

- The
- Robert
- Wood
- Johnson
- Foundation
- Quarterly
- Newsletter

**Physicians Talk to Congress Members About Uninsured**  
PAGE 3



**Youth Rally Against Tobacco**  
PAGE 9



**First Circle of Life Awards Made**  
PAGE 10



## Better Health Outcomes Possible Using Evidence-Based Medicine

Medical errors have been big news lately. Since a November Institute of Medicine report indicated that errors in care cause upwards of 44,000 deaths annually in the United States, both the federal government and major employers are taking new steps to cut down on these costly mistakes.

High on the list of strategies is greater use of evidence-based medicine — an approach The Robert Wood Johnson Foundation has long embraced and actively supports.

Evidence-based medicine is generally characterized as care for a particular disease or condition that is based on scientifically established best practices. In theory, greater use of evidence-based guidelines, particularly those calling for identifying and tracking high-risk patients, would not only cut down on errors within the system, but would result in better population outcomes by bringing more patients in earlier.

“Our agenda is much broader than just addressing errors,” says Doriane Miller, MD, an RWJF vice president charged with leading the Foundation’s Clinical Care Program Management Team. “We want to see better health outcomes overall.”

While evidence-based medicine is commonly seen as barely out of its infancy, there’s no shortage of protocols, critical pathways, and clinical best practices for everything from expensive coronary artery bypass procedures to daily, at-home monitoring of asthma and diabetes. The problem is they are honored mainly in the breach.

The Foundation hopes to change that with programs identifying why evidence-based approaches are not being used and developing innovative systems strategies to overcome those obstacles. “The goal is to narrow the gap between what is known and what is practiced,” Miller says. “What we are trying to do is look not at clinical research, but at the gaps around the process of adopting evidence-based medicine.”

However, many of the obstacles are not clinical in the traditional sense, Miller points out. Some are cultural, such as the typically passive role patients play in managing their illnesses. Others are structural, such as inadequate systems for tracking patients with chronic diseases and following them proactively to prevent costly flare-ups and complications.

See Evidence-Based Medicine — page 2

### FEATURES

- Profile 4
- ABridge 5
- Grants 11
- People 12

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To receive *ADVANCES*, or to report a change of address, write to:

Editor, *ADVANCES*

The Robert Wood Johnson  
Foundation

P.O. Box 2316

Princeton, N.J. 08543-2316

[advances@rwjf.org](mailto:advances@rwjf.org)

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Solving these problems will require efforts far beyond supporting researchers or even front-line providers. Patients, health systems, health plans, government, and employers also will have to get actively involved.

## BETTER SYSTEMS MEAN BETTER OUTCOMES

The Foundation's approach to promoting evidence-based medicine is based in quality improvement theory. The basic idea is that systems of care influence the outcomes of care — in this case, population morbidity, mortality, and functional status. Improvements in the systems of care can reduce morbidity and mortality, and improve functional status.

The *Improving Chronic Illness Care* program provides a good example of what RWJF wants to emphasize. While the \$25-million program starts with a new model for treating chronic illnesses and supports research advancing the state of the art, its major thrust is helping health care providers across the country change their operations so the new findings can be put to use.

That's being done through three "breakthrough series," each of which targets two chronic conditions. Health system leaders meet to identify obstacles in their own organizations to providing excellent chronic care. These obstacles often revolve around lack of resources and systems to support patients managing their own conditions, and lack of information systems to cue providers and identify and track patients. They then go back to solve the problems and reconvene to analyze their progress.

The program has each participating health system work with two chronic conditions to spotlight elements they have in

common, such as the need to develop effective patient registries, says Ed Wagner, MD, who directs the program from the Center for Health Care Studies at the Group Health Cooperative of Puget Sound in Seattle. Approaches learned in chronic care for one illness, such as diabetes, can be applied to others, such as asthma.

Wagner expects this cross-fertilization to extend beyond the boundaries of individual systems. "We're hoping the breakthrough series will get the word out about how chronic care can be improved," he says.

Promoting evidence-based medicine also is a major component of the *Medicaid Managed Care Program*. And like the chronic illness program, system change is the focus, says Karen Brodsky, who is the Medicaid program's deputy director and a vice president at the Center for Health Care Strategies in Princeton, N.J.

The program works with Medicaid agencies in every state to identify and help implement clinical and administrative best practices. It has succeeded in getting more best practices research support for pregnancy and childhood asthma. But administrative issues also are critical to success.

For example, managed care programs that offer exceptional AIDS care could easily be overwhelmed with high-cost patients unless the system is set up to risk-adjust payments, Brodsky says. And administrative systems that identify and track pregnancies, and ensure coverage for basic prenatal care as well as for risk factors such as substance abuse, are also essential to improve birth outcomes.

The program takes advantage of the Medicaid administrative structure to disseminate its findings. "Medical directors in Medicaid managed care plans are

often isolated from their practice community. This is a way we can reach them and help them build their own support community," Brodsky says.

## WHERE THE MONEY IS

All the Foundation's programs promoting evidence-based medicine are designed to leverage existing structures to promote better outcomes. But perhaps the largest potential leverage is through the National Health Care Purchasing Institute. This five-year educational program targets some 300 top executives in Medicare, Medicaid, and Fortune 500 companies who are collectively responsible for administering \$600 million in health care expenditures annually — that's about 55% of the US total.

Informing this key audience about what they should demand from health care providers and health plans in the way of proof of quality and outcomes will go a long way toward encouraging evidence-based practice, says Kevin Piper, director of the National Health Care Purchasing Institute and a vice president at the Washington, D.C., Alpha Center. "Evidence-based medicine is a mechanism for improving care and the delivery of care," Piper says. "It is a tool purchasers can use to effect better outcomes. The payor is tremendously important in that they can set standards and expectations for care."

That not only improves medical outcomes but may lower costs — a significant element in gaining acceptance of evidence-based practice, RWJF's Miller says. "The clinical evidence is fine, but there's more to it than that. We are doing this in a market-based system where financial incentives matter."

— HOWARD LARKIN

# RWJF Funds Juvenile Justice Drug Intervention Program

Aiming to treat rather than punish adolescents who abuse drugs and alcohol, The Robert Wood Johnson Foundation is funding an initiative to integrate drug treatment and rehabilitation with the juvenile justice system, where an increasing number of substance-abusing adolescents find themselves.

The \$21-million, five-year initiative, tentatively called *Youth Intervention Networks: Enhancing Substance Abuse Treatment Within the Juvenile Justice System*, is RWJF's first national program involving the treatment and rehabilitation of alcohol- and drug-abusing youth. In the mid-1990s, the Foundation funded a pilot test of a drug intervention program for adolescents and women incarcerated at Rikers Island in New York City. Subsequent evaluations of that program showed that treatment and counseling services are effective in helping former inmates stay out of jail.

"This new program takes a restorative approach to kids who have a substance abuse problem and who have been involved in the criminal justice system," says Kate Kraft, PhD, RWJF program officer.

With the identification of some highly effective intervention strategies, such as community-based care, alcohol and drug abuse among adolescents has declined somewhat, although it remains a significant national problem. The communities hardest hit by adolescent substance abuse generally lack the resources to provide any kind of intervention or treatment, which is one reason why a growing number of substance-abusing youths are landing in the juvenile justice system. Solid numbers are hard to come by, but experts estimate that at least 60% of the 2 million

juveniles ages 10 to 17 who were arrested in 1998 had a substance abuse problem, Kraft says.

Yet the juvenile justice system is even less equipped than most communities to provide the services and care that these youngsters need.

"These are the most troubled kids and they are in the juvenile justice system," Kraft says. "They are not in school. They are generally not connected to their families anymore. They have fallen through the cracks in the social service system. The last stop is in the juvenile justice system. If you're going to have a final opportunity to intervene, this is where you're going to find them."

The RWJF initiative plans to create broad networks of community-based, comprehensive drug treatment and rehabilitation services that are directly linked to the juvenile justice system.

It will fund up to 10 juvenile justice systems — each receiving \$250,000 per year for five years — to develop and coordinate their own network of community-based drug treatment and rehabilitation services. The services, which will be integrated with the juvenile justice system, will include individual and family counseling, after-school programming, mentoring, employment, case management, and advocacy.

The initiative also will provide training and leadership development for judges to increase their knowledge of the substance abuse treatment field. According to Kraft, two judges or prosecutors from each project community will participate in a yearlong training/fellowship program where they will learn about substance abuse and treatment as well as important skills such as convening and collaborating.

"Judges are incredibly powerful community members, and they can do a lot to change the service mix in their communities just by the kinds of orders they write," Kraft says. The National Council of Juvenile and Family Court Judges will participate in the initiative's leadership development component.

The Institute for Strengths in Juvenile Justice, located in Portland, Ore., and directed by Laura Burney Nissen, PhD, will be the National Program Office for the initiative. The Institute will provide leadership, technical assistance, and oversight for the 10 chosen sites. Nissen is nationally known for her work in building restorative juvenile justice systems and developing adolescent substance abuse treatment and rehabilitation strategies that focus on youngsters' assets and competencies. She will co-direct the initiative with Don Costello, an experienced municipal and family court judge in Bend, Ore., who will run the judicial leadership aspect of the program.

"The networks initiative is about demonstrating the power of working together to intervene effectively and redirect young people who are starting out troubled to become drug-free and crime-free in their communities," says Nissen. "This intervention is full of promise. One system, one group, one organization can't do it alone."

According to Kraft, sites are to be selected by fall of 2000. Program directors anticipate finishing the five-year initiative with several very successful models that can be replicated in other areas, she says. Each of the 10 juvenile justice systems will be eligible to receive funds to conduct evaluations of local community treatment providers that demonstrate promising approaches to substance abuse treatment and rehabilitation.

"With this new initiative, RWJF hopes to prove that with enough coordinated, community-based effort, the future can be restored for even our hardest-to-reach youngsters," says J. Michael McGinnis, MD, RWJF senior vice president and director of the Health Group.

— ANDREA KOTT

## In February, 16 project directors from The Robert Wood

Johnson Foundation national program *Reach Out: Physicians' Initiative to Expand Care to Underserved Americans* visited Capitol Hill to share the lessons they have learned during the five years of the program. They held 35 meetings on the Hill with members of Congress and their staffs, and spoke with them not only about their own projects, but also about the role of volunteerism in providing care to the uninsured. Below, left to right: Nilda Soto, MD, project director, Good News Care Center, Florida City, Fla., talks with Congresswoman Ileana Ros-Lehtinen (R-Florida).





A recent episode of the television drama “ER” centered on a series of dramatic medical mistakes. But in real-life hospitals, most errors are unspectacular, everyday events, caused not by inept or unethical doctors, but by badly designed safety systems. Lucian Leape, MD, adjunct professor of health policy at the Harvard School of Public Health, helped to bring those systems failures to light in a landmark study of medical errors, published in 1991. A member of the Institute of Medicine’s Committee on the Quality of Health Care in America, Leape co-authored the report *To Err is Human: Building a Safer Health System*, which led the White House to call for a new national initiative on patient safety. As a grantee under the *Investigator Awards in Health Policy Research* from The Robert Wood Johnson Foundation, Leape also is working to reshape the way we think about medical mistakes and their causes.

In this interview with *ADVANCES*, Leape talks about new ways to approach the fundamental principle of medicine: “First, do no harm.”

**President Clinton recently called for a new federal center on patient safety, plus mandatory reporting of serious medical errors. What took so long?**

**LEAPE** — When we published our original study showing the extent of medical injuries, it didn’t receive much national attention; the issue of medical errors and patient safety was not a matter of public consciousness. Then in 1995, there was a series of rather remarkable adverse events, starting with the Betsy Lehman case — an unfortunate death from an overdose of chemotherapy. We also began to see papers on the systems that had been so successful in reducing errors in other industries, suggesting the same approach held great promise for health care. That combination got people interested. Soon afterward, the Institute of Medicine launched its major effort on quality of care. The way these things work, I would think five years is a remarkably short time to go from no awareness to a change in public policy.

**Much of American medicine is based on the notion of the autonomous physician. How would you convince both doctors and hospitals that the real cause of adverse events is often system failure, not physician error?**

**LEAPE** — I think the most successful way is to demonstrate it. We now have hundreds of hospitals and health care systems throughout the country that have used a systems approach to address the injury and error problem. There are a large number of success stories, and the word is spreading.

**How does a hospital create an internal reporting system that actually results in fewer errors and improved care?**

**LEAPE** — Those systems work only if they’re safe and productive. People are not going to report errors if they’re going to be

punished, and they’re not going to report if nothing happens to solve the problem. The real purpose of reporting is to begin the process of figuring out what happened, and how to keep it from happening again.

**The recent findings that bone marrow transplants apparently do not prolong life in breast cancer patients point out just how hard it is to convince patients — and their doctors — to rely on evidence-based medicine. How can you convince the public to accept a more scientific practice of medicine?**

**LEAPE** — Tom Chalmers, one of the pioneers of randomized clinical trials would say, “Randomize the first patient.” Once a new treatment has been shown to possibly be effective, it becomes very difficult to enroll patients in a randomized trial. The solution — which nobody has ever done — is to require that when someone develops a new treatment, they are not allowed to use it unless the experiment is part of a formal randomized trial. Within a very short time — maybe as few as 100 patients — we would know about efficacy.

There are two major barriers to this. One is the natural enthusiasm that people feel about a possible discovery. The other is that third-party payors have refused to pay for experimental treatments. To me, those payors have got it exactly backwards. How many tens of millions were spent on bone marrow transplants? The payors could have saved millions if they had funded randomized trials from the beginning. We should insist on good evidence for everything new that comes down the pike.

**What can patients do to prevent errors?**

**LEAPE** — The most important thing they can do is to understand

their treatment. If the doctor doesn’t explain, ask. With the Internet, patients are becoming better and better informed. A patient who has just done a literature search may know more about her condition than her doctor does. I don’t believe that patients’ increasing knowledge about their problems is a threat to a doctor’s authority; I see it as an advantage. To the extent that patients understand their condition and treatment, they become the last line of defense if somebody makes a mistake. A well-informed patient is the best defense against an adverse event.

**Even the most competent, best-intentioned doctor can make an error; unfortunately, the results can sometimes be devastating. How do you convince patients and their families that a punitive response ultimately works against everyone’s best interests?**

**LEAPE** — When something goes wrong, we need to be honest about it, inform the patient, then tell them what we’re doing about it. One of my colleagues runs a program in mediation, where they meet with an aggrieved patient and doctor. Almost always, the patients want three things: They want the doctor to explain what happened; they want to hear the doctor say “I’m sorry”; and they want to know that the doctor is going to do something to keep it from happening to someone else. If we were honest with patients, and let them know that we take these problems seriously, I think they’d be grateful and much less likely to sue. I practiced surgery for 27 years; when I admitted a mistake to a patient, they were almost always understanding and forgiving. Many would say, “That’s all right, doctor, we all make mistakes.”

— INTERVIEW BY  
ELIZABETH AUSTIN

- Selected

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- Summaries

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- of Recently

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- Published

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- Research by

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- RWJF Grantees

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## The Impact of Worksite Smoking Bans on Smokers

For more than a decade, second-hand smoke has been recognized as a health hazard causing disease and death in people who do not smoke. To provide a safe environment for employees, many US firms implemented workplace smoking bans in the late 1980s. By 1993, more than 80% of employees worked in settings that restricted smoking to some extent; nearly half worked in 100% smoke-free environments.

These bans decrease worksite environmental tobacco smoke (ETS) exposure for nonsmokers — but do they change the smoking habits of smokers? Two recent studies — one small in scope with a long follow-up period, and the other an extensive national survey — examined the impact of workplace smoking restrictions on smoking cessation. The first study found that enacting workplace smoking restrictions without enforcing them has no effect on smoking cessation. The second, larger study found that the stricter the smoking ban, the more likely employees are to stop smoking or at least cut back.

The first study surveyed 369 Massachusetts smokers over a 3-year period. Previous research — which followed smokers for only brief time periods — failed to show a significant increase in smokers quitting even among employees working in firms with the strictest smoking regulations. The authors hypothesized that by following workers continuously employed in smoke-free settings over a longer period of time, they would see more smokers kick the habit. The study team interviewed adult smokers in 1993 and again in 1996, asking them about workplace smoking policies.

Nearly 40% of smokers said their workplace had a smoking ban in place in both 1993 and

1996. Another 25% indicated that their workplace moved from few smoking restrictions in 1993 to a smoking ban in 1996.

At the 1996 survey, 15% of smokers said they had quit smoking. Based on their analysis, the investigators conclude that because workplace smoking bans are poorly enforced, they had no significant effect on smoking cessation. But other variables apparently did play a role. For example, smokers noted that their communities had cracked down on public smoking. More than 90% of respondents said that the number of places where they could smoke freely in their community decreased over the survey period. For more than three-quarters of those who quit smoking, that played a role in their decision to stop.

In addition, levels of exposure to ETS at work were related to smoking cessation. Smokers continuously employed at workplaces with minimal ETS were nearly 7 times more likely to have quit smoking than those employed at worksites with higher levels of ETS.

Interestingly, even at workplaces that banned indoor smoking, more than 12% of workers reported recent exposure to ETS in their work area. The authors suggest that “the most insidious effect of noncompliance may be its effect on smokers’ perceptions of their ability to quit.” Smokers who continue to smoke in the face of workplace bans likely perceive themselves as unable or unmotivated to quit.

The second study looked at changes in smoking and smoking cessation among nearly 100,000 employed adults — 25% of whom reported smoking at the time of the survey. The researchers used data from three different editions of the Current Population Survey, a monthly national survey of approximately 57,000 households conducted by the US Census Bureau that includes questions about smoking.

The researchers estimated the effect of moving from no smoking restrictions to a smoke-free policy and found that it decreases the prevalence of smoking by 23% and reduces daily cigarette consumption by 14% or nearly three cigarettes per smoker. Less restrictive bans cut these effects in half. Workplace smoking bans produced the greatest decreases in smoking among older workers (aged 40 to 65), college graduates, and workers in the wholesale and retail trades.

According to the authors, their results “show a consistent pattern: the more restrictive the workplace policy, the greater the decline in smoking.”

Together, these two studies suggest that strictly enforced workplace smoking bans appear to motivate smokers to smoke less or stop smoking altogether.

Biener L and Nyman AL. Effect of Workplace Smoking Policies on Smoking Cessation: Results of a Longitudinal Study. *Journal of Occupational and Environmental Medicine* 41 (12):1121–1127, 1999.

Farrelly MC et al. The Impact of Workplace Smoking Bans: Results from a National Survey. *Tobacco Control* 8 (3): 272–277, 1999.

## Predicting Life Expectancy for the Chronically Ill: Are the Criteria Up to the Task?

For nearly a decade, terminally ill Medicare recipients choosing to forgo aggressive medical treatment have been able to elect the Medicare hospice benefit. Under this benefit, Medicare provides comprehensive coverage for palliative care — also known as comfort care. However, the Medicare hospice benefit has a stiff qualifier: both the patient’s physician and the hospice medical director must certify that the patient’s life expectancy is “six months or less if the terminal illness runs its normal course.”

For patients with metastatic cancer, the prognosis is often straightforward. Most cancer patients experience a fairly predictable final course marked by “a one- to two-month phase of progressive decline at the end of life.” In contrast, predicting life expectancy for patients slowly dying from chronic illnesses such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or end-stage liver disease (ESLD) is not so clear-cut. Many of these patients never experience a time during which they are clearly dying of their disease. Cancer’s distinctive markers of approaching death — and chronic illnesses’ comparatively ambiguous ones — help explain why the majority of hospice patients are terminally ill cancer patients.

Experts have suggested that hospice care be expanded to manage the end-of-life care of persons dying of chronic illnesses. In 1996, the National Hospice Organization (NHO) issued guidelines for determining prognoses — and hospice eligibility — for selected noncancer diseases. Already, these guidelines have been applied in specific cases to approve or deny Medicare coverage. How well do they work? Can health care providers identify chronically ill patients who are appropriate for hospice care?

To determine this, a recent study applied prognostic criteria similar to the NHO guidelines to seriously ill patients with COPD, CHF, or ESLD. Their cases were taken from a database of patients who were enrolled in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), funded by The Robert Wood Johnson Foundation.

For each patient included in the study, the researchers analyzed 7 variables: 5 were general clinical criteria such as hospital readmission, use of home care, or significant weight loss, that applied to all patients regardless of their disease. Two were disease-specific clinical criteria. The study team

## RESEARCH NOTE

### Abused Immigrant Women Face Obstacles Getting Help

An estimated 10% of Latina and Asian immigrant women are physically or sexually abused by their partners. Are these women reaching out to health care providers for assistance? If not, what prevents them from doing so?

To understand how social and cultural milieu affect help-seeking behavior, this recent study brought together 28 immigrant women in the San Francisco area in four focus groups — two composed of Latina women and two of Asian women. Participants were asked to discuss their definition of intimate partner abuse, identify sources of help for problems related to abuse, and comment on what would encourage or discourage them from seeking help.

The focus groups were audiotaped and transcripts were read by experts in partner abuse from disciplines including medicine, public health, psychology, medical anthropology, and social work. These experts

identified issues discussed frequently in the transcripts. Each transcript was read by experts of the same and different ethnicity.

Among Latina focus group participants, the median time they lived in the United States was 6 years; for Asian participants, 10 years. The median age in both groups was 35 years. Most participants were either divorced or separated.

In earlier research, the authors identified the following issues that discouraged abused women from seeking help from the health care system: fear of retribution by the abuser, unwillingness to involve the law, lack of financial resources, and long waits for appointments. In these focus groups, abused Latina and Asian women voiced similar concerns. Other social barriers mentioned frequently by participants were social isolation living in an unfamiliar land, difficulty speaking and writing English, fear of deportation, a cultural belief that partner abuse is a private issue, and expectations of racial and ethnic prejudice

in interactions with health care providers. A significant cultural barrier to seeking help was the desire to maintain an intact family at any cost. Latina women said they viewed the marital bond as sacred, so they were willing to tolerate the abuse. Asian women avoided seeking help because they believed disclosing the abuse would bring shame upon their family.

The authors suggest that future research should “identify the role of social and medical institutions in developing community outreach programs directed toward educating new immigrants about their rights and available services.”

Bauer HM, Rodriguez MA, et al. Barriers to Health Care for Abused Latina and Asian Immigrant Women. *Journal of Health Care for the Poor and Underserved* 11 (1): 33-43, 1999.

*Dr. Rodriguez is a former Robert Wood Johnson Clinical Scholar.*

applied these criteria to patients with a preference for palliative care in 3 different combinations “aimed at providing a low, medium, and high threshold for selecting patients eligible for hospice care based on the NHO recommendations.” The low threshold required the presence of only 1 of the criteria; the medium threshold required the presence of at least 3 criteria; and the high threshold required the presence of 5 of the 7 clinical criteria.

Although 44% of the 2,607 patients included in the study expressed a preference for palliative care, only 2% were discharged to a hospice program. Patients discharged to hospice were slightly older, more often white, and a higher proportion had COPD or ESLD than CHF.

Using the low threshold — which required evidence of only one of the clinical criteria — the researchers identified 923 patients

with a prognosis of 6 months or less; 70% of these patients survived more than 6 months after discharge. Using the medium and high threshold, the investigators identified 300 and 19 patients, respectively, with a prognosis of 6 months or less. In both cases, more than 50% of patients survived more than six months. In contrast, only 22% of patients actually discharged to hospice outlived their 6-month prognosis.

The study showed that these criteria are not very effective at identifying seriously ill patients who will not live more than 6 months. For example, the medium threshold that required patients to have at least 3 criteria was capable of identifying only 16% of patients who would die within 6 months.

Thus, the criteria predicted a survival of 6 months or less for many patients who ended up surviving longer and did not

properly identify most of the patients who did die within 6 months. Actual discharge to hospice was a more effective predictor of death within 6 months.

The authors conclude: “The goal of determining in advance — with a high degree of accuracy — which individual patients with COPD, CHF, or ESLD will die within 6 months is unrealistic . . . if a high degree of predictive accuracy is demanded by those who interpret the 6-month prognostic requirement for hospice enrollment, few patients who die of these types of chronic diseases will be eligible for hospice care.”

Fox E et al. Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients with Advanced Lung, Heart, or Liver Disease. *The Journal of the American Medical Association* 282 (17): 1638-1645, 1999.

## Physicians Do More Under Managed Care — Maybe Too Much

Among the strategies that managed care organizations use to control medical costs are incentives to physicians to reduce referrals to specialists and cut down on unnecessary or marginal services. But these controls may be causing primary care physicians to care for sicker patients and expand their range of services beyond levels that they should provide.

To determine how primary care physicians' scope of practice has changed in recent years, this study analyzed the results of a national survey of 12,385 primary care physicians and specialists.

The researchers asked the primary care physicians if, in the past 2 years, the complexity or severity of patients' conditions

they cared for without referral to a specialist had changed. The answers were chosen from a 5-point scale ranging from "increased a lot" to "decreased a lot." Specialists were asked a comparable question about the condition of the patients they saw upon referral.

The primary care physicians also ranked the appropriateness of their scope of care — from "much greater than it should be" to "much less than it should be" — with regard to the complexity or severity of patients' conditions they were expected to treat without referring to a specialist. The specialists used the same scale to rank the condition of the patients they saw at the time of referral.

The survey results were quite startling: 30% of primary care physicians said their scope of care had increased over the previous 2 years, and 50% of the specialists

agreed. Almost one-quarter of the primary care physicians felt that the level of care they were expected to provide was greater than it should be. More than a third of specialists felt that, at the time of referral, patients were worse off than they should be.

While an increased scope of care for primary care physicians is neither a positive nor a negative aspect of managed care medicine, the authors assert that steps need to be taken to "ensure that all primary care physicians are adequately prepared to fulfill their expanding roles effectively." Because of these changes, the health care system will need to monitor the quality of care and the accessibility of specialist services.

St. Peter RF et al. Changes in the Scope of Care Provided by Primary Care Physicians. *The New England Journal of Medicine* 341 (26):1980-1985, 1999.

Dr. St. Peter is a former Robert Wood Johnson Clinical Scholar.

The investigators considered a reduction in length of stay to be the number of days by which the health plan reduced hospitalization time relative to the total number of days requested by the treating physician.

The investigators analyzed the surgical and procedural admissions separately from the admissions for a medical diagnosis. They classified reductions in length of stay as modest (1 day) or substantial (2 or more days) when evaluating the effect on the likelihood of readmission. They analyzed patients needing cardiac catheterization separately, since these patients commonly need to be readmitted to the hospital for angioplasty or bypass surgery. Disease severity also was considered in the analysis.

Only 5 patients were denied requests for admission outright. A much greater percentage of patients had their hospital lengths of stay restricted by utilization review. The median length of stay requested for medical admissions was 5 days. In 10% of cases, this was reduced by 1 day, and in 7% by 2 or more days. For procedural admissions, the median length of stay requested was 4 days; 11% of these requests were reduced by 1 day and 8% by 2 or more days.

While the utilization review program did not substantially impact access to hospital care, the constraints it imposed on hospital lengths of stay may have adversely affected clinical outcomes for some patients. Among the 8% of patients admitted for a procedure whose hospital length of stay was reduced by 2 or more days, the researchers found a 2.6-fold increase in the risk of 60-day readmission. The more days the procedural patients were denied in the hospital, the greater their likelihood of returning.

The authors note that average hospital lengths of stay have continued to decline since the data from their study were collected. Given this decline, they believe it is possible that length-of-stay

## Shorter Lengths of Stay Can Increase Readmissions for Cardiovascular Patients

After health care researchers blew the whistle on high rates of unnecessary medical care in the 1970s and '80s, health plans initiated a system of prospective utilization review. By approving the number of days patients could be hospitalized, health plans tried to curb costs. But what impact has utilization review had on access and quality?

Researchers reviewed 4,326 privately insured patients with cardiovascular disease to see whether utilization management affected access to hospital care and length of stay, and the likelihood of readmission to the hospital within 60 days. About 40% of the patients reviewed were admitted for surgery or another procedure; the remainder were hospitalized for treatment of angina and several other cardiac conditions.

### Physicians' Assessments of Change in Primary Care Physicians' Scope of Care

#### Change in Previous 2 Years

##### Primary Care Physicians



##### Specialists



- Increase
- ▒ No change
- Decrease

### Physicians' Assessments of Appropriateness of Primary Care Physicians' Scope of Care

#### Scope of Care

##### Primary Care Physicians



##### Specialists



- Greater than should be
- ▒ About right
- Less than should be

reductions imposed by utilization reviews today “might have an even greater impact on clinical outcomes.” Therefore, they emphasize the need to continually monitor the impact of utilization management on patient outcomes.

Lessler DS and Wickizer TM. The Impact of Utilization Management on Readmissions Among Patients with Cardiovascular Disease. *Health Services Research* 34 (6):1315-1327,2000.

## Physicians' Brief Advice to Problem Drinkers Has Cost Benefit

Alcohol abuse is a costly health problem for individuals, health care systems, and society as a whole. Many cost/benefit analyses have been done on various treatment methods, but one intervention that has captured the attention of managed care organizations is the brief advice that physicians can give people during an office visit. Researchers analyzed the economic effectiveness of a Wisconsin brief advice intervention program for problem drinkers. They compared the patient and health care costs of brief advice with any economic benefits associated with changes in health care utilization, legal events, and motor vehicle accidents. Most of the physicians in this study were in managed care organizations.

The brief advice intervention consisted of two 15-minute sessions with the physician scheduled 1 month apart. Patients received a workbook documenting their current health behaviors, a worksheet on drinking cues, a drinking agreement in the form of a prescription, and drinking diary cards. They were followed up at 6 months and 1 year.

The intervention reduced patients' overall drinking by about 40% per week and binge

## RESEARCH NOTE

### Doctor-Patient Relationship Lowers Emergency Department Use

A study among the elderly in Washington State, all of whom were Medicare patients receiving care in the fee-for-service sector, has shown that the patients who had a regular physician made fewer visits to the emergency department (ED) than patients who did not.

Although the overall use of the emergency department among these elderly patients was rather high, with 18% having at least 1 visit during the year, the majority of the visits were for serious conditions. The sickest 20% of the patients made the most visits,

but even in this group, having a principal-care physician cut the rate of visits by about one third. It wasn't just “inappropriate” visits that were reduced, either, because very few of the visits in the study were classified as nonemergency.

According to the study investigators, these results confirm that having a regular physician affects ED use. They caution that changes in insurance coverage can disrupt doctor-patient relationships, causing adverse effects for patients and the medical care system. Since having a principal-care physician does not depend on the structure of the patient's insurance plan, the authors

believe that managed care plans and fee-for-service systems can structure themselves so that patients have predictable access to a regular physician.

Rosenblatt RA, Wright GE, Baldwin L, Chan L, Clitherow P, Chen FM, and Hart LG. The Effect of the Doctor-Patient Relationship on Emergency Department Use Among the Elderly. *American Journal of Public Health* 90 (1): 97-102, 2000.

*Drs. Baldwin and Chan are former Robert Wood Johnson Clinical Scholars. Dr. Chen is a current Robert Wood Johnson Clinical Scholar.*

drinking by about 50%. It saved almost \$200,000 in emergency department and hospital costs and about the same in costs from crime and motor vehicle accidents. The average benefit per person was \$947, versus an average cost of about \$200, for a benefit-to-cost ratio of roughly 5:1.

This is the first time that the benefits of a brief advice intervention for problem drinkers have been quantified. The authors believe that adoption of this strategy by primary care practices throughout the country could have enormous implications.

Fleming MF et al. Benefit-Cost Analysis of Brief Physician Advice with Problem Drinkers in Primary Care Settings. *Medical Care* 38 (1):7-18,2000.

## Children Learn Skin Cancer Prevention by CD-ROM

Multimedia computer programs have been used successfully for patient education, mostly among adults. But tremendous untapped potential exists for their use with

children, especially for disease prevention. The interactivity of computer programs enhances learning because it allows kids to manipulate their environment.

Researchers developed a pilot multimedia CD-ROM program on skin cancer prevention for schoolchildren to test whether it could improve their knowledge and shape their attitudes and behaviors. The CD-ROM, “Playing It Safe in the Sun,” takes approximately 18 minutes to complete. Three cartoon characters portray three different behaviors: Perry Paranoid (overly protective), Ray Reckless (overly risky), and Sam Sensible (appropriate).

The investigators field tested the CD-ROM with 192 third and fourth graders in a rural North Carolina public school. They randomly assigned the students to three groups: one group used the CD-ROM, one received standard teacher instruction, and one received no skin cancer education.

The students' knowledge, attitudes, and self-reported behaviors were evaluated by a validated survey administered the day before and the day after the

field test, and again at 7 months. Before the field test, most students knew the seriousness of skin cancer, about half considered suntans attractive, and nearly all who reported sunburns had at-risk skin colors. Afterward, the students who used the CD-ROM showed a significant increase in their knowledge and had healthier attitudes about suntans compared to the other groups. Behavior scores were not significantly better in any one group. At 7 months, the CD-ROM students had retained their knowledge the best, although they no longer had significantly better attitude scores.

This pilot program showed that multimedia CD-ROMs are an effective vehicle for health education for children. The authors hope that this prototype will become a model for future disease-prevention programs, especially for conditions associated with high-risk behaviors among children.

Hornung RL et al. Interactive Computer Technology for Skin Cancer Prevention Targeting Children. *American Journal of Preventive Medicine* 18 (1): 69-76,2000.



# Vaccines: Still Needed, Still Safe

Most American parents trust vaccines when it comes to protecting their children against childhood diseases such as polio, diphtheria, pertussis, tetanus, or measles — diseases that vaccines nearly eradicated years ago. But some health and public health providers believe that vaccines have become victims of their own success. Although the United States currently enjoys the highest immunization rates in its history, anecdotal reports of vaccines' adverse affects have caused some parents to question their value and safety.

"Most parents today have never seen someone with polio or whooping cough," says Paul Tarini, senior communications officer at The Robert Wood Johnson Foundation. "For some, fear of the disease has been replaced by fear of the shot."

It is these parents the Foundation hopes to reach by funding the National Network for Immunization Information (NNII), a communications effort designed to help health care providers educate parents, legislators, and the media about the science, safety, and efficacy of vaccines.

The two-year, \$2.7-million project was developed by the Infectious Diseases Society of America (IDSA) in partnership with the Pediatric Infectious Disease Society, the American Academy of Pediatrics, and the American Nurses Association.

"If, as health care providers, we fail to provide that information — and the basis for it — then not only do we let our patients down, but we run the risk that they will come to conclusions based on whatever information they do receive," says Bruce G. Gellin, MD, MPH, of Vanderbilt University Medical Center, the project's director. And unfortunately, he says, some information about vaccines comes from sources that are not based on the best available science.

It's not only patients who are not getting the most accurate information about the safety and efficacy of vaccines, Gellin says. Last year, more than ten states saw measures introduced to expand exemptions to vaccine mandates, and in many of these states the provider and scientific communities were not prepared

to provide legislators with accurate, timely information about the science and history of immunizations.

Gellin and his colleagues launched the project under an initial planning grant from RWJF by conducting focus groups and a national telephone survey with parents to assess their understanding and misconceptions about vaccines. What they learned was striking.

They learned that 87% of parents surveyed ranked immunization as the most important action they can take to keep their children healthy. They also learned that 78% of parents surveyed viewed immunizations as "one of the safest forms of medicine ever developed."

However, 19% of parents said immunizations are not always proven safe before being approved for use, and 25% expressed concern that "their child's immune system could become weakened as a result of too many immunizations."

The researchers also found that most parents get their information on immunizations from

doctors and other health care providers. At the same time, research with providers found that most felt ill equipped to answer parents' questions about vaccines.

During the next two years, the NNII plans to produce and distribute materials by mail and through the Internet <[www.immunizationinfo.org](http://www.immunizationinfo.org)> to help health and public health providers educate parents and answer their questions about vaccines. The campaign also will use materials to train provider leaders in 30 states to help them educate legislators and the media about vaccine efficacy and safety.

The NNII is seeking additional funding to support other elements of the campaign, including regular opinion tracking of parents, legislators, and providers; a white paper series on the current science on specific issues of vaccine safety; continuing education courses for doctors and nurses; and a speakers' bureau. Ultimately, the NNII wants to make sure that anyone who is in a position to give the public information about vaccines has the proper information to give. Says Gellin, "Good health policy can only start with good science."

— ANDREA KOTT

## Kids Energize for Kick Butts Day

"Uncle Sam" gets a crowd of more than 350 kids revved up at a convention-style rally at the National Press Club to kick off the fifth annual Kick Butts Day National Event in Washington, D.C., sponsored by the Campaign for Tobacco-Free Kids. Also on stage are Secretary of Health and Human Services Donna Shalala and emcee of the event, Washington Redskin defensive back Darrell Green.

In conjunction with Kick Butts Day, the Campaign hosted a contest inviting youths to write letters to presidential candidates George W. Bush and Al Gore recommending actions the next president should take to address the problems of tobacco. More than 20,000 youths participated. The two winners, Atyah Hadaddin, 12, of Stanton, Calif., and Megan Elizabeth Weaver, 14, of Canton, Ohio, read their letters at the kickoff.

Across the country on Kick Butts Day, April 5, more than 1,350 creative events took place to highlight the dangers of tobacco use and the tobacco industry's manipulative marketing practices. In New York City, first lady Hillary Rodham Clinton addressed a middle-school rally; kids paraded through the streets of Napoleonville, La., in a traditional New Orleans jazz funeral for "Mr. Butts"; US Surgeon General David Satcher joined kids at a soccer camp in Atlanta, Ga.; and Olympic figure skating champion and Campaign spokesperson Tara Lipinski recognized winners of an anti-tobacco essay-writing contest in Wilkes-Barre, Pa.

"Kids are particularly effective advocates against youth tobacco use when they speak with one voice — as they do on Kick Butts Day," says Campaign president Matthew Myers.



# Rethinking Health Care to Handle an Impending Chronic Care Crisis

It's a demographic time bomb set to explode about 25 years from now, when the first wave of baby boomers turns 80. By the year 2030, nearly 150 million Americans will have some type of chronic illness, a 50% increase since 1995. Over that same time, direct medical costs for chronic conditions are expected to increase 70%, reaching a whopping \$798 billion.

"We are going to have a tremendous increase in demand for services for people who are chronically ill," says Stuart Schear, senior communications officer at The Robert Wood Johnson Foundation. "And I don't simply mean clinical medical services, but also services to support people

living at home, comfortably making the transition to alternative housing when necessary, and perhaps, for some, eventually moving into a nursing home.

"What we need is a full array of support for people with chronic illness," he says, "but the infrastructure simply isn't there."

It is not an exaggeration to describe the situation as "an impending crisis," says David Colby, PhD, RWJF senior program officer.

But, it seems, few people are taking notice.

Officials at RWJF and The Johns Hopkins University hope to send up a number of warning flares, using a \$7-million, three-year national program aimed at

raising awareness among the public, policymakers, and business leaders.

The program, the *National Public Engagement Campaign on Chronic Illness*, will combine research and communications initiatives to explore the impact of chronic disease on individuals, families, business, government, the health care system, and society; to discuss possible solutions; and to spread the word to the general public and specific audiences, such as health care providers and family caregivers. Gerard Anderson, PhD, a professor of public health at Johns Hopkins, is heading the project.

"Back in the '50s and '60s, acute illnesses were the most common problem in the United States," says Anderson. "But that isn't the case now. Chronic illnesses are the predominant health care problem in America today.

"Our whole health care system, however, was designed to take care of acute care illnesses. So the demographics and epidemiology have changed, but the health care financing, delivery, and education systems have not kept pace," explains Anderson.

And much of the day-to-day care for people with chronic illnesses takes place outside of the "official" health care system, provided by family members or friends. There are an estimated 25.8 million such informal caregivers in the United States, according to a study from Montefiore Medical Center in New York, published last year in the journal *Health Affairs*.

One would think with so many families dealing with chronic illness, the issue already would be prominent on the national agenda.

One reason it isn't, says Anderson, is that people dealing with a specific chronic illness, understandably, focus only on that particular condition — whether

diabetes, Alzheimer's, or asthma. And the advocates working on specific illnesses, of course, focus on that illness.

"One of our goals," Anderson says, "is to make people aware that all of these chronic illnesses share some common issues, such as dealing with the lack of coordination of care in the system."

As part of the research project, Anderson and his colleagues, with Harris Interactive, Inc., are conducting a public opinion survey, examining awareness and attitudes toward chronic illness. They also are surveying Fortune-100 companies about their benefits packages. Those companies that offer such options as case managers, prescription drug benefits, and coverage for respite care for caregivers tend to be helpful for people with chronic conditions, according to Anderson.

As part of the communications campaign, Anderson and Schear are bringing together a consortium of representatives from several chronic disease organizations, such as the National Alliance for the Mentally Ill and the American Diabetes Association.

"They will help to make sure we focus on the most important issues," Anderson says. "And they'll also help make sure our findings reach a broader community."

And the communications effort will include developing an extensive Web site, according to RWJF's Schear.

"Our goal is to create the premier site on chronic illness," says Schear. "Groups that work on individual illnesses do important, excellent work and that will continue. But what's been missing is across-the-board cooperation on issues that affect many individuals with chronic disorders. We're looking for a way to address what we describe as cross-cutting issues."

See Chronic Care Crisis — page 12



A health system, a hospice, and a prison are the first recipients of the Circle of Life Award: Celebrating Innovation in End-of-Life Care. This new award, which includes a \$25,000 prize, will be given annually to innovative programs that improve the care people receive in the last days of their lives. PBS broadcaster Bill



Moyers presented the awards at the annual meeting of the American Hospital Association's subsidiary, Health Forum, in Orlando in May. The three award winners are pictured at left, from top to bottom: Georgeann Trandum, director of Improving Care through the End of Life program, Franciscan Health System, Tacoma, Wash.; Mary Labyak, president and executive director, The Hospice of Florida Suncoast, Largo, Fla.; and Pat Truett, assistant warden for medical services, Louisiana State Penitentiary Hospice, Angola, La. The programs will be featured in coming



months in the highly regarded electronic journal *Innovations in End-of-Life Care* <[www.edc.org/lastacts.org](http://www.edc.org/lastacts.org)>. Funded by The Robert Wood Johnson Foundation, the awards were initiated by the American Hospital Association, and co-sponsored by the American Medical Association, the National Hospice and Palliative Care Organization, and the American Association of Homes and Services for the Aging.

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

- For the College Alcohol Study IV, \$1.9 million to Harvard University School of Public Health, Cambridge, Mass.
- Evaluation of the program, *Healthy Nations: Reducing Substance Abuse Among Native Americans*, \$733,616 to University of Alaska Anchorage College of Business and Public Policy.
- Building support for the Framework Convention on Tobacco Control, \$724,054 to National Center for Tobacco-Free Kids, Washington, D.C.
- Information resources for substance abuse prevention practitioners, a renewal award of \$161,000 to Alcohol Research Information Service, Lansing, Mich.
- For disseminating the best practice intervention for smoking cessation during pregnancy, a renewal award of \$749,568 to The American College of Obstetricians and Gynecologists, Washington, D.C.
- National Resource Center for Expanding Treatment and Recovery in American Communities, a renewal award of \$6 million to Boston University School of Public Health.
- For continuing the development and maintenance of a tobacco and alcohol products and promotions exhibit, a renewal award of \$251,893 to Foundation of the University of Medicine and Dentistry of New Jersey, Newark.
- For the 12th National Alcohol Policy Conference, a renewal award of \$196,407 to National Crime Prevention Council, Washington, D.C.
- *National Spit Tobacco Education Program (NSTEP)* planning for 2001 and beyond, a renewal award of \$735,134 to Oral Health America, America's Fund for Dental Health, Chicago.
- *SmokeLess States: Statewide Tobacco Prevention and Control Initiatives*. Renewal awards to two sites, totaling \$450,000.
- *Substance Abuse Policy Research Program*. Awards to six sites, totaling \$692,218.

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

- Evaluation of the initiative, *Communities in Charge: Financing and Delivering Health Care to the Uninsured*, \$1.8 million to University of Michigan School of Public Health, Ann Arbor.
- For Evaluation of the *Southern Rural Access Program*, a renewal award of \$1.1 million to University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
- For developing and assessing workable strategies to expand health insurance coverage, \$738,519 to Economic and Social Research Institute, Washington, D.C.

- For a research study on welfare reform and Medicaid enrollment variances, \$575,717 to The Research Foundation of State University of New York, Albany.

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

- For an assessment of the *Independent Choices* program, \$259,972 to University of California, Los Angeles.
- For cataloging, surveying, and reporting about health care ombudsman programs, \$399,950 to Families USA Foundation, Washington, D.C.
- For developing and applying claims-based process of care measures for Medicaid-enrolled children with asthma, \$167,675 to Georgetown University Medical Center, Washington, D.C.
- For a traveling and virtual photographic exhibition on older Americans, \$210,000 to Independent Media Institute, San Francisco.
- For Clinical Research Roundtable, \$225,000 to National Academy of Sciences-Institute of Medicine, Washington, D.C.
- For conducting inventory and profiling of successful community strategies and best practices to support elder health and well being, \$290,529 to Visiting Nurse Service of New York, N.Y.
- For a video to assist parents of children with disabilities to create a supportive home environment, a renewal award of \$180,862 to Foundation at New Jersey Institute of Technology, Newark.
- *Community-State Partnerships to Improve End-of-Life Care*. Renewal awards to two sites, totaling \$754,869.
- *Faith in Action Phase II: Program to Expand the Continued Replication of the Interfaith Volunteer Caregivers Model*. Award of one grant of \$4.6 million to Visiting Nurse Service of New York, N.Y.
- *Improving Hospital-Based Palliative Care*. For preparing a practical guide to the establishment of palliative care services, \$285,700 to San Diego Hospice Foundation.
- *Promoting Excellence in End-of-Life Care*. For Guiding Responsive Action for Corrections at End of Life (GRACE), a renewal award of \$251,696 to Volunteers of America, Alexandria, Va.

### Other Programs and Those That Cut Across Foundation Goals

- For a statewide preventive care system for families with young children, a renewal award of \$1.3 million to Ounce of Prevention Fund, Chicago, Ill.
- For exploring public financing of social supports for youth after school, \$300,006 to The After School Corporation, New York, N.Y.
- For analyzing audiences for evidence-based preventive service guidelines, \$331,383 to The American College of Preventive Medicine, Washington, D.C.

- For establishing an agenda for interdisciplinary bio-behavioral/biomedical research, \$160,000 to Center for the Advancement of Health, Washington, D.C.
- For integration of proven behavioral strategies into health care practices, \$397,038 to Center for the Advancement of Health, Washington, D.C.
- For Internet-based prevention and intervention services addressing health-related problems among youth, \$250,000 to KidsPeace, Orefield, Pa.
- For *Guide to Community Preventive Services*, \$377,273, to the National Foundation for the Centers for Disease Control and Prevention, Atlanta.
- For The National Youth Summit, \$250,000 to Points of Light Foundation, Washington, D.C.
- For building national support for prevention research, \$399,459, to Research America, Alexandria, Va.
- For partnerships for a healthy workforce: engaging businesses in achieving Healthy People 2010 objectives, a renewal award of \$738,219 to Partnership for Prevention, Washington, D.C.
- *Turning Point: Collaborating for a New Century in Public Health*. Renewal awards to 13 sites, totaling \$9.7 million.
- For information on state health policy legislation, \$293,281 to National Conference of State Legislatures, Washington, D.C.
- *Colleagues in Caring: Regional Collaboratives for Nursing Work Force Development*. Award of one Phase II grant of \$150,000 to University of Alaska Anchorage School of Nursing and Health Sciences.
- *Health Professions Partnership Initiative*. Awards to seven sites, totaling \$2.4 million.
- *Health Tracking*. For a health history supplement to quality tracking study, a renewal award of \$639,494 to RAND Corporation, Santa Monica, Calif.
- *Investigator Awards in Health Policy Research*. Awards to three sites, totaling \$734,864.
- *Changes in Health Care Financing and Organization*. Awards to four sites, totaling \$1 million.
- *Sound Partners for Community Health*. Support for sites under the program, \$1 million to Benton Foundation, Washington, D.C.
- For a citywide program to strengthen human services and resources, \$350,000 to New Brunswick Tomorrow, New Brunswick, N.J.

- Support for the 1999-2000 annual campaign drive, \$550,000 to The United Way of Central Jersey, Milltown.
- Support for the 1999-2000 campaign, \$175,000 to United Way of Greater Mercer County, Lawrenceville, N.J.

# New Grant Results Reports Posted on RWJF Web Site

Forty new Grant Results Reports and two new National Program Reports have been posted this quarter on The Robert Wood Johnson Foundation Web site <[www.rwjf.org](http://www.rwjf.org)> under *Grant Outcomes & Related Publications*. These include:

- **Alternative Sentencing Program to Provide Rehabilitation to Substance Abuse Offenders.** The Genesis Counseling Center in Collingswood, N.J., launched that state's first drug court, in Camden County in 1996. Drug courts provide an alternative sentencing program that provides treatment and other services for individuals charged with drug-related offenses. More than 80% of those arrested in Camden County in 1995 tested positive for one or more illegal drugs. The Foundation's grant of \$50,000 ran from September 1996 through July 1997 and was matched two to one by the county. Fifty probation violators received treatment and other services. The program, since expanded to include nonviolent and first-time arrestees, has three phases: detoxification to wean participants from drug use; stabilization, emphasizing continued abstinence and the development and attainment of personal goals; and aftercare,

building self-reliance and promoting education and training. Of the 50 initial participants, 21 had graduated from the program by the spring of 1998. By this time, the caseload had grown to 160. In March 1998, RWJF made another \$50,000 grant, running through January 2000, to allow the project director to act as drug court coordinator and expand the program, including the addition of an adolescent program and continued outreach efforts to other communities. The drug court also received federal funding of \$358,000, of which \$268,000 was for treatment services. The drug court has expanded from one to three days a week, with the third day for adolescents. Three other New Jersey counties have since launched drug court programs. *Contact: Gabriel L. Guerrieri, MEd, 609-858-9314.*

- **The Role of Work Organizations, Human Resources Practices, and Industrial Relations in Hospitals' Adjustment to a Competitive Health Care Market.** The Economic Policy Institute in Washington, D.C., conducted a study in the Minneapolis/St. Paul area to assess the impact of labor-

management cooperation and new employment and human resource practices on hospital performance, processes, and outcomes. The Foundation's grant of \$199,973, from April 1995 through March 1998, supported data collection from 16 of the area's 18 hospitals and interviews with 3,800 nurses, ancillary hospital workers, and administrators. The study found that higher levels of cooperation between labor and management led to a higher ratio of registered nurses to patients, higher levels of employee involvement, and better financial performance among the hospitals studied. It also demonstrated that the quality of information available to nurses about patient status is central to determining patient outcomes. The study found that when hospitals transfer routine tasks once performed by registered nurses to nursing assistants, the quality of information declines, the frequency of medication errors increases, and patient perceptions of the quality of care declines. *Contact: Gil Preus, PhD, 216-368-0799, gap4@po.cwru.edu.*

These new postings bring the total available on the Web to more than 220 Grant Results Reports and 12 National Program Reports, covering 500 grants. 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.

— MOLLY MCKAUGHAN

## PEOPLE

### WELCOME

**CALVIN BLAND, MS,** joined the Foundation in February as a senior program advisor in the Executive Office. Prior to coming to RWJF, Bland was president and CEO of St. Christopher's Hospital for Children in Philadelphia.



**CAROLINE ROAN, MPA,** began working at the Foundation in March as a program associate in the Program Office.

Before joining RWJF, Roan was associate director for the Center for Interdisciplinary Research on AIDS at Yale University, New Haven, Conn. In May she received an MPA degree from Columbia University, New York, N.Y.

**SARA THIER, MPH,** joined the Foundation in February as a program associate in the Program Office. Prior to coming to the Foundation, Thier was an evaluation specialist for the dean's office at the UCLA School of Medicine in Los Angeles.



From Chronic Care Crisis — page 10

One challenge of the program is to frame the issue in a way that hits home with the American public, similar to how concerns about the future of Medicare and Social Security have evolved, says Colby.

"When we use phrases such as 'chronic illness' or 'chronic condition' in the abstract, those are not terms that resonate with people," Colby says. "As part of the communications work, we need to figure out terms we can use that will have an effect."

Schear agrees. "We want to build the awareness so that at some point we will be involved in a full-fledged discussion in the United States about what policies make sense for people with chronic illness," he says. "Our concern is that we, along with others, need to elevate the

debate and encourage more discussion of these issues. If we don't, we'll be hit very hard in two or three decades without appropriate measures having been taken in advance."

— LAURIE JONES