

# Development of a Comprehensive Women's Health Program in an Academic Medical Center: Experiences of the Indiana University National Center of Excellence in Women's Health

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## ABSTRACT

**Background:** The IU National Cancer of Excellence (CoE) in Women's Health was funded by the Office on Women's Health, Department of Health and Human Services, in 1997 as part of the "second generation" of CoEs. The purpose of this paper is to describe the changes that the existence of this Center have wrought within the IU School of Medicine.

**Methods:** This paper describes the creation, mission, and function of the IU CoE, as well as some of its accomplishments to date.

**Results:** Through its missions targeting clinical care, research, education, community outreach, and leadership development, the IU CoE has significantly changed the delivery of care to and by women at this institution.

**Conclusions:** The IU CoE has been responsible for major changes in the concepts of women's health from a clinical, research, education, and leadership perspective at the IU School of Medicine. Similar cases can be made for most of the other CoEs around the country. The challenges being faced continue to be sustained and sufficient funding for these valuable Centers.

## INTRODUCTION

PRIOR TO 1997, THE INDIANA UNIVERSITY (IU) School of Medicine provided traditional educational programs for its students, residents, and other trainees. These included women's health-related subjects as parts of various clerkships, although these topics often were not specifically identified as such. In addition, sessions on career choices, balancing career and family, and informal mentoring programs were provided, mainly for female students and other trainees. The IU School of Medicine also assisted its female faculty in their quest for promotion and tenure and in honing

their research, writing, and grantsmanship skills, as it did its male faculty. Excellent medical care was provided for all patients, including traditional obstetrics and gynecology, endocrinology, other subspecialty care, surgery, and general medical and pediatric management for women. In September 1997, the IU School of Medicine received funding from the Office on Women's Health (OWH), Department of Health and Human Services (DHHS), as one of six sites designated as the second-generation of National Centers of Excellence (CoEs) in Women's Health. (A competition in 1996 produced the first six Centers, known as the "vanguard" centers.) This accomplishment

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The Indiana University National Center of Excellence in Women's Health is supported by contract number 282-97-0025 from the Office on Women's Health, DHHS.

changed the concept and practice of women's education, training, promotion, and clinical care, not to mention research and community outreach, at the IU School of Medicine. Groups coalesced, fell apart, collaborated, and stumbled along on a frequently tortuous path to the beginnings of a new way of viewing the female in healthcare, both as provider and recipient.

The purpose of this paper is to describe and summarize as concisely as possible the route taken by our institution to respond to the challenges attendant upon the receipt of the designation as a CoE. We have learned much from this enterprise, and we continue to learn more each day. It has not always been an easy experience, but it has been a valuable one. One of the mandates given to all CoEs by DHHS was to create, and to serve as, a model for women's healthcare, and this paper describes the model we have created in Indianapolis as the IU CoE. The collective experiences of the CoEs in various areas have been published as a series of papers in this and other journals.<sup>1-20</sup>

## BEGINNINGS

The first challenge we encountered in the creation of our model was that of responding to the Request for Proposals (RFP) from DHHS. Because of their granting authority, the RFP was a contract, that is, an RFQ or Request for Contracts, and not a traditional NIH grant. This, in itself, made writing the proposal more complex. A contract requires the applicant to both respond to specific queries and agree to produce certain deliverables. The most difficult part of this is describing what a site can and wants to do while remaining within the confines of the RFQ. More importantly, though, we needed to identify what could be done at IU and who should be involved. The contract mandated a broad interdisciplinary approach to women's health, including integration of the five components of clinical care, research, education, outreach, and leadership development. We knew that all of these pieces existed to some extent at IU, but the greatest challenge was to find them. In the end, we were able to create a strong and collegial alliance that initially included the Schools of Medicine and Nursing; the Wishard Health Services, the community hospital for Marion County that is located on our medical school campus and is staffed by our fac-

TABLE 1. PARTNERS OF THE IU CoE

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IU School of Medicine
IU School of Nursing
Wishard Health Services and its community clinics
Indiana University Purdue University at Indianapolis (IUPUI)
IU Cancer Center
IUPUI School of Science
IU School of Dentistry
The Office of Women's Health, Indiana State Department of Health
The Marion County (Indianapolis) Department of Health
Local not-for-profit groups involved in health education and outreach for the African American and Hispanic populations of the city, including the Indiana Minority Health Coalition, Midwest Hispanic Coalition, the Hispanic Center of Indianapolis
The Marion County Public Library
The Purdue University Cooperative Extension Service
Indiana Coalition Against Sexual Assault
Domestic Violence Network of Greater Indianapolis
Julian Center for Victims of Domestic Violence
Central Indiana Community Foundation
The Women's Fund of Central Indiana
Girls, Inc.
Citizen's Action Coalition
Ruth Lilly Health Education Center
The Ruth Lilly Foundation
The Little Red Door Cancer Agency
The Regenstrief Institute for Health Care

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ulty, and its community health centers around the city; and the other groups shown in Table 1. Getting all these groups together provided us with a very steep learning curve, as we discovered in depth what they could bring to this endeavor and how very large our resource base was in central Indiana. We also discovered that we were not alone in not knowing who all of our potential partners might be, and one of the truly valuable and enduring outcomes of the creation of the IU CoE has been the development of links among so many groups providing care and support to women.

During the process of getting these groups together to discuss and participate in the creation of the CoE and while gaining the support of many key individuals in our community, including the deans of the Schools of Medicine and Nursing, the chancellor of IU Purdue University at Indianapolis (IUPUI), the president of IU, the wife of the governor of Indiana, the director of the Office of Women's Health at the Indiana State Department of Health, and the director of the Marion County Department of Health, we also identified people who would be well suited to direct the various components of the CoE. Remarkably, no one turned down the chance to participate, and

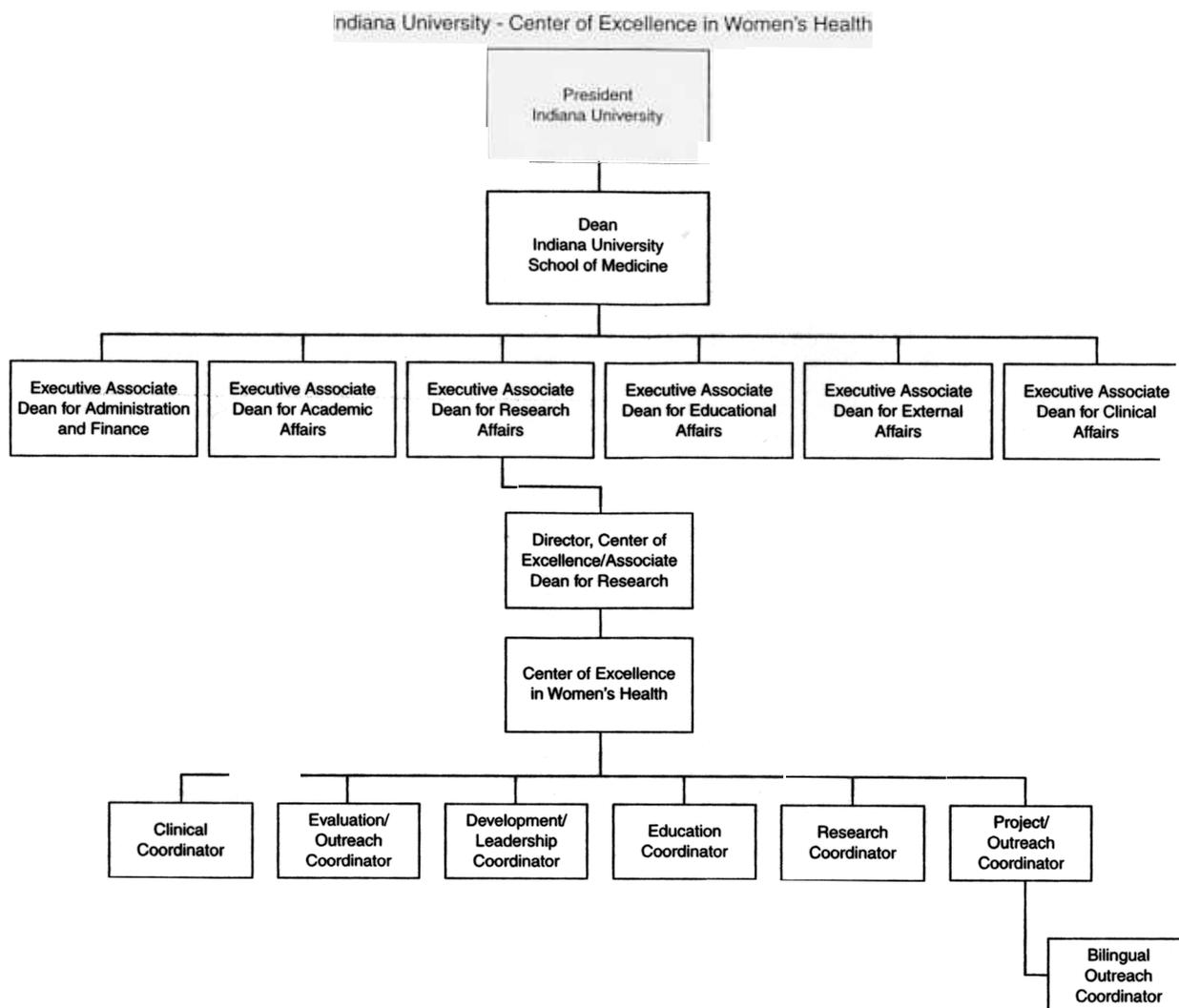


FIG. 1. Organizational chart of IU CoE

we had the initial structure of the CoE. This consisted of five components: clinical, research, education, leadership, and evaluation. The organizational chart is shown in Figure 1.

### GETTING STARTED

Perhaps as much to our surprise as to everyone else's, our site was selected and funded in this second competition in 1997. Then, we faced the continuously daunting challenge of making it all work by creating functional and useful components and finding the funding to do so. It should be pointed out that the baseline funding provided by OWH is very modest, to say the least, and is restricted virtually entirely to salary. Furthermore, the amount of funding available

was not revealed until negotiations were conducted after announcement of the site's selection as a CoE. As a result, the ability to establish and maintain the activities of the CoE has required what has turned out to be substantial contributions from our parent institutions. This was only one of many times when our collaborations with our partners in this undertaking proved so valuable. The School of Medicine provided us with some salary support for several key members of the CoE and with support for fund-raising through its Development Office. Wishard provided us with a newly renovated clinic area and support staff, including nurses, as in-kind support. IUPUI provided us with publicity, in terms of announcements and events spotlighting the CoE. Other agencies ultimately provided us with grant and contract support for various activities,

and numerous individuals supplied us with critical suggestions, ideas, and good counsel. One of the early grants that we received was most critical: an award from the Central Indiana Community Foundation of that rarest of funding types, infrastructure, to enable us to hire a Project Coordinator, without whom we could not have accomplished what we have to date.

### THE MISSION

The mission of the IU CoE, which is posted on our website ([www.iupui.edu/~womenhlt/](http://www.iupui.edu/~womenhlt/)) is "to develop a coordinated, unified framework in which to provide state-of-the-art clinical care for women, to teach health care providers and lay people about women's health issues, to create new programs to deliver information about preventive medicine to women and their families throughout the State of Indiana, to learn from women how to provide them with better and more user-friendly health care, to develop a research agenda linking basic science with clinical care, and to foster the development of careers of women in academic health centers."

### THE CLINICAL COMPONENT

The first order of business was to create a CoE clinic. OWH's mandate was that such a clinic must provide "one-stop shopping"; that is, all of a woman's healthcare should be "under one roof," easily accessible, and requiring as little time as possible out of a woman's daily routine. Our Clinical Director decided to approach this from the standpoint of what was most needed by our potential patients. Wishard is the designated safety-net hospital for the indigent population of Marion County, as well as anyone else who wishes to attend. Thus, most of our patients were well below the poverty line, receiving their healthcare by virtue of Medicaid, Medicare, or a novel program called Wishard Advantage, which functions like an HMO but is actually funded by Wishard program dollars and is for those who have no other insurance and do not qualify for Medicaid or Medicare. Perhaps 20% of the Wishard population is insured by third-party payers. Our Clinical Director ascertained, based on her long experience with this population and on discussions with her colleagues, that as the women already were obtaining their basic gen-

eral medicine and obstetrical/gynecological care from Wishard's providers (who were "under the same roof" as the CoE, albeit a few floors below or in an adjoining building), their most pressing needs were the particular types of care not readily available to them but as necessary for them as for insured women, if not even more so: pain management, continence care, cardiology, bone densitometry, mammography and breast follow-up, weight management, and reproductive endocrinology. These were specialties to which the women often needed to be referred but that were not usually readily available at Wishard (or, in some cases, at many other hospitals). Thus, the Clinical Director proceeded to invite specialists in these areas to begin seeing patients in the CoE Clinic. She asked for and obtained a used bone densitometer that previously had been used in clinical trials in Endocrinology but was being retired. She identified individuals with interests in developing pain and weight management programs but who previously had no venue for them, and she recruited nurse practitioners and urogynecologists with an interest in continence care to participate in the clinic and created designated rooms for them, using donated equipment.

As this clinical program blossomed, we discovered, much to our surprise, as we and everyone else, including the patients, thought it was such a marvelous creation, that DHHS was not satisfied. Although they were impressed with our accomplishments, they still wanted to see their formal "one-stop shop" approach, which included having primary care practitioners not just in adjacent buildings or even nearby clinics but essentially in the next room. Their goal was for as many healthcare services as possible to be provided to women under one roof, so to speak. This was not as simple an undertaking as it might initially appear to be. Wishard was replete with primary care physicians, especially general internists and obstetricians and gynecologists, but these individuals already were comfortably based in established clinics, and it was not obvious how we could move them and their practices (or why it was necessary to do so) from their current site to ours. Each existing clinic included a group of physicians who were accustomed to and expected to cover for each other when someone was on vacation or at a meeting, for example, and moving someone from such a setting to the CoE clinic would have upset these arrangements.

In the long run, our solution to this dilemma, which probably turned out to be the best of all,

was for our Clinical Director to move her practice from an off-campus site at one of the Wishard community health clinics to the CoE. She now sees primary care patients 4 days a week at the CoE, which satisfies OWH's requirements for multiple on-site primary care sessions per week and also has the added benefit of attracting numerous new patients, including a great number of faculty, staff, and other insured women, to the clinic because of her reputation as a superb and caring clinician. She has been joined by the Chief of Obstetrics and Gynecology at Wishard, who sees patients on a biweekly basis at the CoE.

The success of our clinical component has been evident from patient satisfaction questionnaires, using a standard tool employed in all clinics at Wishard. The CoE clinic usually ranks among the top five of the scores of clinics in the institution (see The Evaluation Component). Additionally, office visits by new patients, referrals by patients of family and friends, and self-referrals continue to increase. In the fourth quarter of 2002, approximately 5800 women were seen in the CoE clinic for billable visits. This included 483 primary care visits, 761 pain management clinic visits, 112 continence care clinic visits, 75 obstetrics/gynecology visits, 63 weight management clinic visits, 24 menopause clinic visits, 1379 mammograms, 244 breast ultrasounds, and 159 bone densitometry scans, to list some of the larger groups. In addition to the CoE Clinical Director, patients are seen by two gynecologists, a physiatrist, a general internist specializing in pain management, an endocrinologist, breast oncologists and surgeons, and nurse practitioners, depending on the reason for their visits. An additional primary care physician is now being sought to partner with the Director in the CoE clinic.

### THE RESEARCH COMPONENT

The research component was mandated to identify ongoing research relevant to women's health on campus and then to foster and grow interdisciplinary collaborations. The first charge appeared simple at the outset. The research component Director was quickly able to compile a list of research related to breast cancer, ovarian cancer, osteoporosis, immunology, sexually transmitted diseases (STDs), and other areas that obviously were classifiable under the rubric of women's health. However, the simplicity vanished as it became evident that numerous other

researchers were working on basic projects concerning, for example, hormones, receptors, cell differentiation, and oncogenes, that were not really gender neutral but had not been identified by the researchers or by us as part of women's health. As we realized this and helped others to do the same, the possibility of interdisciplinary research among scientists—basic, clinical, and behavioral—who probably did not even know each other before this task began started to develop. Within a few years, several interdisciplinary collaborations have been created and some have gotten funded, and although the CoE cannot take credit for all of them, we certainly like to think that our activities and the publicity attending them facilitated such interactions.

One of the activities we initiated at the outset to foster such cross-disciplinary thinking was a Pilot Project Program. Through this peer-reviewed program, we have awarded competitive small grants of \$10,000–15,000 to new investigators or mature investigators changing directions to enable them to pursue research related to women's health and to ultimately obtain pilot data enabling submission of proposals for extramural funding. It should be remembered throughout that DHHS provided no funding for any of these activities while mandating that we promote research. Through a now annual series of solicitation requests from the CoE Director, targeting various departments and clinical practice plans as well as philanthropic and pharmaceutical sources, we have been able to obtain annual support sufficient to permit us to fund two or three meritorious projects a year, selected by a review committee representing multiple disciplines on campus. As our pilot project program has grown, so too have the quality and number of submitted proposals. Additionally, a few of our early awards already have resulted in externally funded projects.

### THE EDUCATION COMPONENT

The mission to enhance the inclusion of women's health issues in the medical school curriculum has resulted in some easy victories and some unexpected obstacles. Our CoE was inaugurated at a time of great change in the IU School of Medicine's curriculum, which helped us because of the nature of the transformation and the ability to include new items in the revamped curriculum. The new curriculum had clinical com-

petency requirements, which included such areas as cultural competency, appreciation of diversity, and gender and ethnic sensitivity. Integrating women's health into this climate was a much less formidable task than it would have been a few years earlier. Thus, we were able to garner six lecture sessions in the Introduction to Clinical Medicine course, taken by all first-year students, that were specifically labeled as women's health. These vary somewhat from year to year but typically include domestic violence, continence management, mood disorders, and STDs. Our goal is to provide important information that is either not covered elsewhere or not integrated clearly into the concept of women's health. Our Education Director has been cataloguing all courses in all clerkships dealing with women's health issues, trying to reduce duplications and provide more time for new topics. We have been able to introduce lectures into the standard noon conference series in Medicine, Obstetrics and Gynecology, and Family Medicine, focusing specifically on unifying subjects related to women's health, not just on the anatomical parts of a woman. We created a CD-ROM on domestic violence to use as a teaching tool for medical students, and this is now a required portion of the Obstetrics and Gynecology rotation for third-year students, complete with an internal test to assess the students' pre-CD and post-CD knowledge. Recently an Objective Structured Clinical Examination (OSCE) on domestic violence was added to the test that all third-year and fourth-year students are required to take at the end of the year to assess their clinical skills.

The surprising obstacle we have encountered has been student attendance in lecture courses. Although students virtually always attend clerkship noon conferences, small-group sessions, and laboratory courses, large lecture courses during the first 2 years are covered by a note-taker, who is paid for his or her efforts and who posts lecture notes and slides on the web. Thus, although we have six sessions in the Introduction to Clinical Medicine course, we often have fewer than 6 of our 150 Indianapolis-based freshmen in the huge classroom. Needless to say, this does not help us to get good speakers to come more than once. One particular session that we were quite pleased to have arranged was a presentation by a domestic violence survivor who had set up a network for other survivors. Her presentation was not one easily captured by note-takers and websites, and we were quite disappointed when only 3 or 4 students showed up to hear her. When

we meet with female medical students who are interested in women's health careers and in participating in our clinics and other activities, they often ask why we do not have more of a presence in the curriculum. We point out that we do and that they probably missed it. This is an issue in evolution that we have not yet resolved.

In addition, we have provided professional education to healthcare practitioners in a variety of venues. We provide CME/CEU courses to medical residents and fellows, practicing and academic physicians, nurses, and other healthcare professionals. We hold conferences for residents and fellows, present a very successful and popular monthly noon conference series for staff, faculty, students, and others on a variety of topics in women's health (biological, psychosocial, and even financial), and give CME/CEU presentations around the state. We have created a number of successful CD-ROMs as educational tools for medical students and physicians. As noted, our first undertaking was a very successful presentation, with testing, for medical students on domestic violence. This has been modified to serve as a CME program, which provides 1 hour of AMA Category 1 credit from IU's Office for Continuing Medical Education. We also have collaborated with the Indianapolis Hemophilia Center to create a CD-ROM for CME credit on bleeding disorders in women.

Another accomplishment of which we are very proud is the creation of the annual Doris H. Merritt, M.D., Lectureship in Women's Health. This was started in 2000 when the author, frustrated by the encumbrances placed on a speaker supported by a local corporation that year and wishing to be able to control the logistics of future lecturers, successfully undertook an e-mail fundraising campaign requesting support for this named lectureship. Doris H. Merritt, M.D., Distinguished Professor and Associate Dean Emerita at the IU School of Medicine, has served as a role model, mentor, and advocate for many women and men at IU, where she held administrative positions such as Associate Dean, Director of Research and Sponsored Programs, Acting Dean of the Purdue University School of Engineering and Technology at IUPUI, Special Assistant to the Chancellor, Indianapolis, and to the President (IU), and at NIH, where she served as Study Section Administrator, Special Assistant to the Director, and Acting Director of the National Center for Nursing Research (NIH). The cachet of Dr. Merritt's persona was sufficient for nearly \$150,000 to be raised

in about 8 days in a campaign now taught as a vignette in the IU School of Philanthropy. This lectureship has enabled us to bring superb speakers annually to our campus to interact with students and faculty and present seminal lectures on a variety of aspects of women's health.

### THE OUTREACH COMPONENT

This area was not a formal component but part of the educational mission of the CoE when the contract was first awarded. It is now an official component. Our educational outreach activities have been extremely successful. DHHS' mandate was basically to provide education for everyone, including students in K-12, medical students, nursing students, other trainees, physicians, nurses, other healthcare professionals, and lay women. We have accomplished virtually all of this, from presentations to schoolchildren in their classrooms, at local girls' clubs, and at the Ruth Lilly Health Education Center, a not-for-profit agency (unrelated to the pharmaceutical company) with hands-on teaching demonstrations for all middle-school students in central Indiana. We have created an undergraduate course on women's health for students at IUPUI, which is taught by a faculty member in the Purdue University School of Science and which has been very popular among the students. We give numerous presentations to lay women, at health fairs and through formal lectures and informal group sessions, in community centers, health clinics, churches, and any other place where women gather. We have been particularly aggressive in trying to reach women in the innercity, who represent our largest clinical audience. We work closely with a health educator from the Marion County Department of Health, who is fortuitously based in the CoE clinic, and provides outreach to African American women, as does our invaluable Project Coordinator. We have been able to hire a Bilingual Outreach Coordinator who makes presentations to Hispanic women and facilitates their access to medical care and social services. Her particular area of specialization started out as breast health but has already expanded to include HIV/AIDS.

One of the activities that has thrived in our educational outreach efforts has been the creation of CD-ROMs on a variety of topics. The CD-ROM that we created on the subject of domestic violence is being transformed into a CD-ROM for lay

women, victims, and others through collaboration with a domestic violence prevention and help network in Indianapolis and with funding from a not-for-profit local agency. A project nearing completion is a CD-ROM about HIV/STDs targeting adolescent and young adult women, especially African Americans and Hispanics, with a Spanish version, which is being produced by the School of New Media at IUPUI. A member of the CoE has developed a video to help women with smoking cessation and has created a very clever CD-ROM game to help young girls and adolescents keep from smoking while building self-esteem. Our Bilingual Outreach Coordinator has spearheaded the creation of a Spanish-language video to teach Hispanic women about the importance of breast health, including screening tests. This was modified from a CD-ROM developed by our Research Director, Dr. Victoria Champion, targeted to African American women.

We have established a Community Advisory Board of individuals involved in women's health and related activities in Indiana who meet with us twice a year to assist us in directing our programs and assessing the needs of the community. In addition, we have an Executive Advisory Board, made up of prominent women in our community, who also meet with us twice a year. Some of the meetings of the two groups are held jointly to enable them to interact with each other and advise us collectively.

### THE LEADERSHIP DEVELOPMENT COMPONENT

This has proven to be perhaps the most difficult mandate given to us by DHHS. We already had in place episodic lectures and brown-bag lunches presenting discussions of various issues concerning how to succeed in academic medicine, targeted to women. We had created a new mentoring program, pairing female faculty with female students. We routinely sent one or two women a year to the AAMC's sessions for junior and senior female faculty. Although this was good-intentioned and good-feeling, even we knew these efforts were not enough. We worked hard to formalize the educational sessions on career advancement, grantsmanship, and negotiating skills to make them recurring presentations with the opportunity for interactions, and we spent much energy on growing our mentoring efforts. These areas are coming along, but they are diffi-

cult. There was a core of perhaps 30 female faculty and 20–30 students who were interested in participating in the mentoring sessions with regularity. It is difficult to find female faculty and students with the time for these activities on a frequent enough basis to make them useful. Episodic meetings may be fine for many, but the students or faculty who would like to establish more routine sessions are rare.

The heart of our leadership development program is the goal of helping all women establish and achieve their career objectives. We try to accomplish this through a combination of formal and informal lectures and meetings, mentoring, and education of the entire academic community on issues of cultural, gender, and racial diversity.

Our efforts are finally beginning to blossom. We have an unusually large and active Student American Medical Women's Association (SAMWA) (in contrast to the grown-up version, which languishes). These young women have lecture series, lunch meetings, and community activities that they develop and implement. They have been turning to the CoE for assistance and support during the last few years, including speakers, suggestions, and sometimes funding. This has turned out to be a very successful two-way relationship; CoE members serve them as informal mentors and role models, and SAMWA members often spend time in the CoE learning about women's health. Another group that has come to our attention is a small collection of female and male students, called the OB Special Interest Group, which was organized by our Education Director before he assumed that position. This group performs community service, especially involving teaching girls and adolescents about their own health. We have made the expertise of the CoE available to these students, and they have collaborated with us in some of their undertakings.

Our Leadership Director recently received an unrestricted educational grant from a pharmaceutical company to present a workshop at IU modeled after the successful AAMC workshops for female faculty. This is scheduled for 2003 and obviously will be available to more people than can attend the AAMC's sessions.

The School of Medicine has just begun a formal mentoring program for both genders, targeting students. Many members of the CoE are involved in this as mentors. Although the CoE did not create this activity, we like to think that our

efforts during the last 5 years have changed the climate so that such an endeavor could come to fruition. One of the goals of this program, which is something that we recognized as critical to the success of any mentoring project from the outset, is to provide mentors with credit in terms of protected time or salary for their mentoring work.

Since the creation of the CoE at IU, we have had a change in deans, with a resultant alteration in the division of labor in the Dean's office. The new Dean, a long-time supporter of and researcher in women's health, created three positions of academic Executive Associate Deans (Research, Education, and Academic Affairs), along with a nonacademic Executive Associate Dean for Financial Affairs. Of the three academic Executive Associate Deans, two are women (and one is the CoE's Leadership Director). In addition, under this Dean's leadership, the author was promoted to the position of Associate Dean for Research, another woman became Associate Dean for Educational Affairs, a woman was named Associate Dean for Information Technology, a woman was named Associate Dean for Research Support and Education, and an African American woman became Assistant Dean for Diversity. Again, although the CoE cannot take direct credit for these appointments, we do not think it a coincidence that they occurred. Finally, thanks to appropriate championing and fund-raising acumen on the part of some of our faculty and development officers, IU acquired a new Endowed Chair in 2000, the Barbara F. Kampen Chair of Women's Health, stipulated to be held by the head of the women's health center and awarded to the author in 2000.

## THE EVALUATION COMPONENT

One of the originally mandated functions of the CoEs was the inclusion of an internal evaluation component. As the program evolved, the decision was subsequently made at DHHS to contract for formal external qualitative and quantitative evaluation. However, for the first 5 years of the IU CoE's existence, we had our own internal evaluation activities. Because of the remarkable computerized medical record system in the Wishard Health Services,<sup>21</sup> we are provided with quarterly summaries of patient satisfaction with all facets of our clinical operations, and we are able to compare our ratings with those of other clinics in our system. The sat-

isfaction with physician care, clinic flow and appearance, clinic personnel, and length of wait has been higher for most aspects of the CoE clinical enterprise than for other clinics. Additionally, patient volume has grown dramatically over the years, more so than in many other clinics.

We have examined the efficacy of all of our activities whenever and however possible. For example, evaluation forms are distributed at all conferences, presentations, and other educational sessions. Students and house staff routinely evaluate all speakers. Assessments are performed on all novel interventions, including CD-ROM programs, Internet sites, pamphlets, and videos.

The current iteration of the CoEs, although still requiring some internal evaluation, no longer includes this as one of the core components. It has been replaced by community outreach as a separate category. Nonetheless, we believe that the internal evaluation methods we have in place are of value to our activities, and we plan to continue them.

### SUMMARY

Our first 5 years as a DHHS-designated CoE have been a valuable experience for us. We have created numerous programs, including our one-stop clinic, that did not exist before and that have provided significant value and improved care to women, especially the underserved women of inner city Indianapolis. We are now attracting more affluent patients, too. We have been able to pull together many researchers who conduct complementary studies but were not aware of each other's existence before we began to develop and encourage multidisciplinary research endeavors related to women's health. We have created a cohesive alliance of organizations, both public and private, that provide services to women in our area. This networking has proven very powerful as a means of improving the care and well-being of women in Indiana. We have been able to implement mentoring and leadership initiatives through our CoE that did not exist previously. We have created new culturally and linguistically appropriate educational programs and have tailored them to the underserved women of our community, including our growing Hispanic population.

There have been downsides to the DHHS designation. The major one is the chronically low level of funding available to the CoEs. The con-

tract method through which they are funded is not comparable to that of NIH Centers, and the difference between our funding level and that of an NIH Center is probably at least an order of magnitude. In the last several years, DHHS has partnered with other federal agencies that want access to the expertise available in the CoEs and, thus, has been able to offer additional support for new projects. However, most of what is needed to run a CoE, including salaries, has to come from other sources. A 25% match by the home institution is required, but even that is not sufficient. Most of the CoEs, including IU, have successfully leveraged funding from their institutions, grant applications, philanthropic sources, foundations, and corporations. Although we have all accomplished this to some extent, it does translate into a great deal of time spent seeking money, sometimes at the expense of instituting programs. All CoEs seek a steady (3–5-year) source of a sufficient level of funding to permit continuation of their activities without the constant need to seek funding. However, this notwithstanding, we look forward to our continued designation as a National Center of Excellence in Women's Health.

### ACKNOWLEDGMENTS

The author would like to thank the following people without whom this CoE could never have happened: Ann Zerr, M.D. (Clinical Director); Victoria Champion, D.N.S. (Research Director); Lynda Means, M.D. (Leadership/Development Director); Anna McDaniel, D.N.S. (Evaluation Director); Peter Marcus, M.D. (Education Director); Christine Darling, B.S. (Project Coordinator); Linda Strickland, R.N. (Director of Women's Services, Wishard Health System); Lois Wells; Carolina Pimentel-Nelson; Antoinette Hood, M.D.; Evan Farmer, M.D.; Robert Holden, M.D. (Dean Emeritus, IU School of Medicine); Jack Williams, M.D.; D. Craig Brater, M.D. (Dean, IU School of Medicine); Ora Pescovitz, M.D.; Angela Barron McBride, Ph.D. (Dean, IU School of Nursing); Gerald Bepko, J.D. (Chancellor, IUPUI); Elizabeth Elkas; J. David Smith, Ed.D.; Michele Rodger Spencer; Kim Gattle; Janet McCully; Lisa Harris, M.D.; Robert Jones, M.D.; Barbara Levy Tobey, M.S. (Director, Office of Women's Health, Indiana State Department of Health). The author would also like to thank all the agencies, foundations, corporations, and individuals who have

provided support to the CoE over the years, including the Central Indiana Community Foundation, the Indiana State Department of Health, the Indianapolis Affiliate of the Susan G. Komen Foundation, Parke-Davis, Pfizer, 3M, the Alliance for Indiana, Wishard Health Services, and, of course, the IU School of Medicine.

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