ADVANCES®
The Robert Wood Johnson Foundation Quarterly Newsletter

INSIDE THIS ISSUE

RWJF President Details Transition, New Framework for Grantmaking

When she was selected as president and CEO of The Robert Wood Johnson Foundation last year, Risa Lavizzo-Mourey, M.D., M.B.A., began an extensive examination of the work of RWJF. She talked with health, health care and philanthropy leaders and gathered feedback from Foundation Board members, staff and grantees. She needed to determine where the Foundation should focus its energies and how it could do so most effectively. Based on that feedback, analysis and staff recommendations, the Board of Trustees approved a new framework for RWJF grantmaking (see sidebar on page 8) in January that focused the areas in which the Foundation will do its work. In an interview with ADVANCES in February, Lavizzo-Mourey discussed the changes ahead and why those changes are important.

ADVANCES—You've outlined a new "impact framework" that creates four grantmaking portfolios cutting across the Foundation's goal areas. Would you explain the thinking behind that structure and what you hope it will accomplish?

LAVIZZO-MOUREY—The impact framework is a new way of thinking explicitly about our grantmaking as a whole. It recognizes that we do several different kinds of grantmaking and that improving the ways the grants work together can enhance the progress we make toward our overall mission.

The first portfolio defines the targeted areas on which the Foundation plans to focus much of its energy. In today's strategic philanthropy, much of the emphasis is on choosing a problem that others may not have the capability or the will to address, then putting together a mix of grants to address that problem. You have to be hard-nosed about making yourself accountable for the monetary investments and the investments of staff time and other resources. At RWJF, we try to identify the problem specifically, define a time horizon and level of investment, and then hold ourselves accountable for accomplishing the objectives we've set out to achieve.

See **RWJF President**—page 6

Week Called Attention to the Problem of the Uninsured

To raise awareness about the plight of the more than 41 million Americans without health insurance, RWJF and a diverse group of national and local partners co-sponsored *Cover the Uninsured Week*, March 10–16, 2003. Former Presidents Gerald Ford and Jimmy Carter served as the week's honorary co-chairs.

"We want to make sure that people are aware that the problem of the uninsured affects almost every American in some way," said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of The Robert Wood Johnson Foundation. "We want them to grasp the dire consequences of being uninsured, for families as well as for the health care system and the economy. This is a crisis for millions of working families."

The activities began March 5, with a launch at Washington's Union Station. More than 650 events planned for *Cover the Uninsured Week* took place across the country in all 50 states and the District of Columbia, among them:

- **Town hall meetings** brought together local, state and federal elected officials to talk about health coverage.
- **Campus events** at schools of medicine, dentistry, nursing and public health engaged the next generation of health professionals in a discussion about the uninsured.
- **Health fairs** provided enrollment opportunities for public health coverage programs.
- **Business and labor events,** including roundtable discussions between business and labor groups, highlighted their joint interest in making certain that all Americans have access to affordable health coverage.
- **Interfaith prayer breakfasts** and other religious events focused on the moral imperative to cover the uninsured.
- **Coverage in the media was extensive and the arts and entertainment industries** got involved. Television shows such as "ER," "Law and Order: SVU," "Hack" and "Passions" incorporated stories of the uninsured in their programs during the week. The cast of "Frasier" recorded a public service announcement on the uninsured.

For more information about the week's events or to sign the *Cover the Uninsured Week* proclamation to get America covered, visit *www.covertheuninsuredweek.org.*

—MAUREEN COZINE

FEATURES

ISSUE 1, 2003

Published quarterly by
the Communications Department of
The Robert Wood Johnson Foundation®
College Road East, P.O. Box 2316
Princeton, NJ 08543–2316

ADVANCES®

PRESIDENT
Risa Lavizzo-Mourey, M.D., M.B.A.

EXECUTIVE VICE PRESIDENT
Lewis G. Sandy, M.D.

VICE PRESIDENT FOR COMMUNICATIONS
David J. Morse

EXECUTIVE EDITOR
Larry Blumenthal

MANAGING EDITOR
Trish Leader Krotowski

ASSISTANT MANAGING EDITOR
Hedda Colossi

PRODUCTION ASSOCIATE
Joan Barlow

WRITERS, *ABridge*
Karin Gillespie
Jane Koppelman

DESIGN
DBA Design
Cambridge, Mass.
www.dbadesign.com

Note to Readers:
To receive *ADVANCES*, or to report a change of address, write to:
Editor, *ADVANCES*
The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, NJ 08543–2316
advances@rwjf.org

Mass Media Gets Masses Moving in West Virginia

Bill Reger, Ed.D., figured that Wheeling, W.Va., an Ohio River town with lots of scenic walking trails, was an ideal place to launch a pilot health campaign to promote walking. Of its 31,400 residents, 35 percent are obese, well above the national average of 27 percent. West Virginia, with 68 percent of its adults reporting no leisure physical exercise at all, ranks third worst among the 50 states for physical activity. Inducing Wheeling's residents to become daily walkers would reduce health risks linked to obesity, including heart disease, diabetes and cancer.

An associate professor in the Department of Community Medicine at West Virginia University, Reger concentrated the media campaign and related community events of "Wheeling Walks," during eight weeks in spring 2001. He was backed by a $354,000 grant from The Robert Wood Johnson Foundation.

If television was a demon contributing to sedentary lifestyles, Reger also felt it might be the vehicle to propel couch potatoes to fitness. To help him, Reger enlisted an ad agency to develop a persuasive message. The ad showed a man and a woman in the target audience of 50- to 65-year-olds walking in their neighborhood, confiding that exercise had energized their relationship.

Rather than settling for free spots that stations dole out in the wee hours, the campaign bought advertising—some $50,000 in television time over eight weeks at two local stations—saturating the airwaves.

Overall, the 20-second television commercials aired 638 times on network-affiliated local stations, and 1,164 times on cable stations. Reger calculated that the average targeted household viewer was exposed to the message more than 50 times during the eight-week period. In addition, the campaign ran one-minute radio ads on 12 stations 1,988 times and placed 14 quarter-page ads in local newspapers.

Moreover, the paid advertising wasn't placed in a vacuum. Wheeling Walks organized community walking activities; brought in nationally known speakers; encouraged participation through local running clubs, health clubs, civic groups and workplace groups; and coordinated walkathons with the mayor and a local shopping mall. A Web site *(www.wheelingwalks.org)* listed the events, profiled converted walkers and offered online registration to become walkers. Physicians were encouraged to use Wheeling Walks prescription pads to write out prescriptions for walking the way they do for drugs.

The media covered many of the walking activities as news events. Exceeding expectations, the initiative received coverage in more than 170 television, radio and newspaper stories over eight weeks, including two articles in *USA Today.*

Reger, who one cycled across America and then sailed to Hawaii, had no illusions about converting chronically inactive folks into triathletes. "It amazes me how much energy it takes to get people off the couch and on the move," he says.

Overall, 2,248 people registered to walk during the campaign. Presumably, many others had begun walking or already walked regularly without bothering to fill out the forms. Telephone surveys found that 14 percent of residents took up walking a half-hour or more a day, five days a week. Reger figures many folks who were already walking were inspired to exercise at a higher level than before.

Wheeling's accomplishments are encouragement for communities nationwide. Says Reger: "People want to live healthier lives, but are not always certain how to start doing so."

—TODD SHAPERA

For more information about Wheeling Walks and an article about the initiative in Preventive Medicine, *see the RWJF Special Report at* www.rwjf.org/special/wheeling.

Twenty Robert Wood Johnson Community Health Leaders

celebrated the 10-year anniversary of the program with unique events in their communities that included a play about what it means to be uninsured, a community-wide challenge for residents to lose a total of 30,000 pounds and a town forum for seniors who have difficulty paying for prescription drugs. The events in 20 locations between November 12 and December 24, 2002, were attended by state policymakers and other local officials, as well as the media, and focused on topics as varied as farm safety, obesity, sexual violence, access to dental care for people with disabilities and reducing asthma.

At right, a physician at the Tri-County Health Center in Dunn, N.C., screens a woman for diabetes. Michael Baker, a 1994 Community Health Leader, is based at the center, and used the anniversary as an opportunity to hold a health fair and a forum on addressing the needs of the uninsured in this rural community.

Strengthening Families Across Generations

Wanda was a teenager living under the specter of repeated abuse, as her mother and grandmother had before her. When Wanda became pregnant, she continued to drink alcohol and smoke cigarettes, putting her baby at risk for dangerous health complications. She seemed destined to carry forward a cycle of family breakdowns and neglect.

Then Wanda was referred to the *Nurse–Family Partnership*, an RWJF-funded program that assigns professional nurses to visit in the homes of low-income, first-time mothers during pregnancy and the first two years of the child's life. The nurse spent time with Wanda, teaching her what steps to take to have a healthy pregnancy and how to care for her baby. She also discussed her education and her hopes for the future.

"Even with all the things that were going against this teenager, the nurse said 'I see something in this young woman,' " says David Olds, Ph.D., who founded the *Nurse–Family Partnership* more than 20 years ago and now serves as chair of its national advisory board. "This nurse was one of the first people who ever showed genuine interest in Wanda and who really believed she could manage her life well." The home-focused, intensive nature of this relationship sparked a reciprocal and lasting trust between the caregiver and the family that is a hallmark of the program.

In Wanda's case, the nurse's visits motivated her to stop drinking and smoking. She gave birth to a healthy baby, earned her high school diploma and proved to be a responsible, loving mother.

In 2002, The Robert Wood Johnson Foundation approved a $3-million grant to the *Nurse–Family Partnership*. This funding supplemented the $10

See **Strengthening Families —** page 4

Turning End-of-Life Precepts into Practical Examples

Death is a difficult topic to cope with for families and patients—but also for health care professionals. Workers in hospitals, nursing homes and hospice organizations face many obstacles as they try to provide good end-of-life care. To help them, *Last Acts*®, a national coalition of more than 1,000 organizations, which is supported by The Robert Wood Johnson Foundation, in 1997 developed a list of five "Precepts of Palliative Care." The precepts include such concepts as communicating with patients about their preferences, coordinating interdisciplinary care and supporting the caregiver.

Then, more recently, members of the *Last Acts*' Institutional Innovations Committee took the project a step further: They decided to help health care providers understand the precepts on a more down-to-earth level. The result of their effort, "On the Road from Theory to Practice: A Resource Guide to Promising Practices in Palliative Care Near the End of Life," contains practical examples of how the precepts can be used to give patients better care at the end of life. An interactive Web component also is to be completed by early 2003.

"The resource guide becomes a road map for innovative providers who want to work in concert with each other," says Judy Peres, L.C.S.W., deputy director of the Washington-based *Last Acts* program. "It's a way we can deliver good palliative care in the most critical settings—hospices, hospitals and nursing homes."

The committee first met to discuss barriers to good end-of-life care. "What they found was hospitals didn't understand nursing homes, and nursing homes didn't understand the hospice," says Karen Long of Stewart Communications (Chicago), which staffs the *Last Acts* Institutional Innovations Committee. Yet people who need end-of-life care stand a good chance of passing through one or more of these settings, she says. Most of the barriers the committee uncovered had a lack of communication as the root cause.

"The precepts are fairly broad statements," Long says. "So how do you actually make this happen in a health care setting? That's where the resource guide comes in. We have spelled out each issue, and listed the barriers and some of the recommendations and promising practices we have identified."

For example, a common barrier to good care occurs when an elderly cancer patient who goes into cardiac arrest is transported from a nursing home to the hospital, Long says. The nursing home staff may be aware that the patient has a do-not-resuscitate order on file, but often the paramedics or emergency room personnel don't realize it. As a result, they may initiate some aggressive—and often painful—interventions that the patient does not want. "It's very important to have continuity of care for these frail, elderly patients—important information should travel with the patient from institution to institution," Long says.

To overcome this barrier, readers of the resource guide could take cues from Oregon, where a regional ethics council was formed. The council worked out a simple solution: Patients who do not want to be resuscitated post their information in a bright orange envelope on their refrigerator, or in a file beside their bed. That way, once paramedics see the orange envelope, they are able to honor the patient's wishes instead of automatically beginning resuscitation.

Authors of the 120-page resource guide hope it will be a useful tool for clinicians in a variety of health care settings. They also want to make it a living document by encouraging providers to post their own ideas on the *Last Acts* Web site. "We're saying, don't wait for the system to change—here are some ideas and here are some people who are already improving care," Long says. "Maybe their ideas could make a difference in your organization."

—Melissa Knopper

"On the Road from Theory to Practice: A Resource Guide to Promising Practices in Palliative Care Near the End of Life" can be ordered online at *www.lastacts.org*, by e-mailing *lastacts@aol.com* or calling (312) 751-0147.

New Awards Entice High School Teachers and Students To Explore Epidemiology

High school students will learn how to unravel the causes of disease and injury as part of a new scholarship program designed to spark interest in epidemiology and public health. Students might investigate whether a cluster of cancer cases in their community has anything to do with living next to power lines, or apply scientific methods to explore the effects of social relationships on health.

The $8.5-million program, Young Epidemiology Scholars (YES), will award grants and scholarships to teachers and high school students. The program is sponsored by The Robert Wood Johnson Foundation and administered by the College Board.

Epidemiology is the science of discovering causes of illnesses and injury by interpreting patterns of their occurrence in the population. Until now, little has been done to encourage talented and creative students to pursue epidemiology. The YES program is designed to reach students and teachers from a broad range of schools across the United States.

"The program seeks to attract the best and brightest students and encourage them to think about the many behavioral, environmental and social factors that affect health," says Pamela Russo, M.D., M.P.H., senior program officer at RWJF. "For example, epidemiology can help students trace the link from increased motor vehicle use to decreased physical activity levels to the enormous increase in obesity rates and related health problems, such as diabetes."

But the program offers another benefit, as well.

"Epidemiology is a discipline that teaches people to think critically, weigh risks based on facts, and determine cause and effect," explains Russo. "These skills will help students make better decisions about many issues—not just health."

The YES program will take place in two phases, consisting of an annual competition for teachers and one for students. Earlier this year, the first phase of the program awarded grants totaling $75,000 to eight teachers who submitted six innovative models for teaching epidemiology in the high school setting. The teachers will use the awards to develop models for mentoring students or for disseminating their methods of teaching epidemiology to other schools.

The first student competition, which will take place in the 2003–04 school year, will award scholarships totaling up to $456,000 to high school juniors. Two national winners will receive scholarships of $50,000 each. Because epidemiology typically is not taught at the high school level, a team of epidemiologists and educators will develop materials and resources for teachers and students. The program also will establish links with six universities around the country that will provide mentors to students and teachers. For more information about the YES program, visit *www.collegeboard.com/yes*.

—Susan G. Parker

From **Strengthening Families** — page 3

million RWJF awarded in 1999 for national replication of the nurse home-visiting program. Both grants financed technical assistance, training and related marketing needed to expand the model throughout the country. At the end of 2002, the program was operating in 230 counties in 23 states, serving an estimated 20,000 families per year.

RWJF's support of the program goes back to 1979, when it provided initial funding for three consecutive randomized experimental trials. Based in Denver; Elmira, N.Y.; and Memphis, Tenn., these studies of the *Nurse–Family Partnership* found consistent benefits for white, black and Hispanic low-income mothers and their children through the child's fourth year of life. Such benefits included:

- Improvements in women's prenatal health.
- Fewer instances of child abuse or neglect, paired with reductions in children's doctor and hospital visits for injuries.
- Fewer unintended repeat pregnancies, and increases in the interval between first and second births.
- Increases in women's employment and marriage, and decreased reliance upon welfare and food stamps.
- Decreased incidence of crime, with fewer arrests of mothers in the program as well as of adolescents who were seen by nurses as infants.

The program also produced significant cost savings over the long run. A 15-year follow-up of Elmira, the longest-running site, found the *Nurse–Family Partnership* saved $4 for every dollar invested.

"The program has sparked interest in a lot of communities because people really appreciate that it's based on solid scientific evidence," says Olds. "It shows that applying evidence-based approaches can make a lasting difference in family health."

Though the U.S. teen pregnancy rate has decreased in recent years, it remains the highest in the western industrialized world. Nearly 1 million young women in this country become pregnant at least once before they reach the age of 20, according to the Alan Guttmacher Institute. To improve the health of teen mothers and their children, and to prevent unintended subsequent pregnancies, more of these young women need access to comprehensive programs such as the *Nurse–Family Partnership*, says Olds.

But with the recent economic downturn, federal and state lawmakers are seeking ways to slash spending, which may curtail efforts to expand *Partnership* programs. In addition to funding from RWJF and other foundations, *Nurse–Family Partnership* programs are financed through various public sources, including Temporary Assistance for Needy Families, Medicaid, the Maternal and Child Health Block Grant, and child-abuse and crime-prevention dollars.

"The program spans a whole range of federal and state budget areas, so it's vulnerable to funding reductions in all those areas," says Olds. "Public officials need to have vision to see the long-term benefits of the investments in the *Nurse–Family Partnership*."

Such vision is essential, he says, because the intensive *Partnership* approach requires higher initial funding than classroom-based parent skills training or short-term substance abuse programs. The program uses clinically trained professional nurses rather than volunteers or nursing aides, for example. However, in these lean budget-cutting times, public officials may balk at the more expensive approach, even with solid evidence that the investment yields long-term cost savings and lasting benefits, says Olds.

There is no doubt that the investment has changed the lives of many young women. Among them was one 15-year-old unmarried pregnant teen whose participation in the program in its early years helped her to grow into an accomplished woman who is now a nurse serving this generation of first-time mothers through the *Nurse–Family Partnership*.

—Laurie Jones

SELECTED GRANTS

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

- *Covering Kids and Families.* Awards to nine sites, totaling $8 million.
- *Hablamos Juntos: Improving Patient–Provider Communication for Latinos.* Planning awards to 10 sites, totaling $1.5 million.
- *State Action for Oral Health Access.* Awards to six sites, totaling $5.7 million.
- *State Coverage Initiatives.* Awards to three sites, totaling $2.6 million.

Projects to Improve the Quality of Care and Support for People with Chronic Health Conditions

- For creating capacity for integrated telephone-based weight management counseling, $308,012 to Group Health Plan, Minneapolis.
- For "Crossing the Quality Chasm" summit, $700,000 to the National Academy of Sciences–Institute of Medicine, Washington.
- For a study to determine standardized measures that define quality mammography centers, $399,863 to National Forum for Health Care Quality Measurement and Reporting, Washington.
- For producing papers on the lifetime risk of disability and long-term care, $244,618 to the Urban Institute, Washington.
- For planning for the Veterans Affairs' partnership for dementia care, a renewal award of $244,632 to Benjamin Rose Institute, Cleveland.
- *Faith in Action II.* Awards to 58 sites, totaling $2 million.
- *Partnership for Solutions: Better Lives for People with Chronic Conditions.* One award of $500,000 to the Johns Hopkins University, Bloomberg School of Public Health, Baltimore.
- *Promoting Excellence in End-of-Life Care.* For measuring the quality of end-of-life care in the intensive care unit, $230,700 to Rhode Island Hospital, Providence.
- *Targeted End-of-Life Projects Initiative*. Award of one research and evaluation grant, for a study on the costs of care and factors associated with terminal admissions for dying veterans, $237,150 to Palo Alto Institute for Research and Education, Palo Alto, Calif.

Projects to Promote Healthy Communities and Lifestyles

- For disseminating evidence-based recommendations for exercise in older adults, $190,752 to University of Illinois at Chicago School of Public Health.
- For addressing barriers to physical activity among adults age 50 and older through community-based organizations, $575,888 to University of Illinois at Urbana–Champaign College of Applied Life Studies.
- For a study of the expansion of the Experience Corps senior volunteer program, $749,995 to Public Private Ventures, Philadelphia.
- For a longitudinal examination of public housing transformation on the health of poor families, $390,000 to the Urban Institute, Washington.
- For "Frontline," a documentary of the child welfare system and foster care, $400,000 to WGBH Educational Foundation, Boston.
- For promoting funding partnerships with the private sector to encourage healthy communities, a renewal award of $250,000 to Collins Center for Public Policy, Miami.
- For "America's Walking – Season II," a public television series about physical activity, a renewal award of $340,000 to Connecticut Public Broadcasting, Hartford.
- For promoting leadership for the field of infant/family health and development—zero to three, $495,033 to National Center for Infants, Toddlers and Families, Washington.
- *Active Living Policy and Environmental Studies.* Awards to eight sites, totaling $750,117.
- *Family Support Services Program.* For developing statewide networks of community-based family support centers, a renewal award of $3 million to Family Support America, Chicago.
- *Injury Free Coalition for Kids: Dissemination of a Model Injury Prevention Program for Children and Adolescents.* Awards to 12 sites, totaling $2.5 million.
- *Urban Health Initiative: Working to Ensure the Health and Safety of Children.* Awards to two sites, totaling $6.4 million.
- For a Consumer Health Action 2003 Conference, a renewal award of $371,439 to Families USA Foundation, Washington.

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

- For addressing substance abuse treatment for hard-to-employ women on welfare, $3.3 million to the National Center on Addiction and Substance Abuse at Columbia University, New York.
- For evaluation of a program to address substance abuse treatment for hard-to-employ women on welfare, $3.7 million to Treatment Research Institute, Philadelphia.
- For integrating adolescent substance abuse services and translating evidence into practice, $320,045 to Child Welfare League of America, Washington.
- For implementing a system of care for drug-involved offenders, $199,984 to State of North Carolina Department of Health and Human Services, Raleigh.
- For developing consensus policies on community reentry from the criminal justice system, $214,403 to Council of State Governments, New York.
- For continuing the development and maintenance of a tobacco products and promotions exhibit, a renewal award of $359,328 to the Foundation of the University of Medicine and Dentistry of New Jersey, Somerset.
- *Innovators Combating Substance Abuse.* For an analysis of the effects of secondhand smoke in the hospitality industry, $300,000 to the Tobacco Control Resource Center, Boston.
- *Paths to Recovery: Changing the Process of Care for Substance Abuse Treatment*. For an evaluation of the program, $999,983 to Oregon Health and Science University, Portland.
- *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol & Crime*. For a technical assistance center for comprehensive, collaborative systems of care development, $752,598 to Portland State University Graduate School of Social Work.
- *Substance Abuse Policy Research Program*. Awards to three sites, totaling $841,190.
- For expanding residential treatment services to women in early recovery from alcohol and other drug dependencies, $300,000 to Crawford House, Skillman, N.J.
- For expanding a wellness program to include mental health and family services for recovering women, a renewal award of $195,331 to Sikora Center, Camden, N.J.

Other Programs and Those That Cut Across Foundation Goals

- For Community Tool Box™: An Online Resource for Community Health Organizations, a renewal award of $475,000 to University of Kansas Center for Research, Lawrence.
- For Clinical Research Roundtable Meetings, a renewal award of $225,000 to the National Academy of Sciences–Institute of Medicine, Washington.
- *Changes in Health Care Financing and Organization*. Awards to seven sites, totaling $1.6 million.
- For addressing nursing workforce development issues through a statewide coalition, a renewal award of $712,213 to Rutgers University Foundation, New Brunswick, N.J.
- For assistance to needy and indigent families, a renewal award of $334,200 to the Salvation Army, New Brunswick, N.J.
- *New Jersey Health Initiatives*. Awards to nine sites, totaling $2 million.
- *New Jersey Health Initiatives*. For planning for an asthma management and education program for children and families, one renewal award of $413,807 to City of Trenton Department of Health and Human Services.

RWJF President Details Transition

From **RWJF President**—page 1

Advances—What about the other three portfolios?

Lavizzo-Mourey—The three other portfolios are Human Capital, Vulnerable Populations and Pioneering. Let me take them one at a time. Some parts of our grantmaking do not fit neatly into a defined problem. These broad-based programs include, for example, our leadership and training initiatives. We have a 30-year history of trying to develop leaders who can help improve health and health care. That kind of work is done over a much longer horizon, over an entire professional career. It requires understanding the kinds of leadership challenges that might be needed in a field, whether that is in research, policy or professional practice. Our training and leadership programs will work together in our human capital portfolio.

We also have had a long experience with programs focused on the people who are the most vulnerable in our society. For these populations, we will continue to fund programs that address needs at the local level, can be demonstrated to be effective and can be expanded to other communities. These programs may not always be on a national scale, but they will improve the lives of those who need us most—the aged and vulnerable. These are the kinds of programs we are thinking about when we describe our third portfolio.

The fourth, our Pioneering portfolio, comes from our long history of trying to think about those areas that are cutting edge—fields or approaches to philanthropy that are high-risk, but could be high gain as well. What we have not done in the past is put aside money specifically for exploring new ideas for the future. This portfolio represents that discipline of committing funding—in good times and in bad—toward programs that keep us looking at how we might do things very differently and more effectively in the future.

Advances—Couldn't some of these projects cross boundaries between portfolios?

Lavizzo-Mourey—Yes, they could, but that is not the intention. Just as if you're looking at a portfolio of mutual funds, you can imagine a single stock meeting the objectives of more than one portfolio. Nonetheless, you still have an overall assumption of what the success of a particular portfolio should be—whether it is to work on solutions to a major problem, to improve human capital and measure the success of the individuals who participated in training programs, or to see if community programs have made a difference. There will be some overlap. This is more about the Foundation understanding how to have the greatest impact with a group of grants and holding ourselves accountable for what each portfolio is trying to achieve.

Advances—How will this new framework affect the Foundation's grantmaking?

Lavizzo-Mourey—It will have a huge impact on how we manage grants and on how we think about the life cycle of a field in which we are investing. Philanthropy, in general, often puts more emphasis on how to start new areas or develop new approaches than on how to continue to nurture and develop those areas. Even less thought goes into how new areas ultimately will be transitioned to being independent. How will they develop wings to fly on their own? How will they attract other funders or revenue streams for their continuation? A fundamental part of philanthropy is helping develop a field, a program or a particular grantee through that entire cycle. By acknowledging at the beginning through the impact framework that we are concerned with the entire cycle, we will change the emphasis we put on the beginning, the middle and the transition to sustainability.

"The time is right to tackle obesity, we have tools we can bring to bear, and it absolutely is in sync with our overarching goals."

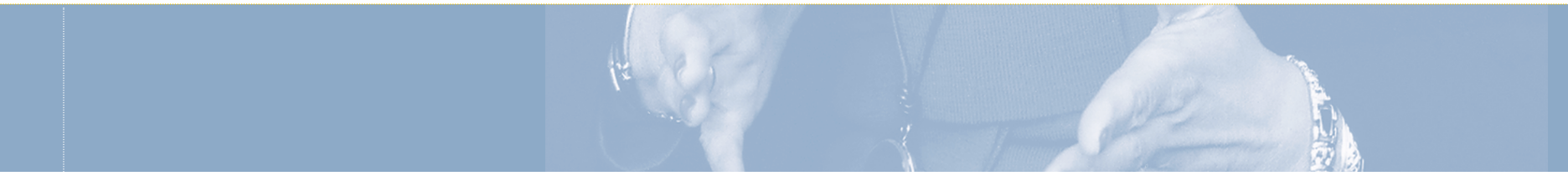
Advances—The first portfolio outlines eight targeted objectives. Why those eight?

Lavizzo-Mourey—We considered a number of factors. We tried to look at big problems that required attention, big problems where our Foundation might have some comparative advantage. We also tried to consider whether the issue was within our means. There are some problems that might just be too big for us to tackle given what we know our resources are likely to be, and, frankly, given the commitments we have already made. We looked at feasibility. We also looked at how well a new objective might build on areas in which we are already engaged and whether there were

compelling reasons to take on the problem at this time. Childhood obesity, for example, fits these criteria. Many times, we spend substantial resources trying to raise awareness about a problem so there is fertile ground in which to develop solutions. With obesity, there is already a high level of awareness, thanks to the attention it has received lately from policy-makers, media and practitioners who perceive a growing epidemic. We have a real opportunity as a resource and as a neutral convener on such an issue for both policy-makers and communities.

Advances—Let's look at each of the eight objectives, starting with obesity.

Lavizzo-Mourey—The work with obesity builds on several streams of work we have been doing for some time. We have promoted physical activity and have begun to understand the kinds of policy changes one would need in order to create activity-friendly communities. That provides a foundation for addressing the issue of obesity, which relates nutrition to physical activity, or the lack thereof. We also have been doing work within the health care system looking at chronic diseases that are related to obesity, like diabetes. Additionally, in our work with tobacco, we have learned a tremendous amount about how to use communications about health and healthy behaviors and can apply that knowledge in the arena of childhood obesity. Our feeling is that the time is right to tackle obesity, we have tools we can bring to bear, and it absolutely is in sync with our overarching goals.



***Advances*—What about improving the public health system?**

Lavizzo-Mourey—This objective recognizes a window of opportunity we have in 2003 that we did not have three years ago. Sadly, that is related to the events of September 11th and the concerns and scares about bioterrorism that followed. Because of those events, we have a heightened awareness of the deficiencies in our public health system and how that system interfaces with the health care system overall. We understand more about the deficiencies in our ability to deal not only with those acute events but also with chronic illnesses. This accentuated awareness presents an opportunity we must seize.

***Advances*—And tobacco? The focus is shifting somewhat from smoking cessation to reducing secondhand smoke and indoor smoking. Why?**

Lavizzo-Mourey—We have been in the field as one of the major funders and innovators for a decade or more. We are proud of the tremendous progress that has been made in changing the way people view the use of tobacco, although it is still a terrible public health problem. We want to see the prevalence of tobacco use go down and to see more opportunity for people to quit. And we would like to see less secondhand smoke. But we think the field is at a point of maturity where there is now an army of individuals who care about the issue and are well-mobilized to address it people who are committed to cessation of tobacco use and who have made great progress in gaining an understanding among policy-makers at the city, state and federal levels. It is time for us to think about how we can use both our financial resources and the staff expertise to help sustain this movement as we look to create progress on a similar scale in other areas.

***Advances*—In the field of alcohol and drug dependence, the Foundation's focus is shifting away from prevention to a heavier emphasis on treatment. Why?**

Lavizzo-Mourey—Over the last few years, we have recognized the tremendous gap between what we know about the treatment of substance abuse and addiction and what is actually done in health care settings. Some of it comes from the stigma that remains attached to drug and alcohol abuse. There is also inadequate dissemination of information to the sites where people who suffer from this disease get treatment: primary care settings. These settings would be the ideal place to begin to screen, refer and treat people who have problems with substance abuse, but the primary care system is ill-prepared for this. Even the outpatient and inpatient settings that are more used to dealing with substance abuse issues face two problems: There are too few of them and the ones that exist are not necessarily schooled on the best, evidence-based practices. While we recognize that prevention is still a huge part of what needs to be done, there has been a lot of progress there. When we look at the gap between what is known and what is being done on the treatment side, we see a great opportunity to make a difference.

***Advances*—What about coverage for the uninsured? This has been a major focus for the Foundation. What kind of role will it continue to play?**

Lavizzo-Mourey—Over the years, we have developed approaches to the problem, analyzed policies, conducted awareness campaigns, and built coalitions to help states initiate new efforts for children and for those covered by Medicaid. There is a great deal of information we have to draw upon. We are now entering a phase where policy-makers, employers, labor, insurers, hospitals, practitioners and other deeply interested parties have the potential to put this issue at the center of the policy agenda. Because of rising health care costs, increased unemployment, and the difficulty that large and small businesses are having covering their employees, there is a sense of angst and vulnerability that did not exist two years ago. There is a critical mass. We are seeing politicians, Republicans and Democrats, saying this is an important issue. As we anticipate the number of uninsured will go up, we see our role at this point as raising awareness. We want to help people understand that and how the lack of health coverage affects their neighbors and them directly and materially. We want them to know that while there may be no perfect solution to getting the more than 41 million uninsured people covered, the worst possible solution would be to do nothing.

"Improving the quality of the care and support for people with chronic health conditions is a big part of our agenda."

***Advances*—The Trustees recently approved changes to two of the Foundation's four overarching goals to include the word quality. What do those changes indicate?**

Lavizzo-Mourey—Those changes are intended to provide a clear signal to the field that a lot of the work we have been doing in an implicit way is now explicit. They are also intended to indicate that when we talk about quality care, the definition needs to be changed for the ordinary person on the street. In our access

goal, we say we want to ensure that all Americans have access to *quality* care. By that we mean care that is safe, effective and efficient; that is patient-centered and evidence-based rather than following the old idea that "more is better." We know that when we use evidence-based definitions, it helps to advance the thinking in the field. There is no reason why *all* Americans should not have that kind and quality of care.

By adding the word quality to our chronic illness goal, we are signaling that improving the quality of the care and support for people with chronic health conditions is a big part of our agenda.

ADVANCES—Quality chronic illness care is also one of the targeted objectives

LAVIZZO-MOUREY—Yes, this is clearly an important area for us. Care for those with chronic illnesses such as diabetes or heart disease could break the bank in the future. As the number of people living with these diseases rises, the sheer size of the challenge may well compromise our ability to provide quality care to them. But that is precisely why it is where we want to focus our efforts.

ADVANCES—Another objective is relatively new for the Foundation: reducing racial and ethnic disparities in health and health care.

LAVIZZO-MOUREY—As the Foundation focuses on quality chronic illness care, we will look in particular at what happens in outpatient settings since that is where most of us get care for chronic illness. That also includes trying to address the real disparity in the quality of the care being delivered to various ethnic and racial groups. Those disparities cannot be explained by differences in the type of care that is indicated, or the type of care the patients or families say they want; they are fundamentally about not delivering the best quality care to certain racial and ethnic groups. When you point out that these disparities exist, everyone is aghast. But there are not a lot of proven methods for helping doctors and administrators identify that there is a problem in their organization and then helping them remedy it. Our agenda is focused on trying to identify interventions that can be put into place.

ADVANCES—And nursing?

LAVIZZO-MOUREY—The nursing shortage is something we have dealt with in the Foundation intermittently over the last couple of decades. As most people know, we are now in the midst of a major nursing shortage. However, this time the projections for the number of nurses we are going to need, given the aging of the population and the burden of chronic illness, are substantially higher than in previous nursing shortages. We know that the problem is not just with recruiting people. It concerns dissatisfaction among nurses with the way the hospital setting works. We need to make hospitals more efficient and more likely to produce high-quality patient care. That is what nurses really want. They need and want to be able to deliver care in a way that is safe, effective and patient-centered. We want to focus on fixing the system at the root of the problem—on what needs to be done differently at the bedside in hospitals.

New Grantmaking Framework

In January, the Board of Trustees approved an "impact framework" that divides RWJF's grantmaking into four measurable portfolios that cut across the Foundation's goal areas.

A *Targeted* portfolio to help solve specific systemic problems in health and health care over a defined time frame. Objectives in this area include:

- **improving the quality of care for those with chronic conditions**
- **reversing the growing epidemic of childhood obesity**
- **reducing racial and ethnic disparities in health and health care**
- **transforming nursing and care at the bedside**
- **ensuring access to quality health care for all Americans**
- **expanding the public health system's capacity and leadership**
- **increasing and improving treatment for abuse of alcohol and drugs**
- **preventing and alleviating harm caused by tobacco use**

A *Human capital* portfolio to improve health and health care workforce;

A portfolio designed to promote effective health and health care services, particularly for the *aged and most vulnerable*;

A *Pioneering* portfolio to explore especially innovative, potentially high-risk grantmaking approaches.

ADVANCES—There doesn't appear to be any mention of supportive services for the aging. Is the Foundation moving away from this area?

LAVIZZO-MOUREY—No. One of our portfolios stresses developing demonstrations and other programs to improve services to the elderly and other vulnerable populations. In addition, our targeted objectives to improve the quality of chronic care and to enhance nursing in hospitals, among others, also disproportionately involve serving older populations.

ADVANCES—Can you talk about the process that preceded this new focus?

LAVIZZO-MOUREY—Last year, with the transition to a new president and CEO on the horizon, our Board challenged us to develop an impact framework and to think about our grantmaking in a way that allowed them to provide both the guidance and governance that boards do so well. This came out of a Board retreat as well as from ongoing discussions. In addition, as I prepared for the transition, I had many conversations with grantees and other leaders around the country to understand what the field was thinking. I also solicited letters and what I termed "one-minute essays," an essay I could *read* in a minute, not necessarily ones that could be *written* in a minute. One of my key questions during that time was what should we stick with and what should we change. As *we* synthesized the information that came from a diverse group of sources—and I emphasize *we* because the team of people engaged in this should not be underestimated or given short shrift—it became clear that we needed to think about a different way of organizing our grantmaking in order to have greater impact.

ADVANCES—How will these changes be implemented?

LAVIZZO-MOUREY—With great care and with respect for the considerable and important work we are currently supporting, but also with some urgency. We have laid out the framework and are now in the process of answering some important questions about each of the portfolios, both for ourselves and for the Board and the grantees. As we move forward, we will be mindful of not only the new directions we are taking, but also how we continue to shepherd and develop the grants we already have in the field. This is important. People shouldn't assume that we simply are no longer interested in all those things we were interested in previously. We have $1.5 billion in current commitments—initiatives our Trustees have authorized that we expect to continue to support for the next several years. And many of

"We need to make hospitals more efficient and more likely to produce high-quality patient care. That is what nurses really want."

See **RWJF President**—page 9

From **RWJF President**—page 8

those efforts fit into one of our portfolios. We will track their results in a way that is in sync with the expectations of that particular portfolio and that, frankly, allows us to get the most learning from those grants so we can help create social change. Few of the grants that have been authorized are going away. Some will be managed the same, and some will be managed differently, but we are not making a 180-degree turn here.

ADVANCES—Still, in focusing on new priorities, the Foundation has decided to reduce its future investments in certain areas in which it has been particularly active—specifically, substance abuse prevention, tobacco cessation and prevention, and end-of-life issues. How will those transitions occur and why are they occurring?

LAVIZZO-MOUREY—The transitions we are making are based on success. These are the programs that have met the test of good philanthropy in the sense that they have gone from being an incipient idea to being an established field, or a nearly established field. What we need to do in our transition is to do it responsibly, so that we do everything we can to make the programs self-sustaining and to continue their momentum.

ADVANCES—RWJF remains the country's largest health and health care philanthropy and the fourth or fifth largest foundation overall. What do you think the Foundation's responsibility for leadership in philanthropy should be?

LAVIZZO-MOUREY—I think our role in leadership vis-à-vis philanthropy should be in helping to develop the field, the techniques, the methods and the standard of rigor. I think we can be innovators in understanding how to use and integrate different kinds of grantmaking to achieve results. For example, The Robert Wood Johnson Foundation is one of the first foundations to integrate communications techniques into its programming to achieve a more dramatic and enduring effect. We probably can do more to integrate performance measurement and evaluation, communications and other techniques in a synergistic way to achieve results. I think we can have a leadership role in defining creative and innovative ways to address the issues of transitions and the life cycle of programming. Programs should have a beginning and a middle and a phase of sustainability. I do not think that, as a sector, philanthropy has done as good a job as it can in defining these three phases and helping grantees to work through all of the stages.

ADVANCES—Your predecessor, Steven Schroeder, left his mark on the Foundation in a number of ways, perhaps most noticeably with work on substance abuse and tobacco issues. Have you thought yet about what you would like your legacy to be?

LAVIZZO-MOUREY—There are several areas in which I would love to see this country make dramatic changes. One is in coverage. To me it is abhorrent that so many people are uninsured. We anticipate working at that until we see substantial reductions in the number of uninsured. We are poised, I think, to redefine what it means to receive quality care in this country. Being a part of that movement is going to be exciting for this Foundation. Finally, and in some ways the area that is the newest for us, is childhood obesity. It is a problem that is similar to other difficult public health problems we have faced in the past where people did not necessarily want to admit it was as perilous as it is and did not necessarily know how to begin to address the problem. This is an issue that will affect so many of our children, not just now but throughout their entire lives, cutting those lives short, creating more disability. Now is the time to try to make a difference.

"Some [of our current grants] will be managed the same, and some will be managed differently, but we are not making a 180-degree turn here."

ADVANCES—You are a medical doctor with a business degree. Your specialty is geriatrics. How would you describe your philosophy of grantmaking?

LAVIZZO-MOUREY—The professional values that I learned as a physician—the commitment to others, the sense of altruism, the sense that we have an obligation to steward the health care resources for populations—not just individual patients—and an understanding of clinical issues are guiding me as I think about our programs. The importance of measurement, of accountability, of taking a disciplined approach to resource management and motivating people, all are skills I learned as part of my training in business. So both streams influence me on a daily basis as I consider the ways our Foundation can do an even better job of improving health and health care.

ADVANCES—Do you think your background as a geriatrician has given you a special outlook and an inside view of the system?

LAVIZZO-MOUREY—Without a doubt. There are two ways my background in geriatrics has shaped how I think about this Foundation and this new job. The first is a focus on chronic illness and the ways that chronic illnesses affect people and their families and their community. When you take care of people who are old and who have not just one, but many chronic illnesses, you understand the impact this can have on them, and the ways in which it is not just the medical care system but the environment, the total community, that allows that person to have the highest quality of life. The other way it affects me is that I learned in geriatrics that teamwork is a very, very effective way to solve problems and get things done. So I probably put more emphasis on teamwork and collaboration than do most physicians or most managers.

ADVANCES—When you were a Robert Wood Johnson Clinical Scholar, did you ever think you'd one day be sitting here?

LAVIZZO-MOUREY—Oh, no, but this is definitely a homecoming. It is an incredible dream come true to be able to steward a foundation like this, one that so shaped me during my early years and gave me the tools to think about how we can make a difference in health care. Clinical scholars are expected to complete a graduate-level research project, so at the time I was solely focused on finishing my project and getting through my presentation without flubbing it. I never had such grandiose ideas. But am I thrilled to be here? Absolutely, and this perch, as my predecessors have known, is ripe with opportunity to help create lasting, systemic change in health and health care and to affect lives for the better on both a broad and a very personal scale. ■

Bringing Outcome-Based Quality Improvement into Home Health Care

Since its debut in health care, continuous quality improvement (CQI) has shaped quality management efforts in hospitals and health care systems across the country. It shifted the quality-improvement orientation from a static approach of aiming for particular standards to an iterative process of enhancing health care from year to year—and ultimately understanding the effects of that care on patient outcomes.

Although CQI was embraced in home health care in the 1980s and 1990s, it focused on service provision (processes of care) rather than patient outcomes—which are vital to physicians, hospital discharge planners, case managers and others making referral decisions. Recognizing this data gap in home health care, in the late 1980s the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) together with The Robert Wood Johnson Foundation and the New York State Department of Health initiated a 15-year research program that culminated with the National and New York State Demonstration Trials to examine the feasibility and utility of measuring patient outcomes for CQI in home health care. In this paper, the authors report on findings from the outcome-based quality improvement (OBQI) demonstration trials and evaluation, which occurred as the final phase of this research program.

In the first phase of the OBQI program, the researchers designed and field tested patient outcome measures at more than 200 home health care agencies over a period of several years. To measure patient outcomes, home health agencies incorporated the final 107-item dataset, known as the Outcome and Assessment Information Set for home care or OASIS, into the assessment forms they used when patients were first admitted and later during follow-up. The 73 home health care agencies designated as OBQI demonstration agencies used 41 OASIS outcome measures. As part of the National Demonstration Trial, investigators collected outcome data on 160,000 patients admitted to 54 home health care agencies in 27 states during a three-year period; in the New York State Demonstration Trial, they gathered outcome information on 106,000 patients admitted over four years to 19 home health care agencies in New York. The OBQI study also looked at hospitalization outcomes among a control group of approximately 248,000 home care patients.

The OBQI agencies collected and transmitted the abbreviated OASIS data to researchers at the University of Colorado Center for Health Services Research. Subsequently, the investigators provided each agency with annual reports comparing its patient outcomes, patient mix and adverse events with other agencies and its own from the previous year. Based on these reports, agencies implemented unique CQI activities targeted at reducing hospitalization and improving other designated health status outcomes as outlined in a written plan of action that they revised annually. This "outcome enhancement process was repeated at the start of each succeeding demonstration year when the annual outcome report was received." According to the authors, "The accuracy and uniformity of information required for patient outcomes introduced greater rigor into the assessment process than had been customary in home health care."

OBQI agencies generally showed substantial and statistically significant improvements in the health status outcomes that were targeted for improvement from one year to the next—for all demonstration years. For non-OBQI home health care agencies, the investigators used Medicare claims data to examine changes in hospitalization rates. Evaluation of the OBQI trials showed that hospitalization rates decreased more than 20 percent over the demonstration period in the OBQI agencies. In comparison, hospitalization rates dropped less than 1 percent in non-OBQI agencies.

The authors conclude: "The aggregate findings . . . suggest that OBQI had a pervasive effect on

Measures Used in Outcome-Based Quality Improvement Demonstrations

Health Status Outcome Measures

Functional: Activities of Daily Living

IMPROVED IN:
- Ambulation/Locomotion
- Dressing Upper Body
- Dressing Lower Body
- Grooming
- Bathing
- Eating
- Toileting
- Transferring

STABILIZED IN:
- Grooming
- Bathing
- Transferring

Functional: Instrumental Activities of Daily Living

IMPROVED IN:
- Management of Oral Medications
- Light Meal Preparation
- Laundry
- Housekeeping
- Shopping
- Telephone Use

STABILIZED IN:
- Management of Oral Medications
- Light Meal Preparation
- Laundry
- Housekeeping
- Shopping
- Telephone Use

Physiologic

IMPROVED IN:
- Pain Interfering with Activity
- Number of Surgical Wounds
- Status of Surgical Wounds
- Dyspnea
- Urinary Tract Infection
- Urinary Incontinence
- Bowel Incontinence
- Speech or Language

STABILIZED IN:
- Speech or Language

Emotional/Behavioral

IMPROVED IN:
- Anxiety Level
- Behavioral Problem Frequency

STABILIZED IN:
- Anxiety Level

Cognitive

IMPROVED IN:
- Confusion Frequency
- Cognitive Functioning

STABILIZED IN:
- Cognitive Functioning

Utilization Outcome Measures
- Acute Care Hospitalization
- Discharge to Community
- Emergent Care

outcome improvement for home health patients. OBQI appears to warrant expansion and refinement in home health care and experimentation in other healthcare settings." Furthermore, they contend that "when . . . OBQI outcome reports for home health agencies become available for all Medicare-certified home health agencies nationally, they will represent a resource for physicians, case managers, and discharge planners for making referral decisions and ultimately for monitoring patient outcomes."

Editor's Note: As the OBQI research and demonstrations were in their final stages, the apparent effectiveness of OBQI resulted in nationwide implementation of the OASIS data set. Outcome, case mix and adverse event reports are now nationally available to individual home health agencies from the Medicare program. Outcome reports soon will be available for referral sources, the consuming public and payers.

Shaughnessy PW et al. "Improving Patient Outcomes of Home Health Care: Findings from Two Demonstration Trials of Outcome-Based Quality Improvement." *Journal of American Geriatrics Society,* 50(8): 1354–1364, 2002.

Research Note

Family Physicians Often Neglect Nutrition Counseling

Diet plays a larger role than many of us would like in determining our health. An estimated 300,000 to 800,000 deaths per year are due to preventable nutrition-related illnesses such as heart disease, stroke, high blood pressure, diabetes, obesity and certain cancers.

Research has found that nutrition counseling *can* change people's eating behaviors, and many medical groups, as well as the federal government, have cited primary care visits as prime opportunities to receive such counseling. This study of family physicians in Ohio found that, too often, these opportunities are missed.

The study set out to determine how frequently family physicians incorporated diet counseling into their office visits, how much time they spent with patients on this topic, and whether the frequency of counseling varied by patient type. Of 138 family physicians observed over two days between 1994 and 1995, only 6 percent included counseling in more than 50 percent of their patient visits. While counseling rates varied largely from doctor to doctor, overall, counseling occurred in 24 percent of all visits.

Family physicians offered nutrition advice most often during well-care visits; 41 percent of these encounters included such counseling. It was offered in 30 percent of visits for chronic illness and in 17 percent of visits for acute illnesses. Providers who discussed nutrition during office visits spent an average of nearly 13 minutes with the patients, 55 seconds of which was spent on advising about diet. Visits that did not include counseling ran, on average, about three minutes shorter.

"Previous research has shown that the majority (72 percent) of primary care physicians consider nutrition counseling to be their responsibility, but it remains unclear how often this responsibility turns into action," the study authors stated.

Providers were more apt to offer nutrition counseling to patients with certain chronic conditions. For instance, counseling occurred in 45 percent of visits for diabetes, and in 25 percent of visits for cardiovascular disease, although these rates fall short of the federal government's goal of including counseling in 75 percent of such visits, as recommended in its report *Healthy People 2010*.

According to the study's authors, the findings can be used to help researchers and medical educators tailor nutrition counseling tools to fit the time constraints faced by most primary care physicians.

Eaton CB, Goodwin MA and Stange KC. "Direct Observation of Nutrition Counseling in Community Family Practice," *American Journal of Preventive Medicine*, 23(3): 174–179, 2002.

Are Internal Medicine Residency Programs Teaching End-Of-Life Care?

End-of-life (EOL) medical care is still evolving in the United States. Terminally ill patients often don't get the information they need to choose between aggressive and palliative care, they struggle with pain, and may not be referred to hospice until days or even hours before death. Families are aware of these inadequacies and even physicians concede that medicine can do better. In fact, in 1997, the American Board of Internal Medicine added EOL care to its residency training requirements: Residency programs must now include "educational methods and clinical training sites that can inspire trainees to critically examine and acquire the knowledge and skills required for effective EOL care."

What kind of progress have internal medicine residency programs made in EOL care in the nearly six years since the implementation of this requirement? To determine this, investigators examined the EOL educational practices and knowledge of residents and faculty at 32 internal medicine residency programs. Subsequently, the residency programs participated in training to further improve EOL care education.

Residency program directors completed an "EOL Institutional Profile," identifying their programs' demographic characteristics, EOL course offerings, methods used to assess residents' mastery of EOL care, and program-specific barriers to EOL care and curriculum reform. In addition, residents and teaching faculty at each program completed a 36-item, multiple-choice exam during the summer of 1998 that tested their EOL knowledge in areas such as pain and symptom management, ethics, communication and hospice care.

All 32 residency programs reported offering some type of EOL education. The most common required curriculum—mentioned by 77 percent of programs—was instruction in ethics. Teaching in pain assessment/treatment was required by about 60 percent of programs. In contrast, less than 30 percent of programs reported required instruction in symptom management and hospice care. The majority of programs provided supervised clinical EOL experiences in a hospital setting, although 78 percent reported having an affiliated home-hospice program. Programs typically rely on faculty's written evaluations to assess residents' understanding of EOL care concepts, despite a deficit in faculty skills in this area. More than one-fourth of program directors said they feel faculty are unskilled in evaluating residents in this area. The biggest perceived barrier to improving EOL instruction was the limited time available to add new curriculum. On the EOL knowledge exam, faculty scored higher than residents and residents at higher training levels performed better than residents just beginning their training. Overall, scores were low, with both "residents and faculty demonstrat[ing] poorest performance on prognosis and transitions from curative to palliative and hospice care, and best performance on communication skills and non-pain assessment and treatment."

All 32 residency programs subsequently participated in a year-long demonstration program to enhance their EOL curriculum. A trainee team that included the program director and several faculty from each of the 32 residency programs attended a two-day EOL curriculum workshop in October 1998. They received instruction in pain assessment, pain management, EOL communication skills, EOL teaching opportunities, hospice care and curriculum evaluation. The teams then developed an action plan for each of the six areas, identifying "intended educational projects and methods to integrate the information presented into their own curriculum." Workshop faculty acted as mentors over the ensuing year. Teams met again nine months later to assess their progress, receive

further instruction and revise their action plans.

The investigators monitored changes in "seven key domains of EOL curriculum" to assess the impact of the training: resident teaching and assessment in the five areas of pain assessment, pain management, nonpain symptom assessment and management, EOL communication skills and EOL clinical care experiences; the inclusion of EOL education in traditional educational formats (such as grand rounds, ethics conferences); and the development of EOL faculty development programs. Each program also completed a written evaluation of the training, indicating the value of the training and their level of commitment to EOL curriculum reform.

An overwhelming majority of the residency programs believed that that training would improve their EOL education. At the 12-month mark, 25 residency programs remained involved with the project and submitted a follow-up report on curriculum changes. All 25 programs had implemented new EOL curriculum. On average, pro-grams added or enhanced curriculum in five of the seven domains. More than 90 percent of programs reported new curriculum in pain assessment, pain management and communication skills. Only 24 percent of programs reported any enhancement to EOL faculty development.

The authors conclude: "We are encouraged with the consistency with which residency programs were able to assess both the need to improve education in EOL care and opportunities for doing so." They continue: "Programs were able to both build on components of EOL care training that were present prior to their participation in the project, as well as to implement curriculum reform in areas that had not been present in their program." Based on the success of this pilot training, the investigators are recruiting an additional 290 residency programs.

Mullan PB et al. "End-of-Life Care Education in Internal Medicine Residency Programs: An Interinstitutional Study." *Journal of Palliative Medicine*, 5(4): 487–496, 2002.

Weissman DE et al. "End-of-Life Curriculum Reform: Outcomes and Impact in a Follow-Up Study of Internal Medicine Residency Programs." *Journal of Palliative Medicine,* 5(4): 497–506, 2002.

States Spend Little of Tobacco-Settlement Dollars on Tobacco Prevention

Four years after all 50 states divided up a multibillion dollar cash settlement from the tobacco industry, very little of the money is being spent on tobacco-control programs, despite the fact that tobacco control was one of the primary goals of the settlement agreement.

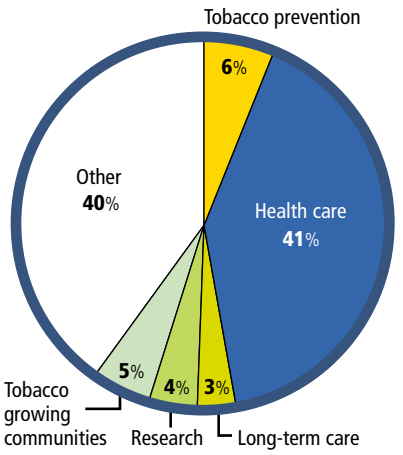
A study of state use of tobacco-settlement dollars for fiscal 2001 found that, on average, states spent only 6 percent of their funds on programs to reduce tobacco use. The mean amount spent on tobacco control was $3.50 out of a $28.35 per-capita award. Most states invested far below the mean $7.47 per capita recommended by the Centers for Disease Control and Prevention (CDC). Only six states exceeded their CDC-recommended rate.

"Because only a very small proportion of the tobacco settlement is being used for tobacco-control programs, the settlement represents an unrealized opportunity to reduce morbidity and mortality from smoking," researchers state.

The study found that in 2001, states spent 41 percent of their tobacco allotment on health care (medical, dental and mental health). States with higher levels of uninsured people tended to use more of their settlement funds for health care. More than one-third of the funds went to either nonhealth programs or to budget reserves. Some 5 percent of all settlement funds went as aid to tobacco-growing communities, 4 percent went to research on tobacco-related illnesses and 3 percent was spent on long-term care.

Still, the settlement was a major funding source for tobacco-control programs, despite their low funding priority among most states. Settlement dollars accounted for about 55 percent of all funds spent on tobacco control in 2001.

Allocation of Tobacco-Settlement Funds for Fiscal Year 2001



Research Note

Children with Asthma Fare Differently Depending on Welfare Status, Parents' Mental Health

Does being on welfare, having health insurance and living with parents with mental health problems make a difference in the well-being and health care use of children with asthma? According to one study of 386 urban children, the answer is yes, although the study could not conclude whether these factors caused the difference.

Researchers interviewed parents of children in six urban clinics and two welfare offices in San Antonio, Texas; most parents were low-income (76 percent lived on less than $18,000 a year). The study categorized families by their relationship to the welfare system (they were current or former recipients, had applications pending, were denied, or had never applied), whether they were insured and the sturdiness of parents' mental health.

When looking at welfare status, researchers found that children whose families were denied welfare scored worst on most of the study's measures. They had higher rates of asthma symptoms, acute care visits, emergency room visits and hospital stays than did welfare and nonwelfare recipients, as well as pending applicants.

Parents of uninsured children reported more barriers to care, and only half as many acute care visits and hospitalizations than children who were always or sometimes insured. Interestingly, parents of uninsured children also reported fewer symptoms and fewer severe asthma episodes than those of insured children.

Children living with parents who scored in the lowest third on a test of mental well-being had more, and more severe, asthma symptoms and used the health care system significantly more than children whose parents scored higher.

Where did these categories overlap? Parents never involved with the welfare system had significantly better mental health scores than current recipients and pending applicants; their children also had lower rates of asthma symptoms, severe episodes and emergency department visits. However, children of pending applicants had the lowest hospitalization rate.

The researchers concluded, "Clinicians should be aware of the high potential for depression and other mental health problems among impoverished parents of chronically ill children and of the impact of these mental health issues on use of health care services . . . . Furthermore, interventions designed for children with asthma must recognize and address these important mental health issues if they are to produce health improvements."

Wood PR, Smith LA et al. "Relationships Between Welfare Status, Health Insurance Status, and Health and Medical Care Among Children with Asthma." *American Journal of Public Health*, 92(9): 1446–1452, 2002.

Lauren Smith, M.D., M.P.H, is a fellow in The Robert Wood Johnson Foundation Minority Medical Development Program.

Interestingly, states with higher rates of tobacco-related health problems did not spend a higher portion of settlement money on tobacco control. In fact, states with higher smoking rates tended to invest less per capita in tobacco control. Tobacco-producing states also spent much less—a mean of $1.20 per person compared with $3.81 for non-tobacco-producing states.

Researchers raised concerns about the future funding for tobacco-control programs. While a national lawsuit now being considered against the tobacco industry may raise more money for states, tobacco control may still be a low funding priority if current behavior is any predictor. Even if states were to have a change of heart, recent reports suggest that due to the economic downturn, state legislatures may be turning to the settlement funds as an alternative to raising taxes or cutting budgets.

Gross CP et al. "State Expenditures for Tobacco-Control Programs and the Tobacco Settlement." *The New England Journal of Medicine,* 347(14): 1080–1086, 2002.

Good News on Elderly Health

Two recently published studies provide good news about the ability of elderly people to recover from disabilities and live more independently as they age. One study found that most long-term research measuring disability rates among the elderly underestimate its occurrence because researchers do not check in often enough with their subjects. The reason for the undercount: Enrollees often recovered from temporary disabilities, so their episodes fell beneath the radar screens of studies that waited long intervals between assessments. The other study found that physical therapy can slow functional decline among the physically frail elderly who live at home.

Research measuring disability rates followed 754 enrollees, ages 70 and older, over two years in a large health plan in New Haven, Conn. All were living in the community, spoke English and were not disabled (e.g., they required no help with four basic activities: bathing, dressing, walking or transferring from a chair). Participants were placed into three groups—low, intermediate and high—depending on their risk for disability. To assess whether they could still perform the four activities, subjects were interviewed monthly, instead of every 6 to 12 months, which is the traditional format for such studies.

Researchers found that in each risk group, disability rates rose substantially over time when assessed monthly. By two years, disability had developed in 20 percent of low-risk, 53 percent of intermediate, and 74 percent of high-risk enrollees. But when measured in six-month snapshots, the disability rate remained about the same over two years for those in the low-risk group and increased only modestly for those in the intermediate and high-risk groups. The rate differences were primarily due to recovery, although as time progressed, they were increasingly influenced by deaths and study-group dropouts.

"Based on our findings, disability for many older persons should be considered an acute reversible event, more similar to falls and delirium than to progressive disorders such as Alzheimer's disease," study authors stated. More frequent assessments can better estimate active life expectancy and provide a deeper understanding of the resiliency of elderly people, they explained.

The study of functional decline among the elderly randomly divided 188 physically frail people ages 75 or older who were living at home into two groups. The control group received six months of health education to promote general well-being. The experimental group received about 16 physical therapy sessions over six months to improve strength, balance and overall mobility. All participants were rated on their ability to perform eight activities of daily living, such as walking, bathing and eating. Overall, participants in the experimental group had less disability than control group members at 3, 7 and 12 months. Using an advancing severity scale 0-16, the scores in the intervention and control groups were 2.3 and 2.8, respectively, when first measured; 2.0 and 3.6 at 7 months, and 2.7 and 4.2 at one year. Researchers found that for the most part only moderately, and not severely, frail participants benefited from the physical therapy program.

"The results of our study indicate that functional decline among physically frail, elderly persons who live at home can be slowed, if not prevented," the authors concluded.

Gill TM, Hardy SE and Williams CS. "Underestimation of Disability in Community-Living Older Persons." *Journal of the American Geriatrics Society*, 50(9): 1492–1497, 2002.

Gill TM et al. "A Program to Prevent Functional Decline in Physically Frail, Elderly Persons who Live at Home." *The New England Journal of Medicine*, 357(14): 1068–1074, 2002.

Thomas Gill, M.D., was a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar at the time of this research.

Research Note

Managing Chronic Kidney Disease

The cost of treating individuals with chronic kidney disease is high: More than $15 billion annually is spent in the United States on its most severe form known as end-stage renal disease (ESRD). Yet less than 40 percent of these patients who are on dialysis survive beyond five years. Many ESRD patients are first under the care of a primary care physician and only see a specialist as their disease progresses. Does the timing of evaluation and care management by a specialist play a role in how long a patient survives? Are some patients more likely than others to see a specialist earlier in the course of their disease? To answer these questions, researchers looked at the experience of 828 ESRD patients enrolled in the CHOICE study (Choices for Healthy Outcomes in Caring for ESRD) who received dialysis at 81 clinics in 19 states from October 1995 to June 1998.

CHOICE patients completed a questionnaire providing their medical history, including the date of their first evaluation by a specialist. The researchers also collected demographic and health insurance information for each patient. A trained research nurse and clinic staff, respectively, assessed the severity of patients' other medical conditions and their degree of physical impairment. In addition, the investigators categorized patients according to the length of time between their initial evaluation by a specialist and the date of their first dialysis: 30 percent received late evaluations that occurred less than four months before dialysis; 22 percent had intermediate evaluations, occurring four to 12 months before dialysis, and 48 percent were evaluated early, at least a year before dialysis.

The results showed that black men, uninsured patients and patients suffering with other diseases in addition to chronic kidney disease were more commonly evaluated late—less than four months before they started dialysis. Patients who received these late evaluations did not survive as long as patients evaluated earlier. In particular, diabetic patients and black patients evaluated late did not survive as long as their counterparts who received earlier evaluations.

The authors suggest that early evaluation is important and may affect survival time because it allows for better management of chronic kidney disease complications and more time for patient education. The study did not examine the causes of late evaluations. The authors caution that "it should not be inferred from our data that the referral practices of primary care physicians are responsible for most late evaluations." Rather, they conclude, "These findings should lead to increased attention to the role of pre-ESRD care in improving outcomes of patients with chronic kidney disease."

Kinchen KS et al. "The Timing of Specialist Evaluation in Chronic Kidney Disease and Mortality." *Annals of Internal Medicine*, 137(6): 479–486, 2002.

Kraig Kinchen, M.D., M.Sc., was a Robert Wood Johnson Clinical Scholar at the time of this research.

People

Brian O'Neil, M.B.A., C.F.A., joined the Foundation as chief investment officer in January.

Previously, O'Neil worked for more than 20 years at the Equitable Life Assurance Society, where he held a variety of investment positions, including chief investment officer and, most recently, headed the Funds Management Group. O'Neil received an M.B.A. from the Columbia University Graduate School of Business.

Susan Krutt, M.A., became the communications associate for the Foundation's Health Group in December 2002.

Formerly, she was a research associate with the Annenberg Public Policy Center at the University of Pennsylvania. Krutt received an M.A. from the University of Pennsylvania's Annenberg School for Communication.

Kristin Silvani joined the RWJF staff in January as a production assistant in the Grant Results Reporting Unit. Before coming to the Foundation, she was an executive assistant at Enable in Princeton, N.J. Prior to that, Silvani worked at the Foundation as a temp for 18 months.

Nicole Bianco began working at the Foundation in January as records assistant in Central Files. Formerly, Nicole was a medical biller at Princeton Medical Center.

Changes

Bob Hughes, Ph.D., became coordinator of special projects in December 2002. His responsibilities include senior-level support on a broad range of issues and activities related to the operations of the Office of the President/CEO; coordination of efforts, resources and ideas throughout the philanthropic community; and review and analysis of internal grantmaking processes.

Farewell

Paul Jellinek, Ph.D., program vice president, Health Group, left the Foundation in December 2002 to work with philanthropies interested in programming focused on volunteers engaged in issues of the underserved.

Nancy Kaufman, R.N., M.S., program vice president, Health Group, bade farewell to RWJF in December 2002 to start her own strategic consulting business.

Lewis G. Sandy, M.D., M.B.A., executive vice president, is leaving the Foundation in April after 12 years to become executive vice president for clinical strategies and policy at UnitedHealth Group, Minnetonka, Minn. As vice president for programs, Sandy led the Foundation's early work to improve systems of care for the chronically ill and developed important new programs for managed care. More recently, as executive vice president, he led the way to major improvements in the Foundation's operations. Sandy's responsibilities will be shared among existing executive staff. Specifically, the Office of Proposal Management will now report to Vice President for Finance Peter Goodwin, Foundation and Building Services will report to Vice President for Human Resources David Waldman, and Calvin Bland, acting senior vice president and director of the Health Care Group, will take on the role of chief of staff and special advisor to the president and CEO.

Doriane Miller, M.D., program vice president, Health Care Group, left the Foundation in December 2002 to join the Health Research and Educational Trust in Chicago, where she serves as project director for an RWJF grant for planning and testing a learning network for the co-management of chronic conditions.

What's New on the RWJF Web Site

"America's Weight Gain 1960–2000" has made its debut on *www.rwjf.org*. This interactive graphic enables Web users to track rates of obesity in adults and overweight in children.

The section on the Foundation's Web site was created to coincide with the launch of The Robert Wood Johnson Foundation Television Health Series, a new project to provide local television news producers with video news releases on issues related to RWJF's mission. A webcast of the first video is packaged with the interactive graphic and an interview with Jacqueline Reed, 1995 RWJF Community Health Leader and executive director of Chicago's Westside Health Authority. See *www.rwjf.org/news/video/childhoodObesity.jhtml*.

Another new interactive tool on the Web site is the "When Bad Ads Happen to Good Causes" quiz. Coupled with a Web-only Special Report, the quiz takes its cue from a book by the same title written by communications consultant Andy Goodman and funded by RWJF and several other foundations.

Based on a 10-year RoperASW study, Goodman suggests that most public service print ads fail. The quiz allows users to evaluate a series of real public service print advertisements and to guess which ones succeeded. Although the approach to the issue is light, the exercise drives home the lesson that failure to plan ads well can have weighty consequences. Visit the Special Report at *www.rwjf.org/news/special/badadsIntro.jhtml*.

RWJF Senior Program Officer Susan B. Hassmiller, Ph.D., R.N., recently received the highest honor of nursing achievement in the American Red Cross, the Ann Magnussen Award. She also received the Clara Barton Award. For details see the Web Special Report at *www.rwjf.org/news/featureDetail.jsp?id=52&contentGroup=specialreport*.

Also look for two new Web profiles at *www.rwjf.org/news/profiles*:

- Janet Hartey, executive director of Coastal Caregivers, a *Faith in Action* grantee along the South Jersey shore
- Richard Killingsworth, director of RWJF's Active *Living by Design* National Program

Both profiles include another feature new to *www.rwjf.org*: interactive photo essays.

—Jeff Meade

Grant Results Reports

Since October 2002, 82 new Grant Results Reports and two National Program Reports have been posted at *www.rwjf.org*. These reports, organized by topic area, detail the results of grants that are now closed. Among the newly posted reports is the following:

- ***Using Managed Care to Facilitate Health-Related Behavior Change***. The Center for the Advancement of Health conducted a comprehensive study of the availability and integration of health behavior change programs in managed care. Among the study's findings are that the programs yielded positive outcomes for patients, encouragement by primary care providers is crucial, and services to manage chronic care conditions are more widely available than services to reduce risky behaviors, such as smoking and physical inactivity. The study's complete findings are available in a series of 13 reports, free on the center's Web site, *www.cfah.org/publications.cfm*.

—Tedi Nessas