
</tr>
<tr>
<td>Brian Yoshio Laing</td>
<td>University of California Los Angeles</td>
<td>Improving access and quality of primary care for safety net populations, chronic disease management, digital disparities in healthcare and mobile technology interventions.</td>
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<tr>
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<tr>
<td>Kimberly Narain</td>
<td>University of California Los Angeles</td>
<td>Exploring the health implications of various social policies and contextual factors in vulnerable populations.</td>
</tr>
<tr>
<td>Katherine Neuhausen</td>
<td>University of California Los Angeles</td>
<td>Improving access to primary care for underserved and vulnerable populations. Expanding the primary care workforce. Evaluating policies that impact the financing of the health care safety net in California and nationally.</td>
</tr>
<tr>
<td>Charles Scales</td>
<td>VA Scholar</td>
<td>Quality of care for urologic diseases, with a particular emphasis on urinary stone disease and the role of technology in managing urologic diseases. He is also interested in quality and safety of patient care in the medical education healthcare environment.</td>
</tr>
<tr>
<td>Gordon Sun</td>
<td>University of Michigan</td>
<td>Variations in diagnosis, treatment, outcome, and other key measures among US veterans and the uninsured with head and neck cancer; epidemiology of common diseases and disorders in otolaryngology; smoking cessation; improvement of integrated healthcare systems; health information technology.</td>
</tr>
<tr>
<td>Alan Teo</td>
<td>University of Michigan</td>
<td>Examination of training interventions and models to strengthen capacity of the mental health workforce, with particular attention to development and implementation of sustainable and scalable methods and comparative effectiveness of care by different healthcare providers. Understanding the influence of social isolation on mental health in order to develop interventions targeting social withdrawal.</td>
</tr>
<tr>
<td>Heather Smith</td>
<td>Yale University</td>
<td>Barriers to cancer screening, especially among underserved populations.</td>
</tr>
<tr>
<td>Adam Sharp</td>
<td>University of Michigan</td>
<td>Quality improvement and translational science. Identifying disparities in emergent care and implementing models of best practice.</td>
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<tr>
<td>Ashaunta Tumblin</td>
<td>Roy Wade</td>
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<tr>
<td>University of California Los Angeles</td>
<td>University of Pennsylvania</td>
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<tr>
<td><strong>Research Interests:</strong> Better integrate the child health services provided through the school and health care systems. She endeavors to evaluate interventions that promote school readiness as a means to decrease the interrelated achievement gap and health disparities.</td>
<td><strong>Research Interests:</strong> Coordination and quality of care for children and youth in the welfare system, primary and secondary child abuse prevention strategies, addressing quality of care for vulnerable pediatric populations specifically through improving access and services provided by School-Based Health Centers.</td>
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<tr>
<td>Anita Vashi</td>
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<tr>
<td>VA Scholar / Yale University</td>
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<td><strong>Research Interests:</strong> Improving the quality and efficiency of healthcare delivery systems and assessing the impact regionalization strategies have on access, resource utilization, patient outcomes, cost, and implications for medical education.</td>
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Robert Wood Johnson Foundation
Clinical Scholars

Continuing Medical Education

Presented by the Department of Social Medicine, University of North Carolina at Chapel Hill.

Jointly Sponsored by University of Colorado School of Medicine Office of Continuing Medical Education and Robert Wood Johnson Foundation Clinical Scholars® National Program Office.

This program is a part of the Colorado Statewide Extended Campus. State funds were not used to develop or administer this program.

Accreditation And Designation 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 University of Colorado School of Medicine (UCSOM) and the Robert Wood Johnson Foundation Clinical Scholars® program. The University of Colorado School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The University of Colorado School of Medicine designates this live activity for a maximum of 19.50 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Colorado Commission on Higher Education Statement
This program is a part of the Colorado Statewide Extended Campus. State funds were not used to develop or administer this program.

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. The COSOM CME office will mail the certificate 3-6 weeks after the completion of the meeting.

Meeting Evaluation
An evaluation survey for the meeting will be emailed to meeting participants along with the CME registration form after the meeting ends.

Behavioral Learning Objectives/ Anticipated Outcomes
At the conclusion of this activity, participants should be able 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 under served 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.

Americans with Disability Act Statement
Please indicate if you have any need for auxiliary aids or special assistance services during the registration process.

Faculty/Speaker Disclosure Information
Consistent with The UCSOM policy, faculty and speakers for this activity are expected to disclose any economic or other personal interests that create, or may be perceived as creating, a conflict related to the material discussed. This policy is intended to make you aware of faculty and speaker’s interests, so you may form your own judgments about such material. In addition, consistent with UCSOM policy, faculty and speakers are expected to disclose to you at the beginning of their presentation(s) any product mentioned during their presentation that is not labeled for the use under discussion or is still investigational. This policy is intended to allow you to form your judgments about such material.
Robert Wood Johnson Foundation
Clinical Scholars

Acknowledgment of Grant Support
This program is supported by the Robert Wood Johnson Foundation Clinical Scholars® National Program Office.

UC OCME Contact Information
University of Colorado
School of Medicine—Office of CME
13001 East 17th Place, C295
Aurora CO 80045
Fax: 303.724.3557
www.medschool.ucdenver.edu/cme

Presented by
Department of Social Medicine
University of North Carolina at Chapel Hill

Jointly Sponsored by University of Colorado School of Medicine Office of Continuing Medical Education and Robert Wood Johnson Foundation Clinical Scholars National Program Office

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Disclosure
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.
A Complete Meeting Package rate of $400 Single and $600 Double has been negotiated for this meeting which includes all room costs, conference fees and meal functions noted on the agenda, and taxes. Please request your room during online registration. All attendees may make requests for additional nights post and prior to the meeting (subject to availability) and the group room rate of $165 plus applicable taxes will be available 3 days post and 3 days prior. The cancellation of guaranteed reservations must be received by THREE days prior to arrival in order to avoid a charge equal to one night’s room package and applicable tax. If you will be commuting or not staying at the hotel, you will be required to select a daily meal package during online registration.

Overnight Room Rates
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 newspaper and in-room gourmet coffee. The meal plan portion of the complete meeting package rate will be prorated.

Single Rate: $400.00 per night. If you are bringing a spouse/partner who will attend meals, the daily meal package will apply (see below for details). There is no extra charge for an additional guest in the sleeping room.

Double Rate: $600.00 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).
Lodging & Meal Information

Daily Meeting Packages
Attendees who are commuting each day and who are NOT staying at the DoubleTree Hotel Crystal City are required to be a part of the daily meeting package. You will need to select the days you will be attending during online registration. Payment will be required at the hotel front desk.

Tuesday, November 8
Reception/Dinner $50
The price includes your meal, coffee and tea.

Wednesday, November 9
Half Day Meeting Package $121.79
The Half Day Meeting Package includes: breakfast, lunch, refreshment breaks, taxes and service fee.

Thursday, November 10
Full Day Meeting Package $171.79
The Full Day Meeting Package includes: breakfast, lunch, refreshment breaks, dinner, taxes and service fee.

Thursday, November 10
Half Day Meeting Package $121.79
The Half Day Meeting Package includes: breakfast, lunch, refreshment breaks, taxes and service fee.

Friday, November 11
Half Day Meetingl Package $121.79
The Half Day Meeting Package includes: breakfast, lunch, refreshment breaks, and service fee. Tax is an additional 7%.

If you have any questions please contact meetingsupport@emcvenues.com or call 800-258-7012.

Responsibility for travel & lodging related expenses is as follows:
Expenses for the following groups will be direct billed to the National Program Office (credit card will be required at check in for your incidentals):
• National Program Office (NPO)
• National Advisory Committee (NAC)
• Guest Speakers
• Alumni Speakers

The following groups will be responsible for self-payment of their own travel and lodging arrangements which (for those associated with a program site) will be reimbursed by your institution:
• RWJF Staff
• Program Site Directors
• Faculty
• Current Scholars
• Community Partners
• Alumni (Non-Presenting)

Credit Cards are required during registration and will be charged at the hotel.
• Others (Non-Presenting)
DoubleTree Hotel Crystal City Meeting Facilities
The Washington DC, Arlington, and Crystal City areas

The Washington DC, Arlington, and Crystal City areas are full of attractions and activities for the entire family to enjoy. Washington DC is an historical destination full of culture with shopping, fine dining, Memorials, Museums and much more to explore our Nation’s past.

MEMORIALS

- The National Mall – Take part in learning about presidential legacies and honoring the courage and sacrifice of our war veterans.
- Washington Monument – Open Daily 9a-5p – Free to public, although ticket required
- Lincoln Memorial – Open 24 hours per day, with park rangers available to answer questions 9:30a-11:30p
- Vietnam Veterans Memorial – Open 24 hours per day, with park rangers available to answer questions 9:30a-11:30p
- Thomas Jefferson Memorial – Open 24 hours, with park rangers available to answer questions 9:30a-11:30p
- Air Force Memorial – Hours are 8 a.m. -11 p.m. April 1-September 30 and 8 a.m. -9 p.m. October 1 – March 31
- World War II Memorial
- Korean War Veterans Memorial

SITES

Experience musical, ballet and theatrical performances at the John F. Kennedy Center for the Performing Arts one day and a Smithsonian museum of your choosing the next. The Smithsonian offers 16 museums and 9 research centers for you to choose from, guaranteed to satisfy every interest.

- The White House
- US Capitol Building
- John F. Kennedy Center for the Performing Arts
  Hours and pricing vary by performance
- Smithsonian Institution
  Hours vary by museum, admission is free
- National Zoo – Hours vary by season, admission is free
- Corcoran Gallery of Art
- International Spy Museum
- National Gallery of Art
- United States Holocaust Memorial Museum

SHOPPING

Washington DC offers world-class shopping that you won’t want to miss! The Fashion Centre at Pentagon City offers over 170 shops and restaurants and is just several minutes from the Doubletree Hotel Washington DC - Crystal City.

- Fashion Centre at Pentagon City – Open Mon-Sat 10a-9:30p and Sundays 11a-6p
The Clinical Scholars program sponsored a special issue of the journal HSR regarding the translation of evidence into policy. This focus builds on strong emphases within the program regarding the design and conduct of research to inform policymakers at multiple levels. Current and former Clinical Scholars were invited to submit manuscripts and more than two-dozen manuscripts were received. The submissions underwent peer review and have been selected for the February 2012 special issue; they encompass a broad variety of research methods, including qualitative and quantitative approaches, local and national data, and cutting-edge work involving community-based participatory research, multi-level analyses, and the use of measures from disciplines outside health and medicine. Most, if not all, of the selected articles will appear online ahead of the 2012 print date, with IQ Solutions providing media support. Cary Gross (Yale Co-Director) and Matt Davis (Michigan Co-Director) served as Co-Guest Editors for the issue, working with Carolyn Clancy of AHRQ.

**PEDIATRICS – Call for Abstracts**

Submission Deadline: November 30, 2011

*PEDIATRICS* and Robert Wood Johnson Foundation Clinical Scholars program announce a call for papers to a special online issue of *PEDIATRICS*: Visioning, Measuring, and Improving the Quality of Health Care for Children – Insights from the Robert Wood Johnson Foundation Clinical Scholars Program. Over the past two decades, Clinical Scholars and alumni have made enormous contributions to our understanding of the quality of health care in general and children’s health care in particular. They have helped draw attention to quality of care as a scholarly issue and an important health care focus. A current federal initiative identified seven centers of excellence to develop a new wave of pediatric quality measures; five of the seven are led by former RWJF Clinical Scholars! Current and former Clinical Scholars are invited to submit manuscripts for consideration for a Special Issue of *PEDIATRICS* that will feature top-quality examples of research on children’s health care quality.

**We are soliciting the following types of submissions:**

1. **Original research describing the quality of children’s health care.**

   The Institute of Medicine has defined key attributes of quality health care as timely, effective, efficient, safe, equitable, and patient-centered. We invite work that describes the quality of pediatric health care, that evaluates approaches for improving the quality of children’s health care, or approaches to studying or improving the safety of pediatric care. We are interested in work from inpatient and/or outpatient settings.

2. **Original research describing methods to measure the quality of pediatric health care and/or to evaluate quality improvement initiatives.**

3. **Original conceptual models with the potential to advance our understanding of pediatric quality of care.**

4. **Analytical reviews or summaries that elaborate key ideas in the development of our current understanding of the quality of health care for children.**

*(over)*
Robert Wood Johnson Foundation
Clinical Scholars

Criteria for selection include:

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<th>1. Responsiveness to this call</th>
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<td>2. Originality, Rigor and potential contribution to the field</td>
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<td>3. Significance</td>
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<td>4. Clarity of writing and presentation</td>
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Manuscripts: Authors may request allowance for longer than typical articles with justification for the excess length.

Clinical Scholars or Clinical Scholar Alumni must be at least the first or last author of the submission (first author preferred). Authors should submit a structured one-page abstract (including headings such as Objective, Patients and Methods, Results, and Conclusions; for more detailed abstract guidelines please refer to the PEDIATRICS author instructions at http://pediatrics.aappublications.org/site/misc/Author_Instructions_2010.pdf.

Submissions should be sent to Kristin Siebenaler:
Kristin_Siebenaler@med.unc.edu
by no later than November 30, 2011.

For more detailed abstract guidelines please refer to the PEDIATRICS author instructions at http://pediatrics.aappublications.org/site/misc/Author_Instructions_2010.pdf.

Inquiries regarding submissions should be sent to Larry Kleinman (CSP UCLA, '92), the guest editor for this special issue, at Lawrence.Kleinman@mssm.edu.