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The Robert Wood Johnson Foundation Quarterly Newsletter

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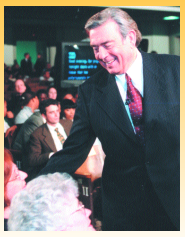

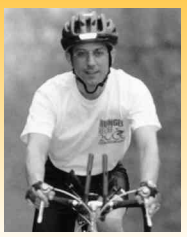

RWJF Steps Up Insurance Coverage Initiatives

These may be the best of economic times for the United States. As the economy nears an unprecedented nine straight years of growth, employment rates are rising while inflation bumps along at near record lows.

Yet one important measure of economic well-being stubbornly refuses improvement — the number of Americans without health insurance. In fact, between 1995 and 1998 the ranks of the uninsured jumped 9%, from 40.6 million to 44.3, according to US Census Bureau estimates.

"With the economy performing so well, and unemployment rates so low, one would expect the number of uninsured to be falling — but it just keeps rising," says David Colby, PhD, senior program officer at The Robert Wood Johnson Foundation, who heads the Foundation's coverage team. "I'm worried that the situation will be even worse when an economic downturn comes."

Lack of insurance is not just an economic problem, but a health problem as well. Studies have shown that, compared with the insured population, the uninsured are more likely to report poor health status, less likely to visit doctors' offices, and more likely to be hospitalized for conditions that could have been prevented with timely outpatient care.

Uninsured Americans, compared with the insured, are:

Source: *No Health Insurance? It's Enough to Make You Sick*. Philadelphia: American College of Physicians — American Society of Internal Medicine, 2000. White Paper.

"Whether or not you have insurance coverage is one of the most important variables as to whether you get access to care," says Jack Ebeler, RWJF senior vice president and director of the Health Care Group.

The current economic good times, combined with renewed emphasis on the uninsured, present a unique opportunity to address the problem, Colby says. So the Foundation is developing a series of linked initiatives with the goal of cutting in half the number of uninsured Americans by 2005.

"Assuring that all Americans have access to basic health care at a reasonable cost has always been a core Foundation goal," Ebeler says. "Increasing the number of Americans with health insurance is one way to do it."

"MAX OUT" AND OTHER WAYS TO EXPAND COVERAGE

The health coverage initiatives will follow two major strategies, Colby says. One is maximizing participation in existing health coverage programs.

A major program already underway is *Covering Kids*. Launched in 1998, the initiative has made grants supporting coalitions in 49 states and the District of Columbia. (See related *Profile*, page 4.) The coalitions conduct outreach, work to simplify enrollment procedures, and coordinate coverage among various plans. The goal is to help states enroll the estimated 7 million children eligible for, but not enrolled in, the State Children's Health Insurance Program (SCHIP) and Medicaid.

Other potential "max out" targets include individuals who are eligible for private insurance but don't take it, Colby says. "About five percent of people who are offered private health insurance by their employer refuse it and don't have coverage from another source. If we could get them covered through their employers,that would take care of twenty percent of the uninsured."

Most of these workers cite the high cost of coverage as the reason they don't take the coverage, according to a recent study by the RWJF-funded Center for Studying Health System Change.

See **Insurance Coverage —** page 2

FEATURES

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THE ROBERT WOOD JOHNSON FOUNDATION

From **Insurance Coverage —** page 1

Other programs target what Colby calls the "leaky bucket" problem, or workers who are still eligible for Medicaid but drop out of the program when they leave welfare for work. Just this January, RWJF announced *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP, and Food Stamps* with the US Department of Health and Human Services and the US Department of Agriculture, a $6.8-million initiative to help states and large counties fix problems in eligibility processes that make it difficult for families to keep Medicaid or SCHIP as they transition from welfare to work.

The second major strategy is increasing coverage opportunities. *State Coverage Initiatives* will play a key role in this effort. Formerly known as *State Initiatives in Health Care Reform*, which included efforts to improve quality as well as access, *State Coverage Initiatives* will focus exclusively on coverage issues, Colby says.

The program will offer states technical assistance on expanding coverage options. It will give states a forum to share experience in obtaining additional federal funding for Medicaid expansions, as well as practical advice on contacting and signing up eligible workers.

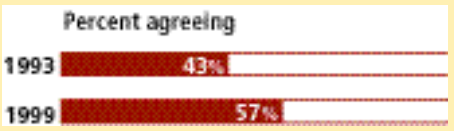
CALLING ATTENTION TO THE PROBLEM

Also critical to expanding coverage options is raising the visibility of the issue of the uninsured — and making it relevant to opinion leaders. An RWJF-funded study shows that a growing percentage of college-educated people believe that the uninsured can get services when they need them. Perhaps it's because most college-educated people have insurance.

"We have to humanize the problem of the uninsured by getting the story out about how it actually affects real people," says Ebeler of the Foundation's efforts to publicize the problem. These programs include seminars and training materials to educate journalists on the issue, and developing a consistent message and language for communicating the Foundation's concerns about the issue.

The Foundation is making a major effort to counter a growing perception that lack of insurance doesn't matter.

MYTH: Uninsured people are able to get the care they need from doctors and hospitals.



Source:Harvard/RWJF Report on Public Attitudes Towards Access to Health,1999.

Just as important will be research documenting who the uninsured are and what impact their insurance status has, not only on health but productivity and overall health costs, Colby says. "We'd like to be able to make a business case for increasing health coverage."

The Foundation also will continue to fund the development and assessment of a wide range of policy options,and, where opportunities arise, test and evaluate different approaches to help understand how ideas actually work in the real world.

A BIG ENTRANCE

To foster interest in these long-term initiatives — and to get people thinking about what kinds of research and demonstration projects might be useful in expanding coverage — the Foundation has sponsored a series of meetings and a publication. The largest was this January's Health Coverage 2000 conference, which was jointly sponsored by the Health Insurance Association of America and Families USA. Its objective was to develop new policy proposals acceptable to these and other divergent interest groups. "They have typically disagreed on the issues, but are now working together because both agree that expanding insurance coverage is important," Ebeler says.

More than 350 people attended the January conference and all eight of the participating groups, including the American Medical Association, the American Nurses Association, the US Chamber of Commerce, and the Service Employees International Union, presented proposals tailored to the current environment. The individual proposals and a side-by-side comparison of them can be viewed on the Foundation's Web site at <www.rwjf.org/events/resources.htm>.

A December conference brought together participants in the *State Coverage Initiatives* to learn how to expand coverage. A November issue of *Health Affairs* spotlighted insurance issues. And a conference last spring with the Employee Benefits Research Institute examined the impact of tax changes on health coverage while a December conference looked at tax options that might encourage coverage.

The RWJF-supported Health Coverage 2000 conference, held in January, was co-sponsored by Families USA (FUSA) and the Health Insurance Association of America (HIAA), two organizations that often disagree on issues. Pictured are Ronald F. Pollack, FUSA vice president and executive director; and Charles N. Kahn III, HIAA president.

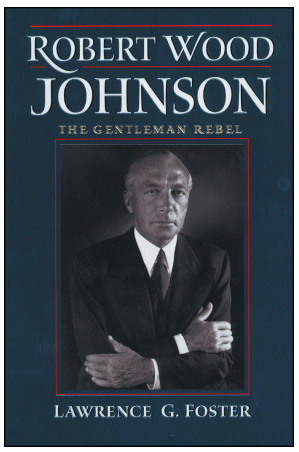
"We're stirring the pot a little to get things going, and, as time goes on, we will establish our long-term efforts," Colby says of the Foundation's launch strategy. "If we don't do something, the numbers of the uninsured are just going to keep going up."

— **HOWARD LARKIN**

Robert Wood Johnson Biography Published

The first biography ever written about Robert Wood Johnson, benefactor of RWJF, has been published. *Robert Wood Johnson: The Gentleman Rebel* (Lillian Press, 673 pages, illustrated) was written by Lawrence G. Foster, former corporate vice president of public relations for Johnson & Johnson, and since 1986, a trustee of The Robert Wood Johnson Foundation.

Though it reads like a novel,the book includes many lessons about building a successful business. Key among them is the one-page Credo of corporate social responsibility that Johnson wrote in 1943. The guidance provided by the Credo has, in part, resulted in Johnson & Johnson developing into one of the world's best known and most admired companies.



The book also relates in detail the origins of The Robert Wood Johnson Foundation, which was begun by Johnson during the Great Depression to help needy families in New Brunswick,N.J., where the headquarters of Johnson & Johnson are located. When Johnson died in 1968, he left virtually his entire fortune — more than $1 billion — to the Foundation to improve the health and health care of all Americans. That bequest has grown to more than $8 billion today.

More than a biography of a businessman, *The Gentleman Rebel* tells the story of Johnson's life, including his childhood, his marriages, and some of his more daring escapades racing sailboats and as a pilot during the early days of aviation. In telling the story of the man,however, it presents the foundations for his vision and his achievements.

CBS News Anchor Dan Rather hosted a town meeting in Philadelphia focusing on the problem of youth violence. More than 500 people attended the meeting, which was sponsored by Philadelphia Safe and Sound,a grantee under RWJF's Urban Health Initiative, and local CBS station KYW. The meeting resulted in a one-hour television special, "Solutions to Violence:An Eye on Education," which aired locally on Dec.4,1999. Safe and Sound,which worked with organizers from KYW to help identify speakers, ran a number of commercials about their efforts during the broadcast.

Last Acts "ER" Promotion Reaches Out

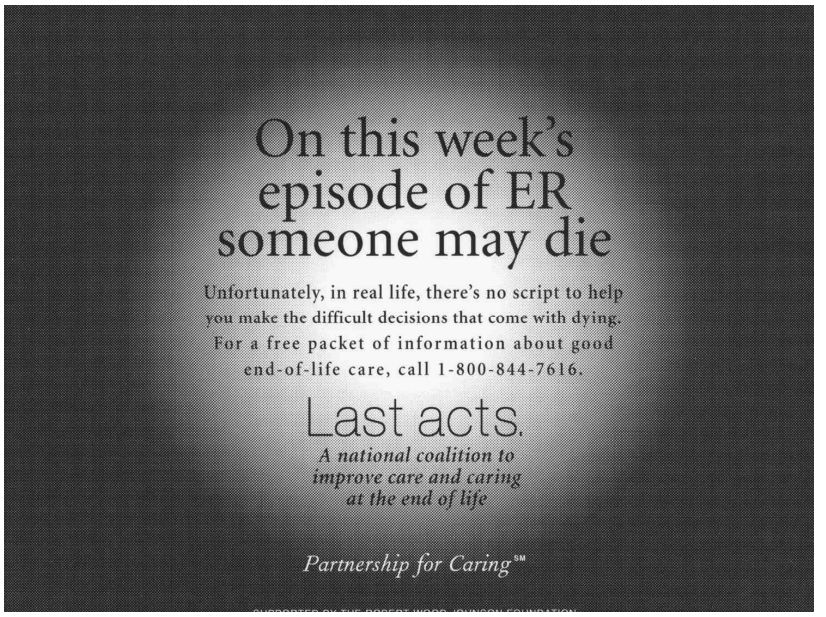
Each week 28 million Americans are captivated by "ER," the Emmy-winning television drama about life in a hectic Chicago emergency room. With advance knowledge from Last Acts Writers' Project consultant Bill Duke that one of the storylines of a November 1999 show would relate to end-of-life decisions, *Last Acts*, an RWJF-supported national effort seeking better care of the dying, launched a promotional campaign to give people basic information about end-of-life services and issues.

Ads purchased in *TV Guide* (shown at right) and in the television sections of newspapers in 21 of the top 25 media markets encouraged people to call a toll-free number, and more than 4,200 callers did so. They received a packet of consumer-oriented information on palliative care and questions to ask their family, doctor, and clergy. (That information also is available on the Last Acts Web site at <www.lastacts.org/er>.)

Just as important as stimulating individual calls was a parallel effort to help *Last Acts* partners and Foundation grantees place stories in their local media. More than 40 television and newspaper stories about end-of-life decision-making resulted.

The "ER" campaign was done in cooperation with one of *Last Acts*' 446 partners, Partnership for Caring, which is dedicated to raising consumer expectations and increasing the demand for excellent care at the end of life.

"The ER episode was a terrific window of opportunity to reach out to the public about end-of-life concerns," says Victoria Weisfeld, MPH, RWJF senior communications officer. "The show dramatized how important it is for each of us to discuss and decide in advance the kind of care we would want throughout a serious illness." She adds, "You know, more than half of 'ER' viewers say they get health information from the program. Given how hard it is to stimulate discussion of the topic of death, we'll be looking to leverage more media opportunities like this in the future."



Thanks to recent federal initiatives, state-sponsored health insurance is now available to children in low-income families. Yet millions of eligible children are not enrolled in these programs. Many low-income working families do not know that their children are eligible for coverage. Others feel that these programs, once linked with welfare, carry a stigma. To reach those families, The Robert Wood Johnson Foundation is funding *Covering Kids*, a $47-million national program designed to help state and local coalitions make health insurance accessible to eligible children. In this interview with *ADVANCES*, Sarah Shuptrine, national program director of *Covering Kids*, talks about how to make subsidized health insurance family-friendly.

There are an estimated 7 million children currently eligible for subsidized health care who are not enrolled in publicly or privately funded health plans. Why aren't their families taking advantage of those programs?

SHUPTRINE — Research has shown that many parents are not aware that their children are eligible. Many do not know that children can be in two-parent families or families with wage earners and still get Medicaid coverage. There is a widespread belief that children have to be on welfare to qualify. That's a real obstacle. Another major reason families aren't enrolling is that the application processes have been complicated and burdensome, primarily because of the association with welfare. Medicaid and the State Children's Health Insurance Program (SCHIP) are not welfare programs and the application questions and verification documents should be kept to a minimum. Places to apply need to be increased, and policies that project a welfare mentality, such as asset testing, should be reevaluated in the context of child health coverage. Once these types of reform are implemented — on a state-by-state basis — I think we'll see more families applying and completing the process to gain health coverage for their children.

Why do so many parents feel that there's a stigma attached to enrolling their children in Medicaid or SCHIP?

SHUPTRINE — In the past, the application process contributed to the stigma. Federal and state eligibility policies created a demeaning environment. We have made some progress but the job isn't done yet in many states. For example,most states continue to ask questions about establishing paternity, stating that non-cooperation can result in denial of coverage when, in fact, federal law makes it very clear that a child cannot be denied Medicaid coverage due to lack of cooperation on the part of an adult. When these types of welfare-related questions are asked, it sends a message to families that child health coverage is welfare. At that point,many will turn away because they don't want anything to do with welfare.

What happens when uninsured kids get sick?

SHUPTRINE — If it's an emergency, they're going to get care at hospital emergency rooms. But many uninsured kids don't get the kind of primary and preventive care they need to avoid emergency room visits. Suppose a child has a severely sore throat, which could develop into a serious health threat. What you want is for that sore throat to be caught at its earliest stage. But if the child is uninsured, the parent usually waits until it gets worse and then finally takes him or her to the emergency room.

Don't health care providers know about the programs currently available for uninsured children? Aren't they encouraging their patients to enroll?

SHUPTRINE — Some health providers are involved, but not enough understand what an important link they are in helping to get the word out and enroll children. The American Hospital Association has a campaign to get more hospitals to understand the value of effective enrollment and outreach programs. Hospitals that have invested in on-site eligibility services have found it to be one of the better moves that they can make — especially if they couple it with an outreach program, so they can actually help the families obtain the required documentation. Physicians' offices are certainly another appropriate target for this kind of outreach. But it takes a lot of one-on-one education to make sure physicians — and their office staff — understand that these programs are available to working families. Once providers begin to understand that Medicaid and SCHIP eligibility is not associated with welfare,they can develop a new mindset and think of ways to help enroll eligible children.

It's perplexing that the problem of uninsured children remains so great despite policy initiatives to get kids covered. Why don't those initiatives translate into real-world progress?

SHUPTRINE — It requires consistent commitment to translate progress in the policy arena into real-life opportunities for families. You have to review all entry points for child health coverage to make sure you've made it as accessible as possible. You have to think through every part of the process, every piece of paper that's required. For example,if you require face-to-face application interviews to get information that they could just as well provide over the phone — you've created obstacles to available coverage,especially if your office is only open during normal work hours. If you have an over-extensive verification process,if you require families to come back to the office for reapplication, you've created obstacles.

A nationwide survey found that only 26% of parents with uninsured children had even heard about SCHIP. How does *Covering Kids* plan to help get the message to the rest of those families?

SHUPTRINE — The 50 statewide and 167 local *Covering Kids* coalitions are working to help develop messages that convey a new sense of what Medicaid and SCHIP are about and how to apply. Identifying effective dissemination strategies and working with appropriate messengers are critical to success. Grantees are bringing the eligibility process out from behind desks, going to schools, churches, community groups,low-wage employers, and shopping centers to assist families in applying for health care coverage. It makes all the sense in the world to get out into the mainstream to reach eligible families. But we have to be diligent about the simplification component, because if families apply at shopping centers or schools, then have to provide a whole lot of additional documentation, they may not complete the process — so you lose them. You have to make sure that your outreach initiatives are backed by a simplified, dignified eligibility system.

— INTERVIEW BY ELIZABETH AUSTIN

Who's Got a Gun at College?

In the wake of gun-related violence in schools across the nation, the federal government, public health professionals,and the public want to know more about the prevalence of weapons on college campuses. Recent media reports point to guns as "a growing menace on campus," but there are very few hard data on gun-related injuries and fatalities — and even fewer data on the number of students who bring their guns to college.

This study analyzed data from the Harvard School of Public Health College Alcohol Study — a survey of the drinking habits of more than 15,000 undergraduates at 130 US colleges under a grant from The Robert Wood Johnson Foundation. In the 1997 survey — the first-ever survey to include information on firearm possession in a national sample of college students — students were asked, "Do you have a working firearm with you at college?" The researchers examined their responses, as well as the information they provided on their drinking behavior, problems related to drinking, and other health issues.

About 3.5% of the students polled said they had a gun at college. Men and students over 21 were more likely to own guns. Location also played a role. More students at public colleges, rural colleges, and colleges in the South and West reported owning a gun. In addition,students with guns were significantly more likely to live off campus, reside with a spouse or significant other, or have an affiliation with a fraternity or sorority.

Students identified as risk-takers through their survey responses were also more likely to own guns. For example, students who reported binge drinking (drinking five or more drinks in a row), drinking first thing in the morning, driving a car after drinking, getting arrested/or driving under the influence of alcohol, and damaging property as a result of alcohol intoxication were more likely to have a gun at school than students who didn't engage in these behaviors. This study suggests that students who engage in activities that put themselves and others at risk for severe or life-threatening injury are the ones most likely to own guns. Gun ownership was also greater among students injured in alcohol-related fights, car accidents, or sports activities.

The authors conclude,"Perhaps the root cause is an attitude toward risk that leads individuals to risk losing control of their behavior and leads them to purchase firearms."

Miller M, Hemenway D, and Wechsler H. Guns at College. *Journal of American College Health* 48 (July):7–12,1999.

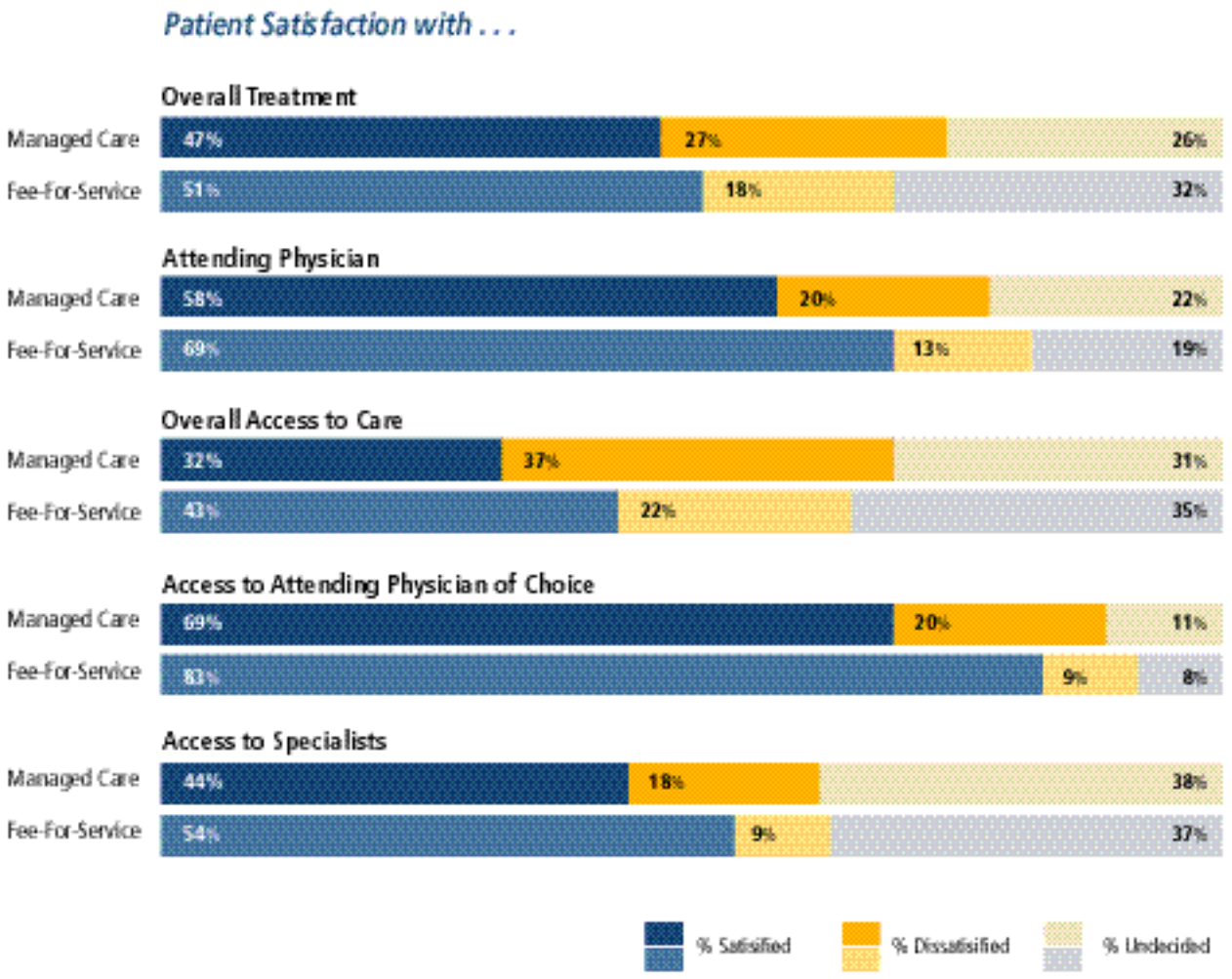
Managed Care Meets Workers' Compensation: Cost Versus Satisfaction

In the United States, workers injured on the job typically receive both medical care and payment for lost wages through a system known as workers' compensation. Unfortunately, it's a less-than-perfect system — costs are high and quality has been questionable. In 1993, national expenditures for medical care for workers' compensation patients exceeded $17 billion, yet treatment outcomes for those patients were worse than for patients treated in the regular health care system.

Seeking to cure these ills, many states launched managed care programs for their workers' compensation systems. In 1993, Washington State initiated the Managed Care Pilot (MCP), which made two significant changes to the workers' compensation system: (1) participating health plans for the first time assumed a level of financial risk, accepting a prepaid rate for each worker to cover medical care; and (2) workers were required to choose a physician from a limited network of physicians, many of whom were trained in occupational medicine.

As mandated in the legislation that authorized the MCP, this study evaluated the effectiveness of managed care within the state's workers' compensation system, comparing costs, outcomes, and patient satisfaction with traditional fee-for-service (FFS) arrangements. (The results of the cost analysis are reported in a companion article.) Some 120 firms in eastern and western Washington — representing more than 7,000 workers — participated in the pilot study. Only those firms that demonstrated agreement by a majority of the employees were eligible to participate. A Seattle-based preferred provider organization (PPO) and a Portland, Oregon-based health maintenance organization

Workers' Compensation Managed Care Pilot Project: Patient Satisfaction 6 Weeks After Injury



provided the workers' compensation coverage. A control group of nearly 400 firms with approximately 12,000 employees participated in the evaluation. The comparison firms had similar numbers of workers and risk factors, and were located in the same counties as the MCP firms.

The investigators tracked injuries, medical care costs and outcomes, and patient satisfaction for both the MCP firms and the comparison firms for one year. Workers from the MCP firms who were injured during the one-year period received medical care through the designated managed care plan for up to 9 months,after which their care reverted to the normal FFS arrangement and workers could obtain care from any provider.

To gauge patient outcomes and satisfaction, trained interviewers spoke with injured workers by phone 6 weeks after the injury. Employees whose injuries resulted in 4 or more days of lost work time also were interviewed 6 months after their injury occurred. In all,more than 2,500 injured workers were interviewed.

Based on workers' responses to questions about their general health, bodily pain, physical functioning, and mobility, there was "little meaningful difference" in medical outcomes between the MCP patients and the FFS patients. The MCP was associated with significantly lower medical and disability costs. On average, medical care costs were 21% lower for MCP patients compared with FFS patients, while disability costs were 45% lower.

Managed care patients were less satisfied with their treatment than FFS patients. Overall, 47% of MCP patients were satisfied with their treatment compared with 51% of FFS patients. The differences in satisfaction levels between the groups increased when they were asked about satisfaction with their physicians and their access to care: 58% of MCP patients reported being satisfied with their physician compared with 69% of FFS patients and just 32% of MCP patients said they were satisfied with their access to care compared with 43% of FFS patients. Among workers who were interviewed again 6 months after their injuries, the level of satisfaction with treatment was equivalent across the MCP and the FFS groups, but MCP patients expressed greater dissatisfaction with access to the providers of their choice. Notably, within the workers' compensation system in general — across both the MCP and FFS patients — satisfaction with overall treatment and overall access to care was low.

"Managed-care and FFS patients clearly differed in regard to their satisfaction with care," the authors conclude. In both the 6-week and the 6-month survey, MCP patients consistently expressed dissatisfaction with the limited access to the provider of their choice. The authors pinpoint choice of provider as an important satisfaction-related issue for workers who receive care through a managed care system. They contend,"By restricting provider choice, managed-care organizations run the clear risk of increasing dissatisfaction among patients." The findings of this research once again demonstrate the trade-off associated with managed care — lower medical costs and diminished patient satisfaction.

Kyes KB et al. Evaluation of the Washington State Workers' Compensation Managed Care Pilot Project I: Medical Outcomes and Patient Satisfaction. *Medical Care* 37 (10): 972–981,1999.

Weight Concerns May Prompt Some Adolescents to Begin Smoking

Despite all the warnings about the dangers of cigarette smoking, adolescents still begin smoking in substantial numbers. Among high school students, smoking has actually increased in recent years. En route to becoming smokers, adolescents pass through 4 decision-making stages: precontemplation, contemplation, action, and maintenance. During each stage, they may be vulnerable to specific influences that push them to the next level. Having a better understanding of the risks at each stage could help in identifying optimal points for intervention.

The investigators hypothesized that concerns about weight control may play an important role in the 3 earliest stages of smoking initiation, and they

expected that these concerns would affect girls more than boys. To test their hypothesis,they studied 15,366 children ages 9 to 14 and asked them if they had ever experimented with smoking or thought they would try a cigarette in the next year. From their responses, the children were classified as precontemplators, contemplators, experimenters, or regular smokers.

To evaluate the children's concerns about weight, the investigators asked the youth to describe their weight in terms of 5 categories (very underweight to very overweight) and compared their perceptions to their actual weight to determine whether they thought they were overweight when in fact they were not.

The youth were also asked about how often they thought about being thinner. Girls were asked how often they worried about gaining 2 pounds and boys how often they wanted bigger muscles. The children also reported on how frequently in the last year they had engaged in dieting, exercising, using laxatives, and vomiting to control their weight.

In the total group of children, approximately 6% were contemplating smoking (7% girls,5% boys), and 10% each of the girls and boys had experimented with cigarettes. Since only a small percentage were regular smokers, these children were combined with the experimenters for purposes of data analysis.

In girls and boys,the proportion who were overweight was higher in the later stages of smoking initiation. However, the relationship between weight and decision-making stage was significant only among boys. Boys who had experimented with cigarettes were 40% more likely to be overweight than those who were still contemplating smoking.

Concerns about weight were more prevalent at the contemplation and experimentation stages than at the precontemplation stage in both girls and boys. Girls at the two later stages were more likely to misperceive themselves as being overweight than were girls at precontemplation, whereas boys' misperceptions about being overweight were significant only at the contemplation stage. In both girls and boys, the contemplation stage was associated with being unhappy with their appearance and changing eating patterns when around peers of the opposite sex.

Weight control measures such as dieting, exercising, and purging were more common during the experimentation stage than in the earlier smoking initiation stages, although these behaviors also were seen during contemplation. Girls exhibited somewhat different behaviors from boys. Girls at the contemplation stage tended to engage in bingeing, but daily dieting and monthly purging were more common at the experimentation stage. Boys at the experimentation stage were more likely to engage in daily exercise to lose weight.

For children as young as age 9 concerned about their weight and at risk for initiation of smoking, the authors conclude that pediatricians and school health programs need to educate youth about healthy methods of maintaining ideal weight and dispel the notion that smoking should be used for this purpose.

Tomeo CA et al. Weight Concerns, Weight Control Behaviors, and Smoking Initiation. *Pediatrics* 104 (October): 918–924,1999.

Health Care Among the Urban Poor

Most poor adults living in urban areas access health care when they need it. Unfortunately, the way they get their care does not make the best use of the health care system. Studies show that homeless adults and other low-income individuals often use the hospital emergency department as a regular source of care.

Determining why low-income adults routinely use care from emergency departments or other care sites can help promote the proper use of primary care and prevention services. This study looked at the care-seeking behavior of homeless and housed poor adults in Allegheny County, Pa., to answer these questions.

Trained interviewers met face-to-face with nearly 400 low-income individuals who frequented any of 24 community sites in the greater Pittsburgh area. These sites included soup kitchens,public parks,drop-in centers, emergency shelters, and transitional housing. The interviewers asked this population about their physical and mental illnesses, recent use of health care services, satisfaction with care, preferences for sites of care, and barriers to care. Using different health care scenarios — such as needing care for a cold or flu, a chronic medical condition, a sexually transmitted disease, or a psychiatric illness — the interviewers assessed participants' knowledge of available health care resources.

Clinical Notes

Better Screening of High School Athletes Could Uncover Hidden Heart Disease

The death of a high school athlete from a sudden heart attack during exercise is tragic and, fortunately, rare. But the sobering reality from a study of high school sports programs in the United States is that few schools adequately screen their athletes for heart disease before competition begins.

Since some cardiac abnormalities associated with sudden death cannot be detected either by stethoscope or electrocardiogram, several national physicians' associations have endorsed the use of a standard form covering three key components of cardiac history, as recommended by the American Academy of Pediatrics (AAP): (1) symptoms with exercise such as passing out, feeling dizzy, or having chest pain during or after exercise; tiring more quickly than friends during exercise; feeling racing heart or skipped heartbeats; (2) previous diagnosis of high blood pressure or heart murmur; and (3) family history of heart attack or sudden death before age 50.

To determine actual use of the recommended prescreening form, researchers mailed a survey to 500 randomly chosen high schools, asking their athletic trainers to submit a copy of the school's form.

Of the 254 schools responding, only 186 sent in forms that included medical history questions. Of these, only 17% covered all three AAP components. Only 25% questioned exercise-related symptoms, about 50% covered a previous diagnosis of high blood pressure or heart murmur, and 30% asked about relevant family history. Having a team physician did not affect the content of forms.

From these results, the researchers emphasize the need for a national preparticipation evaluation form. They feel that "some lives could be saved by making this inexpensive and practical screening procedure" a standard part of the routine athletic evaluation.

Gomez JE et al. Current Use of Adequate Preparticipation History Forms for Heart Disease Screening of High School Athletes. *Archives of Pediatric and Adolescent Medicine* 153 (July): 723–726, 1999.

Dr. Gomez is a former Robert Wood Johnson Foundation Generalist Physician Faculty Scholar.

More than 85% of the adults who participated in the study were male,78% were African American, and nearly 77% were between 30 and 49 years old. About 60% of the participants had been homeless for less than a year. The majority of those interviewed had graduated from high school and nearly 30% were currently employed. About two-thirds of the participants said they had used health care services within the past 6 months and most had some type of health insurance — usually either Medicaid fee-for-service or managed care — that covered their medical care.

More than 90% of respondents identified a source of regular medical care; 51% reported using traditional ambulatory care sites — such as hospital-based clinics, community and VA clinics,and physician offices — for their routine care. The next most frequently reported source of regular care was the emergency room, mentioned by 29% of those interviewed.

Individuals who routinely used the emergency room or said they had no source of regular care were more likely to lack health insurance,had not received any medical care in the previous 6 months, and were non-veterans. Interestingly, when asked where they would go for care if they needed a physical exam or preventive care, more than 60% of participants said they would visit a traditional ambulatory care site, although only 51% identified this as their usual site of care.

Among participants who received medical care within the past 6 months,satisfaction was high. A majority said that staff were respectful, care was helpful, and their questions were answered. Less than one-third reported facing a long wait — even in the emergency room — and very few said they had any difficulty getting to the site of care. Overall satisfaction with care was highest among individuals using shelter-based clinics, followed by those treated at a community clinic or physician office. Satisfaction was lowest among regular users of the emergency room, yet nearly 73% of these individuals were satisfied with their care.

More than a third (35%) of those surveyed said that at least once in the last 6 months they were sick enough to need medical care but failed to get it. The number one reason for not getting care was lack of transportation. Individuals who used ambulatory care sites for their regular care were more likely to report barriers to obtaining care — such as lack of identification, inability to keep an appointment, and lack of money — than were individuals who used the emergency department. Most respondents felt it was necessary to have insurance in order to receive care at either ambulatory care sites or an emergency department.

According to the authors, 4 of the top 5 reasons for not getting care represent structural or system-based barriers. These findings "underscore the importance of issues in addition to health insurance that affect access to care." They suggest that "efforts to redirect primary and nonacute care away from emergency departments and improve access to regular care need to focus on outreach, education, and medical insurance coverage."

O'Toole TP, Gibbon JL, Hanusa BH,and Fine MJ. Preferences for Sites of Care Among Urban Homeless and Housed Poor Adults. *Journal of General Internal Medicine* 14 (0ctober):599–605,1999.

Dr. Fine is a former Robert Wood Johnson Foundation Generalist Physician Faculty Scholar.

Ethnic Similarity Smoothes the Doctor-Patient Relationship

The style of interpersonal communication between physicians and patients of different races and gender can play an important role in health care delivery. Most patients feel more satisfied with their physician when the physician uses a participatory style, involving them in the decisions about their health care. In our increasingly diverse nation, it would be useful to know if racial, ethnic, and gender differences affect perceptions of what is "participatory." Do white patients and minority patients, for instance, view the decision-making style of their physicians differently? Do white physicians and minority physicians, according to their patients, participate differently in treatment decisions? If the patient and physician are of the same race and gender — or not — does this make a difference?

Investigators set out to answer these questions in a study of 1,816 patients served by managed care practices in Washington, D.C. They conducted a telephone survey in which they asked the patients 3 questions about their physicians: (1) If there were a choice between treatments, how often would your doctor ask you to help make the decision? (2) How often does your doctor give you some control over your treatment? (3) How often does your doctor ask you to take some of the responsibility for your treatment?

The mean age of the patients was 41 years (range, 18 to 65). About half were seeing white physicians, 27% were seeing African-American physicians,and 26% were seeing physicians of other races. Approximately two-thirds of the physicians were men. Compared with the white patients in the study, the African-American patients tended to be slightly older, and more of them were women, unmarried, and less educated. They also tended to have poorer perceived health and to be seeing African-American physicians.

After analyzing their data, the investigators found that the patient's race, rather than the physician's, was a more significant factor in ratings of participatory style. African-American patients rated their physicians as having a less participatory style than did white patients, and this trend was also seen for other minority patients, although not to a significant degree.

Although the physician's race did not significantly affect how patients rated participatory style,the physician's gender did: women physicians were credited with more participatory visits than men.

As for the impact of similarities, physicians got the highest scores for participatory decision-making style when they and their patients were of the same gender and race.

"This study," the authors conclude, "adds to a growing body of research indicating that ethnic differences between physicians and patients are often barriers to partnership and effective communication." On the one hand, physicians may be influenced by ethnic stereotypes and be unaware of ethnically defined disease models. Minority patients, on the other, may lack health literacy and self-management skills and be hindered by language barriers. But shared cultural beliefs may allow patient and physician to communicate more effectively and comfortably.

This being the case, interventions that improve cross-cultural communication in primary care settings should be developed. All levels of health professionals could benefit from training in "cultural competence," that is, understanding of health-related beliefs and cultural values,disease incidence and prevalence,and treatment efficacy. These strategies could lead to "more patient involvement in care, adherence to recommended treatment, higher quality of care, and better health outcomes."

Cooper-Patrick L et al. Race,Gender, and Partnership in the Patient-Physician Relationship. *The Journal of the American Medical Association* 282 (August 11): 583–589,1999.

Dr. Cooper-Patrick is a fellow in the Robert Wood Johnson Foundation Minority Medical Faculty Development Program.

Public Opinion Helps Guide Strategies

If you've dedicated your working life to reducing underage drinking, it's natural for you to view that issue as one of the top problems facing Americans today. But what about all those people who don't work on alcohol abuse prevention? How do they view the subject? Would they support community programs or policies that address the issue?

"Many other people may not think it's as important a problem and they may be skeptical about whether or not you have a solution for this problem," says Robert J. Blendon, ScD, professor of health policy and political analysis at the Harvard University School of Public Health.

To get a handle on public attitudes toward health and health care issues, Blendon and his colleagues have a two-year Robert Wood Johnson Foundation grant for opinion polling, which began in September 1998. The subjects covered include access to health care, national problems and priorities, end-of-life issues, alcohol, smoking, and illegal drug use and drug treatment.

"It's essential to know what the public thinks," says Stuart Schear, RWJF Foundation senior communications officer, who works on health care access and coverage projects. "If part of our job is to inform people, we need to find out what it is they need to know," says Schear. "We think more [insurance] coverage is very important for health and health care for all Americans. We need to fully understand the public view of that proposition so we can plan our communications strategy accordingly."

Blendon's recent polling showed a majority of Americans "seem to view the issue [of the uninsured] as being less real than they did five or six years ago," says Schear.

Compared to 1993,more Americans today believe the uninsured are able to get the care they need, despite the fact that the number of uninsured is growing and those without insurance face many barriers to health care, according to Blendon.

Partly as a result of these survey findings, the Foundation is developing communications projects aimed at "raising the public's interest in the issue and increasing understanding that the lack of health care coverage does have serious consequences for individuals," says Schear.

For the Foundation's tobacco group, the survey results have helped target their efforts,says Joe Marx,senior communications officer.

"We've found people are very strong in the feeling that they don't want kids to smoke, and they see education programs as a way to achieve that," says Marx. "On the other hand, when it comes to adult smoking, many people feel adults should be able to smoke if they choose."

Such information about public opinion, says Marx,"is an important tool, somewhat like a compass, to help us know if our strategies are on course."

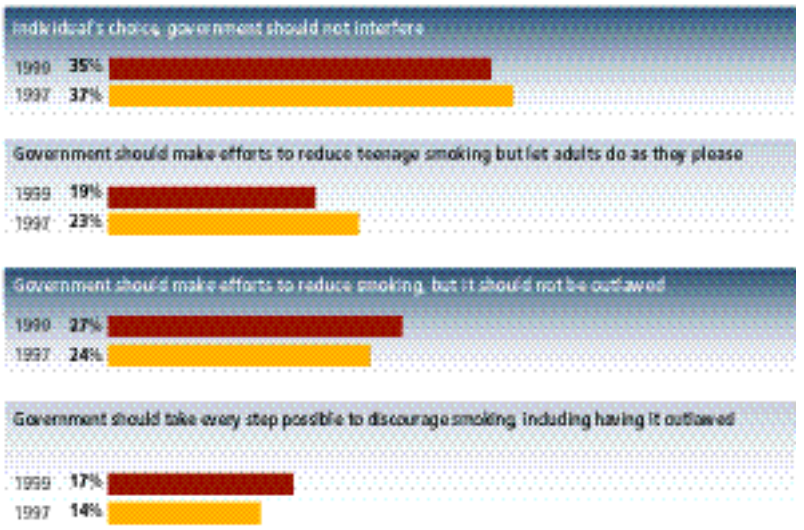
Survey results in other subject areas include:

- A majority of Americans think illegal drug abuse is a bigger problem now than it was five years ago.
- African Americans (80%) are much more likely than whites (53%) to say that the illegal drug problem has gotten worse.
- Most Americans do not believe college alcohol abuse and alcohol abuse in general are bigger problems now than five years ago.
- Only 14% of those surveyed have ever discussed with their doctor what kind of care they would want at the end of life.
- About one-third of those surveyed had never had a discussion about their preferences in end-of-life treatment with either their family or their doctor.

"When you talk about general issues in health,nobody's against anything," says Blendon. "People say, yes, we should do something about that,and yes, we should do something about this. But when you ask them about specific topics, some things are more important to them than others. So we try to give the Foundation a sense of what the really salient issues are in people's minds. We help them think about what these issues mean from the public's perspective."

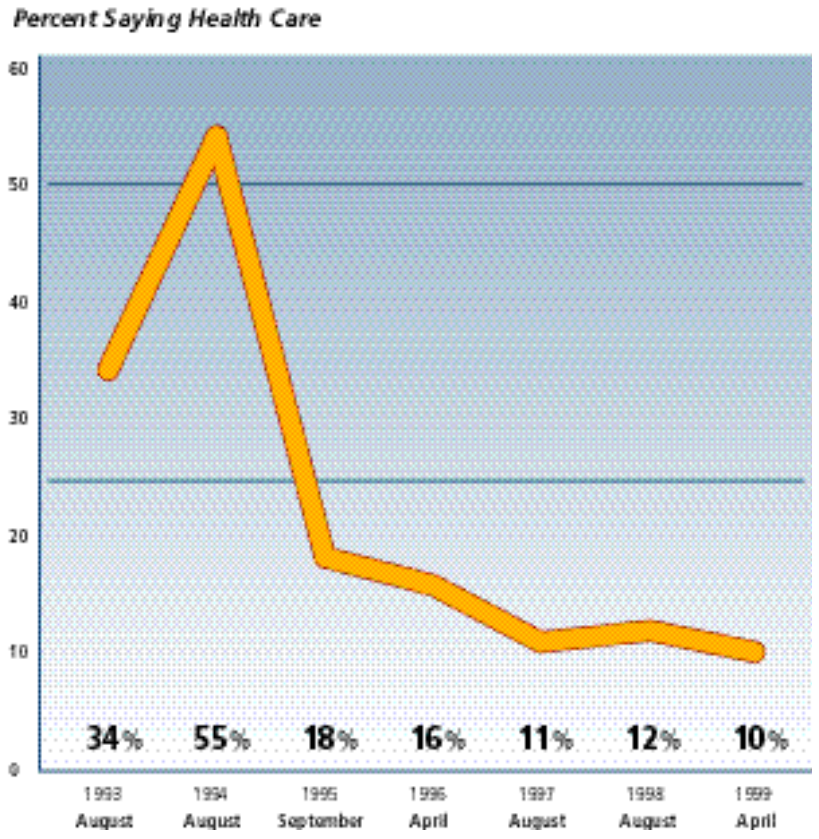
— LAURIE JONES

Americans' Views of the Government's Role in Smoking



Americans want government to be active in reducing teen smoking. However, a majority do not want government to pass laws to restrict smoking by adults.

One of Two Most Important Issues for Government to Address



Since 1994, there has been a significant decline in the proportion of Americans who list health care as one of the two most important issues for government to address.

New Grant Results Reports Posted on RWJF Web Site

Twenty-two Grant Results Reports and two National Program Reports are newly posted on the RWJF Web site <www.rwjf.org> under the section *Grant Results & Related Publications*. Lists of reports are organized by topic area. A search engine allows a full-text search. Each report describes the purpose of the project, its results, and gives project director contact information. Highlights include:

- **Development of and Support for a State Midwifery Resource Center.** The University of Florida College of Medicine in Gainesville established the Florida Midwifery Resource Center (FMRC) to increase the availability and accessibility of midwifery services throughout the state. Two grants totaling $477,806 ran from August 1992 through May 1997. The number of private doctors delivering obstetrical care in Florida had decreased from more than 2,000 in 1985 to 1,007 in 1991, while the number of births per year had increased by 30,000. A survey of health care providers in the state about the actual and potential role of midwives provided the basis for a strategic plan to educate additional nurse-midwives and promote the development of free-standing birth centers. Since the first grant began, there has been an 82% increase in the total number of nurse-midwifery graduates in Florida, most of them trained through state-funded distance education programs. The FMRC also facilitated improved nurse-midwifery practice situations in hospitals, promoted the inclusion of nurse-midwives and birth centers in managed care networks, and helped birth centers with accreditation and marketing. The FMRC is now part of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida, College of Public Health, Tampa, and continues to serve as a resource for providers, payers, and prospective and practicing midwives. *Contact: Charles S. Mahan, MD, 813-974-6603, arichter@com1.med.usf.edu.*
- George Washington University received a grant of $43,770 in August 1996 for **Developing a Toolkit to Help Hospitals Measure Quality of Care at the End of Life.** A conference of 31 experts reviewed current knowledge and developed consensus on a draft toolkit of measurements based on the perspectives of dying patients and their families. The toolkit is available on the World Wide Web at <www.chcr.brown.edu/pcoc/toolkit.htm>. The

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RWJF National Program Director Honored for Work Against Hunger David Altman,PhD, has a passion for public health issues. He's a professor of public health sciences and pediatrics at Wake Forest University School of Medicine in Winston-Salem, N.C.,and director of the RWJF Substance Abuse Policy Research Program. But he also cares very much about hunger in the United States and took that concern on the road in February and March — with a 16-city, 3,000-mile bike trek from California to North Carolina to raise public awareness about hunger and $1 million to support Hunger Relief 2000 and MAZON:A Jewish Response to Hunger.

In recognition of his commitment to hunger awareness and relief, Altman was one of five regional winners of the David Yurman Thoroughbred Humanitarian Award in November 1999. Steven Spielberg was the national award winner.

Altman has studied hunger in Bangladesh,Northern Ireland, Poland,and Russia,as well as within the United States. The prevalence of hunger here, however, has less to do with a lack of food (the United States produces 20% more food than Americans can consume) than with a lack of financial, political,and social resources to distribute food and to alleviate poverty. And the number of hungry Americans continues to rise. About 26 million Americans, most of them children,rely on assistance from food banks to prevent hunger;35 million Americans live in food-insecure households. Lack of nourishment affects children's school performance and social interactions as well as their physical health and development.

More information about the Hunger Relief 2000 project and MAZON is available at <www.hunger-relief2000.org> and <www.mazon.org>.

Breaking Ground for New Ideas RWJF Board Chairman Robert Campbell (center), RWJF President and CEO Steven A.Schroeder, MD (right), and Plainsboro Mayor Peter Cantu (left), braved the snow and wind January 27 for the groundbreaking ceremony for the Foundation's new headquarters.

The three were joined indoors by RWJF trustees and staff — including locally based national program directors and their staff — as well as the architects, engineers, and construction team creating the new facility. Schroeder traced the history of the buildings the Foundation has occupied — from its first, a three-bedroom Victorian house in New Brunswick, N.J., which held a few staff in 1972, to RWJF's current headquarters physically located in Plainsboro, N.J., which houses several hundred staff and will soon include the new facility opening in 2001.

Quoting Robert Wood Johnson, recognized as an industrial innovator, Schroeder captured the spirit of the Foundation as it begins this new endeavor: "We build not only structures in which men and women will work, but also the patterns of society in which they will work," Johnson said. "We are building not only frameworks of stone and steel, but frameworks of ideas and ideals."

The groundbreaking is the first step in what is anticipated to be a 22-month project of new construction, renovation of the existing facility, and then relocation of staff to the entire expanded Foundation headquarters.

SELECTED GRANTS

Projects to Promote Health and Reduce the Personal, Social, and Economic Harm Caused by Substance Abuse — Tobacco, Alcohol, and Illicit Drugs

- For a tobacco control leadership fellows program, $399,625 to The Advocacy Institute, Washington, D.C.
- Planning support for a collaborative effort to revise and evaluate the DARE middle school program, $432,797 to The University of Akron, Ohio.
- For evaluation of the *Addressing Tobacco in Managed Care* initiative — Phase I, $226,072 to Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, Mass.
- For a national youth summit to prevent underage drinking, $250,000 to Mothers Against Drunk Driving, Irving, Texas.
- Support for the 2000 Tobacco Use Prevention Training Institute, $150,000 to University of North Carolina at Chapel Hill.
- For building consensus and public awareness activities for a national drug policy based on medicine and public health, a renewal award of $749,951 to Brown University Center for Alcohol and Addiction Studies, Providence, R.I.
- *SmokeLess States: Statewide Tobacco Prevention and Control Initiatives*. Renewal awards to three sites, totaling $845,067.
- *Substance Abuse Policy Research Program*. Awards to nine sites, totaling $2.4 million.

Projects to Assure That All Americans Have Access to Basic Health Care at Reasonable Cost

- *Communities in Charge: Financing and Delivering Health Care to the Uninsured*. Awards to 20 sites, totaling $3 million.
- *Southern Rural Access Program*. Awards to two sites, totaling $1.7 million.
- *State Coverage Initiatives*. One award of $400,000 to State of Rhode Island Department of Human Services, Providence, for planning a comprehensive health care coverage program for the uninsured and underinsured

Projects to Improve the Way Services Are Organized and Provided to People with Chronic Health Conditions

- For nursing faculty development in end-of-life care, $2.2 million to American Association of Colleges of Nursing, Washington, D.C.
- For supporting state cancer pain initiatives, $1.4 million to University of Wisconsin–Madison Medical School.
- For evaluation of an education program for families of persons with serious mental illness, $202,401 to University of Maryland School of Medicine, College Park.
- For engaging national organizations in *Self-Determination for Persons with Developmental Disabilities*, $206,567 to University of New Hampshire, Durham.
- For the HMO Workgroup on Care Management, a renewal award of $264,294 to AAHP Foundation, Washington, D.C.
- *Community-State Partnerships to Improve End-of-Life Care*. Awards to five sites, totaling $1.9 million. Renewal awards to nine sites, totaling $3.3 million.
- *Managing Pediatric Asthma: Improving Clinical Care in Vulnerable Populations*. One award of $495,689 to Center for Health Care Strategies Supporting Organization, Princeton, N.J., for exploring barriers to financing and treating pediatric asthma.
- *Strengthening the Patient-Provider Relationship in a Changing Health Care Environment*. Awards to four sites, totaling $1.2 million.
- *Targeted End-of-Life Projects Initiative*. Award of three program grants, totaling $236,582.
- *Workers' Compensation Health Initiative*. One award of $350,265 to University of Texas Health Science Center at Houston for developing and testing of a standardized method to create an interstate database on workers' compensation medical care.

Other Programs and Those That Cut Across Foundation Goals

- For replication of a prosocial schooling model, $2.8 million to the Developmental Studies Center, Oakland, Calif.
- For implementation of an education campaign on vaccine safety, $2.7 million to the Infectious Diseases Society of America, Alexandria, Va.
- For the State Health Policy Leadership Information Project, $2 million to the National Conference of State Legislatures, Washington, D.C.
- For establishing a community-wide family health development program, $799,854 to HCR Cares, Rochester, N.Y.
- Interim support for Eric B. Chandler Health Center, a renewal grant of $1 million to the Foundation of the University of Medicine and Dentistry of New Jersey, Newark.
- *After School: Connecting Children at Risk with Responsible Adults to Help Reduce Youth Substance Abuse and Other Health-Compromising Behaviors.* One award of $5 million to Youth Sports Connection, San Francisco, for a community initiative to increase participation in youth sports.
- *Children's Futures.* One award of $382,207 to Thomas A. Edison State College, Trenton, N.J., for development of options to improve health outcomes for children in Trenton.
- For identifying environmental and policy factors impacting physical activity among African-American women, $139,957 to University of Alabama at Birmingham.
- For evaluation of the Cleveland Eastern Suburban Born to Learn program, $671,836 to Case Western Reserve University School of Medicine, Cleveland.
- For understanding citizen involvement in the development of community capacity: an exploratory study, $178,783 to Florida Atlantic University, Boca Raton.
- For a computer-assisted prevention system for primary care, $197,015 to The Miriam Hospital, Providence, R.I.
- For encouraging safe, active modes of transportation for children and youth, $205,000 to Pedestrians Educating Drivers on Safety, Atlanta.
- For a pilot program to evaluate walking paths designed to encourage physical activity in Rhode Island communities, $618,828 to Rhode Island Public Health Foundation, Providence.
- For expansion of a news service on community engagement, $400,010 to Center for Living Democracy, Brattleboro, Vt.
- *Health Tracking*. A renewal award of $5 million to University of California, Los Angeles, Center for Health Sciences, for understanding changes in alcohol, drug abuse, and mental health services.
- *Multistate Initiative to Help Build a Health Information Infrastructure*. A renewal award of $443,208 to Foundation for Health Care Quality, Seattle.
- Developing a dispute resolution quality assessment protocol, $239,998 to New York University, Robert F. Wagner Graduate School of Public Service, New York, N.Y.
- For a national coalition to educate health professionals in genetics, a renewal award of $749,093 to Foundation for the National Institutes of Health, Bethesda, Md.
- For an evaluation of *Scholars in Health Policy Research Program*, $148,371 to Syracuse University, Maxwell School of Citizenship and Public Affairs, Syracuse, N.Y.
- *Changes in Health Care Financing and Organization*. Awards to eight sites, totaling $968,580.
- *Minority Medical Education Program*. A renewal award of $1.5 million to the United Negro College Fund, Fairfax, Va.
- *Minority Medical Faculty Development Program*. Awards to four sites, totaling $1.5 million.
- *New Jersey Health Initiatives*. Awards to eight sites, totaling $2.3 million.
- For a neighborhood family support services program, $400,000 to Renaissance Community Development Corporation, Somerset, N.J.
- For assistance to needy and indigent families, $228,700 to The Salvation Army, New Brunswick, N.J.

WELCOME

LINDA BILHEIMER, PHD, joined the Foundation in November as a senior program officer in the Evaluation and Research Unit. Before coming to RWJF, Bilheimer was the deputy assistant director for health for the Congressional Budget Office in Washington, D.C.

KAREN DAVENPORT, MPA, began working at the Foundation in November as a program officer in the Program Office. Before joining RWJF, Davenport was a legislative assistant to US Senator Bob Kerrey, in Washington, D.C.

MICHELLE LARKIN, RN, MS, joined the Foundation in November as a program associate in the Program Office. Previously, Larkin was a health policy analyst with the Centers for Disease Control and Prevention's Office on Smoking and Health in Washington, D.C.

ANNE WEISS, MPP, came to RWJF in November as a senior program officer in the Program Office. Prior to joining the Foundation, Weiss was the senior assistant commissioner with the New Jersey Department of Health & Senior Services in Trenton.

CONGRATULATIONS!

RWJF PRESIDENT AND CEO STEVEN A. SCHROEDER, MD, was named to the Board of Trustees of the American Legacy Foundation in December. The nonprofit foundation was incorporated and financed as part of the landmark tobacco settlement reached by 46 states,five US territories, and the tobacco industry. Legacy's goals are to reduce youth tobacco use, reduce exposure to secondhand smoke, and decrease tobacco consumption among all ages and populations.

FLOYD MORRIS, MHA, was promoted to senior program officer in January. Previously, Morris held the position of program officer.

PAUL TARINI, MA, was promoted to senior communications officer in the Communications Office in January. Tarini was formerly a communications officer.

MAUREEN LANE MICHAEL, MGA, was promoted to program officer in the Evaluation and Research Unit in January. Prior to her promotion, Michael held the position of program associate.

BOARD OF TRUSTEES

In January 2000, **GEORGE S. FRAZZA, ESQ., WILLIAM L. ROPER, MD, MPH,** and **RICHARD B. WORLEY** were elected to the RWJF Board of Trustees. Frazza serves as counsel to the law firm of Patterson, Belknap, Webb & Tyler LLP, in New York City. Prior to that, Frazza spent more than 30 years with Johnson & Johnson, where he held the positions of corporate secretary, vice president and general counsel, and member of the executive committee. Roper is dean of the School of Public Health, University of North Carolina at Chapel Hill (UNC). He is also professor of health policy and administration in the School of Public Health,and professor of pediatrics in the School of Medicine at UNC. Worley is president, chief executive officer, and chief investment officer of Morgan Stanley Dean Witter Investment Management Company in West Conshohocken, Pa.

Also at the January 2000 meeting of the Board, **EDWARD C. ANDREWS, JR., MD,** and **JAMES E. BURKE,** trustees of the Foundation, were elected trustees emeriti. Andrews served as a trustee since August 1987; Burke served since December 1987.

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Institute of Medicine used the executive summary and new measures in its report, *Approaching Death: Improving Care at the End of Life*. Two further grants from the Foundation are developing a validated version of the toolkit, an accompanying resource guide, and software for analysis and reporting of data.
Contact: Joan M. Teno, MD, MS, 401-863-1560, joan_teno@brown.edu.

- **The Coming Home® Program: Affordable Assisted Living.** The National Cooperative Bank Development Corporation provides technical assistance to help rural communities develop affordable assisted-living residences that integrate and coordinate health, social, and personal care services and housing for frail or chronically ill older persons, assisting them to live as independently as possible and avoid unnecessary nursing home placement. As of February 1999, three *Coming Home* facilities are occupied, two in Illinois and one in Oregon, with a total of 155 residents. Construction has begun on two facilities in Colorado and Arkansas; seven others have moved into the pre-development and/or construction phase; five are viable for pre-development. Additional sites are expected in Illinois, Oklahoma, and Colorado.

Contact: David C. Nolan, 510-496-2225, dnolan@ncbdc.org or John Rimbach, 510-496-2226, jrimbach@ncbdc.org.

These new postings bring the total number of Grant Results Reports to more than 220 — plus 12 National Program Reports — that are available on the Foundation's Web site.