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FEATURES

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Help Heal Thyself: Engaging Patients in Their Health Care

One of the great ironies in medicine is that the system often excludes the very person for whom it exists. It treats patients but doesn't empower them. It talks more than it listens. It leads better than it follows.

The Institute of Medicine's 2001 seminal report *Crossing the Quality Chasm: A New Health System for the 21st Century* envisioned a model that corrects those deficiencies, a model more inclined to be of the patient, by the patient, for the patient. Of the report's 10 rules for health care reform, four seek to make the patient not merely the object of attention but a care collaborator and "the source of control." Rather than simply accepting whatever the system prescribes, patients participate in all aspects of their case management, setting their own goals and taking charge of their own care.

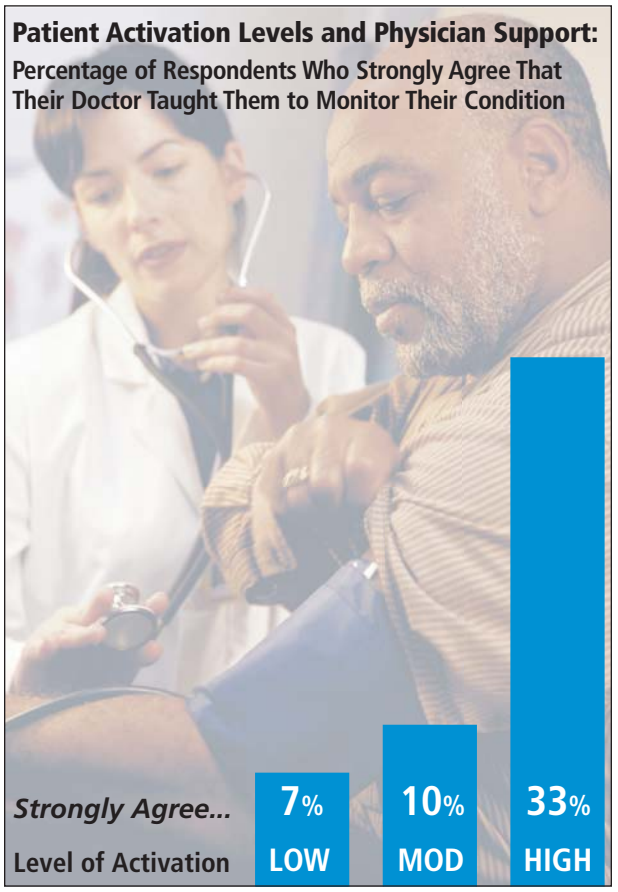
These notions of patient activation, or patient engagement, are most relevant to the chronically ill, the individuals who rely on the health care system most frequently. The Robert Wood Johnson Foundation's eight-year, $25-million national program *Improving Chronic Illness Care*, which works with health organizations throughout the country to raise the standard of chronic care, has increasingly emphasized patient activation during the five years since its inception.

"If you think about the typical medical show [on TV], you see the professional doing most of the talking and the patient assuming a relatively passive role," says Edward Wagner, M.D., M.P.H., director of the Seattle-based initiative. "What business would design all of its products and systems without asking its customers what is important to them?" Fostering patient activation, he says, is simply "bringing basic customer orientation into medicine.

"The evidence strongly suggests that patients are more likely to make good decisions and do positive things on behalf of their health if they are more engaged, better informed and feel confident that they can take care of themselves well. That is different from just submitting." Conversely, the uninformed, unassertive, unengaged patient who lacks confidence in his ability to influence his health is less likely to fare well with his illness. "That's the evidence," Wagner emphasizes. "This is not politics, this is science."

Improving Chronic Illness Care's efforts to encourage patient activation recognize the inescapable: in an aging society with a growing prevalence of chronic disease, even frequent users of the health care system must care for themselves most of the time.

"Even if you go to the doctor once a week and get that little 12-minute visit, you have still got 167 hours a week when you're on your own with your asthma or your arthritis or whatever it is," says David Lansky, Ph.D., president of the Portland, Ore.-based FACCT (Foundation for Accountability), an RWJF grantee that advocates a greater role for patients in shaping their own care. "There is no other solution for taking care of one's chronic illness except self-care, so you have got to be engaged in knowing about



Source: National Survey, Judith H. Hibbard, University of Oregon, 2003.

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your illness, knowing how to care for it, knowing how to reduce risks. Any assumptions that the doctors or institutions of medicine are going to consistently perform with high degrees of reliability and rigor are wrong. From the point of view of safety and quality, if you are not looking out for yourself, you're really at pretty grave risk."

RWJF's $6.3-million, two-program national Diabetes Initiative, headquartered at Washington University School of Medicine in St. Louis, has placed patient activation squarely at the center of its campaign to combat a disease that afflicts an estimated 17 million Americans. Providing funding, training and consultation to 14 primary care providers and community coalitions serving diverse populations around the country, the initiative emphasizes three components to help out-patients manage their disease: setting goals, acquiring the skills to meet those goals and trouble-shooting as problems arise. The patient actively collaborates at every stage—to personalize the approach and make it congruent with his or her predilections and lifestyle—and the care provider offers ongoing support and encouragement.

"We feel that if the patient is involved in setting the plan, the commitment to the plan is going to be greater," says Edwin Fisher, Ph.D., the initiative's project director. "If you hate walking, being told by your doctor to walk 30 minutes a day, five days a week, is not terribly useful. Not everybody knows what a complex carbohydrate is, so simply talking to people about eating more complex carbohydrates and fewer refined carbohydrates does not make sense if people haven't been taught the skills for doing that."

From the primary provider's perspective, active, assertive, involved patients represent a drawback because they require more time. But the physician needn't be the one who expends that time. Most of the Diabetes Initiative sites use lay health workers specifically trained to meet the engaged patients' expanded needs. The cost of additional staff—or additional training for existing staff—could probably be accommodated, Fisher speculates, by relying less on "high-tech, dazzling interventions that are very expensive. My hunch is that we could reallocate resources to support more patient-activation types of services and not see a net increase in health care costs—and perhaps even a net decrease."

Even if a high degree of patient engagement results in better outcomes, not all patients are created equal. With funding from RWJF, University of Oregon Professor of Health Policy Judith Hibbard, Ph.D., recently devised a questionnaire that measures where individuals fall on a patient-activation scale. If you do not know the nature and causes of your condition or why you take your medications, you are not highly engaged. People higher on the scale know a great deal about their disease and self-treatment, and they have confidence that they can handle stresses and changes when they occur.

"Older people tend to have lower scores than younger people," Hibbard says. "Women have a little bit higher scores than men. People with more education and more income have higher scores. Those who have more disability and rate their health lower have lower scores," as do ethnic minorities.

Are our aptitudes in this realm fixed? In a medical culture that prefers compliance, the inchoate trend toward empowering patients is predicated on the notion that people—and the system—can change. "You have to encourage people on a path that's really going to improve their health," Hibbard says. "I believe that patients taking an active role is part of that pathway."

—LEE GREEN

For more information on *Improving Chronic Illness Care*, see *www.improvingchroniccare.org*. For information on the Foundation for Accountability visit *www.facct.org*. For information on the Diabetes Initiative, see *http://diabetesnpo.im.wustl.edu*. For more on RWJF's quality efforts, see *www.rwjf.org/quality*.

Examples of Survey Questions Assessing Patient Activation

Taking an active role in my own health care is the most important factor in determining my health and ability to function.	Strongly Disagree	Disagree	Agree	Strongly Agree ✓
When all is said and done, I am the person who is responsible for managing my health condition.	Strongly Disagree	Disagree	Agree	Strongly Agree ✓
I know what each of my prescribed medications do.	Strongly Disagree	Disagree	Agree	Strongly Agree ✓
I am confident that I can follow through on medical treatments I need to do at home.	Strongly Disagree	Disagree	Agree ✓	Strongly Agree
I am confident I can tell my health care provider concerns I have even when he or she does not ask.	Strongly Disagree	Disagree ✓	Agree	Strongly Agree
I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.	Strongly Disagree	Disagree ✓	Agree	Strongly Agree
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.	Strongly Disagree	Disagree ✓	Agree	Strongly Agree

Source: The Patient Activation Measure, Judith H. Hibbard, University of Oregon, 2003.

Programs Promote Faster Access, More Efficient Substance Abuse Treatment

Posing as a heroin addict, David Gustafson, Ph.D., learned first-hand about the barriers that people with substance abuse face when they decide to seek treatment.

Gustafson, who heads a Robert Wood Johnson Foundation-funded program working on this issue, tried to get himself checked into a Wisconsin treatment program. He told an intake clerk that he had been shooting heroin for 30 years, that his wife had just kicked him out of the house and that he had lost his job as a forklift driver.

At the intake interview Gustafson had to endure two-and-a-half hours of personal, sometimes humiliating questions. The clerk said that he needed to be in residential care but that no beds were available. She told him to call back in a week. He did, and got an answering machine that did not even identify the agency. For the next seven weeks, Gustafson kept calling the agency, each time getting an answering machine. Finally, he received a call that a bed was available. By this time, he was angry.

"When I have the guts to call up and say I need help, I don't need it in seven weeks," Gustafson says. "I need it now. I'm trying to make a choice between you, the addiction treatment agency and the guy on the street with a bag of heroin. For you to delay me for seven weeks, you might as well not even talk to me."

Gustafson is the program director of *Paths to Recovery: Changing the Process of Care for Substance Abuse Treatment,* a $9.5-million, three-year RWJF national program that seeks to help substance abuse centers admit clients more quickly and keep them in treatment longer *(www.pathstorecovery.org)*.

Paths to Recovery is currently funding some 12 (another 15 in round two) addiction treatment centers to help them reduce waiting times, reduce the number of people who do not show up for appointments, increase admissions and increase the number of people who continue in treatment. The RWJF program is partnering with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strengthening Treatment Access and Retention (STAR) program, which is funding 13 substance abuse centers or treatment facilities to undertake similar work. Many of the changes that treatment centers can make are relatively simple, such as maintaining same-day open slots for cases, eliminating unnecessary paperwork and questions, and placing new clients in pre-treatment groups so that they begin receiving some type of support immediately.

For years, RWJF has focused its efforts on substance abuse prevention, with an emphasis on young people. In recent years, the Foundation has broadened its funding to include treatment as well, recognizing that despite all the work in prevention, some people still will become addicted to drugs or alcohol and need help.

Many people are not receiving the help they need. Treatment centers serve only about 20 percent of the people who need substance abuse treatment, according to SAMHSA. Staff at RWJF also know that neither they nor any other foundation will be able to fully fund the need for expanded treatment, which already costs about $12 billion a year, says Victor Capoccia, Ph.D., a senior program officer at RWJF. Instead, RWJF is funding programs that help treatment centers and states find more efficient ways to use the resources that they already have.

Another RWJF national program, *Resources for Recovery: State Practices That Expand Treatment Opportunities,* is a $3-million, three-year effort that is funding 15 state agencies to find ways to more efficiently use their resources to provide substance abuse services *(www.resourcesforrecovery. org)*. About 60 percent of substance abuse services are federally or state funded, but states are not always aware of how they can gain access to these public funds, according to Capoccia.

Through getting technical assistance from peers in other states as well as working with consultants, state participants are finding ways to tap into these funds and to work across state agencies more efficiently, says Patrick Lanahan, the national program director of *Resources for Recovery*. Some states are setting up systems to receive Medicaid funds for substance abuse for the first time. Other state agencies are seeking to change practices so that they can shift from expensive hospital substance abuse care to less costly community-based and residential-based care. States are also looking for ways to coordinate the purchasing of substance abuse services among different state agencies. For example, if a mother with an addiction has children who are in foster care, states might find a way to link family support, child protection and addiction treatment into a more efficient bundle of care for the family.

"Not only does the mom achieve abstinence and get her children back faster than if we do not address the substance abuse problem," Lanahan says, "but the child welfare system saves a lot of money."

—Susan G. Parker

In Memoriam

Leighton E. (Lee) Cluff, M.D., the second president of The Robert Wood Johnson Foundation, died on April 14 in Gainesville, Fla. Cluff had suffered a head injury after a fall and did not recover. He would have been 81 in June.

"The world of philanthropy has lost a dedicated servant who brought many health care issues to the national forefront and inspired many important careers," says Risa Lavizzo-Mourey, M.D., M.B.A., RWJF president and CEO. "We are saddened by Lee's passing, but his contributions will serve as a lasting legacy."

Cluff joined the Foundation as a vice president in 1976 and was promoted to executive vice president in 1980. In 1986, he became the second president of the Foundation, succeeding David Rogers, M.D., and served until his retirement in 1990. He continued as a trustee emeritus.

Among the many significant programs developed under Cluff's leadership were the *Chronic Disease Care Program*, the *Interfaith Volunteer Caregivers Program* (precursor to *Faith in Action*) and the *AIDS Health Services Program*. Cluff's concern about the poor quality of care for critically ill patients led to the groundbreaking SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) project, which in turn gave rise to the Foundation's decade-long work to improve end-of-life care.

He is survived by his wife, two daughters and two grandchildren.

Raising the Standard for Quality Care

Q&A
with
Michael Rothman, M.P.P.

A Robert Wood Johnson Foundation-supported study by RAND Corp. published last year concludes that patients have just a 55 percent chance of receiving the right care when they go to their doctor. The Foundation is working on several fronts to help raise that percentage substantially, specifically targeting people with chronic conditions being served in outpatient settings. RWJF's quality health care efforts are aimed at producing national standards for quality and piloting programs in select locations to test ways to raise the level of care. In this interview, the leader of the Foundation's Quality Health Care Team, Michael Rothman, talks about the Foundation's strategy in this important area.

What is quality health care?

ROTHMAN—I would define it as getting all the care that can help you, not receiving any care that cannot possibly help you, and not being hurt by the care you do receive.

As patients, we have rather passively accepted that we are hurt by medication errors, and that we do not receive all the care that can help us. We have accepted all this partly because it is hard to distinguish the effects of being sick from the effects of poor quality.

Why has the Foundation made it a high priority to address quality of care, particularly for people with chronic conditions in outpatient settings?

ROTHMAN—With the aging of the population and the successful technical interventions of health care, we are going to have a very large number of people who have one or more chronic conditions as they age. Right now, it is estimated that more than 125 million Americans are living with a chronic condition. By 2020 that number is expected to increase to about 157 million. It is going to be a huge cost issue for the country. If care is not high quality, the cost to the country will be even higher—and lots of people are going to needlessly experience poor quality of life, or die too young.

We know that the most effective way to keep a person as healthy as they can be and out of the hospital is effective patient self-management supported by outpatient care. Even someone with severe congestive heart failure, for example, is probably going to spend more time out of the hospital than in the hospital. So we're focusing on outpatient settings as the way to achieve ideal outpatient care.

What is the significance of the RAND study published in the *New England Journal of Medicine* in June 2003?

ROTHMAN—That study is the most powerful articulation of what is wrong *(www.rwjf.org/research/cqi)*. We and others supported RAND to carefully catalog all of the care that is evidence-based: Exactly what should happen to you if you have a complicated pregnancy, exactly what should happen if you are diabetic and so on. RAND defined 400-plus indicators related to situations where we know exactly what should happen.

RAND researchers then interviewed a large number of people from across the country and reviewed all their medical charts. The researchers carefully assessed the question: "Did these people get the right care?"

What they found was that people got the right care—the care the evidence said they should get—only about half the time. RAND did this again in another study, focusing on the elderly, and got exactly the same result: People received the right care only half the time (*www.annals.org/cgi/content/abstract/139/9/740*). That means when you go to your doctor, there is a 50-50 chance that you are going to receive the right care.

What are the goals of the Foundation's Quality Team?

ROTHMAN—If the chance of getting the right care now is 50 percent, our goal would be to move that number up to 80 or 90 percent. We recognize that is hard to do, so we have a two-part strategy.

First, we need to promote agreement on a national level on what "quality" is, so that we have a shared basis for making things better. The Foundation provided initial funding for the National Quality Forum (*www.qualityforum.org*), a consensus group made up of diverse stakeholders, purchasers, providers, health plans, consumers and researchers that is working toward agreement on the right quantitative measures of quality to use in the outpatient setting. We hope they will adopt standard measures by the spring of 2005.

Second, we plan to concentrate intensive efforts on certain local markets. We have growing evidence about what would have to happen in a specific region to really move that number from 50 percent to 90 percent. To start, providers would need to redesign their practices. There are a lot of fundamental changes in how health practices work that would have to happen for them to deliver reliable care.

We also know that given the way doctors are paid, if they move toward the ideal system, they might make less money. There is not a business imperative right now for providers to improve quality. Purchasers can change that business imperative a bit by developing financial incentives for higher quality care.

Also, as a consumer, I do not know what I should look for in the care my doctor provides. What can we do to activate consumers to be as careful in interacting with their doctor or choosing a physician as many consumers are in buying cars or washing machines and other services?

We are going to try to align forces more powerfully in certain local markets to demonstrate that better quality can be less expensive and that improving quality takes waste out of the system. Let's get these standard quality measures reported, let's help providers redesign their practices, let's work with purchasers to make sure they reward providers when they improve quality of care, and let's see how much we can persuade consumers to be engaged with providers. If all those things happen in one place, there is evidence we should see some good movement. We have never seen all those things lined up in one place.

This is a big effort, and we cannot do it alone. We are working closely with other foundations and the Centers for Medicare & Medicaid Services and other federal agencies. We think we have to push at multiple levels of the system, at least initially while there is still lots of resistance.

See **Raising the Standard**—page 8

To see summaries of more research funded by The Robert Wood Johnson Foundation, including links to the full text, visit the RWJF Research Center at *www.rwjf.org/research*

Covering the Uninsured Parents of Publicly Insured Children

Through Medicaid expansions and creation of the State Children's Health Insurance Program, federal and state governments have made a concerted effort to insure low-income children. Their parents, however, have not fared as well. Although there is growing interest in expanding programs to include the parents of publicly insured children, two significant obstacles stand in the way: (1) the fear that only individuals who use a lot of expensive health care services will enroll, and (2) an assumption that the target population cannot afford even minimal premiums. Alliance Family Care, a subsidized health care plan in Alameda County, Calif., that insures low-income children *and* their parents, provided a natural laboratory for researchers to examine enrollees and their health care utilization—and address these concerns.

The Alliance Family Care Program, which is administered by a public, nonprofit health maintenance organization, insured more than 5,000 parents and 2,000 children as of March 2003, less than three years from its inception. Applicants are asked about pre-existing medical conditions, and in 2002 fewer than 1 percent of applicants were denied coverage. Monthly adult premiums range from $20 to $120, depending on age, and cover physician, hospital and laboratory services, as well as prescription drugs.

Using telephone surveys of 471 adults newly enrolled in the program between August and December 2001, the investigators obtained information on health status, health care access and use over the previous year, employment and sociodemographic characteristics. Adult enrollees reported comparable health care use and better health status than other low-income nonelderly populations in Alameda County. In addition, although the "typical" enrollee lived in a five-person household with an annual household income of $23,000—and was less likely to be employed than other low-income groups in Alameda County—they were willing and able to pay the monthly premium for insurance coverage. In fact, historically, just 2 percent of enrollees disenroll from the program each month, either because they fail to pay the premium or for other reasons.

"These results suggest that fears of serious adverse selection were not realized," the authors conclude. However, the authors currently are conducting additional research on enrollees after six to 12 months in the program to determine actual health care use under the plan.

Taylor EF, Kullgren JT and McLaughlin CG. "Who Enrolls in a Program for Parents of Publicly Insured Children?" *Health Affairs* (Web Exclusive), September 24, 2003, W3 460–471.

For more information on this research, visit *www.rwjf.org/special/coveringparents.*

Is There Still a Nurse Shortage?

In 2002, anecdotal evidence by hospitals of falling vacancy rates and decreased employment opportunities for new graduates of nursing education programs suggested the current nurse shortage might be coming to an end. This study analyzed employment and earnings trends to determine if there is any empirical evidence supporting the notion that the shortage, which began in 1998, may finally be winding down.

Using data from the U.S. Bureau of Census Current Population Survey, which samples 100,000 people each month and gathers data on employment and earnings, the investigators found that between 2001 and 2002 overall employment of RNs increased by nearly 105,000 nationwide, and all of this increase occurred in hospitals. A one-year increase in employment of this size is exceptional, and was driven by the sharp growth (nearly 5 percent) in 2002 inflation-adjusted wages and by the concurrent climb in the national unemployment rate to 6 percent.

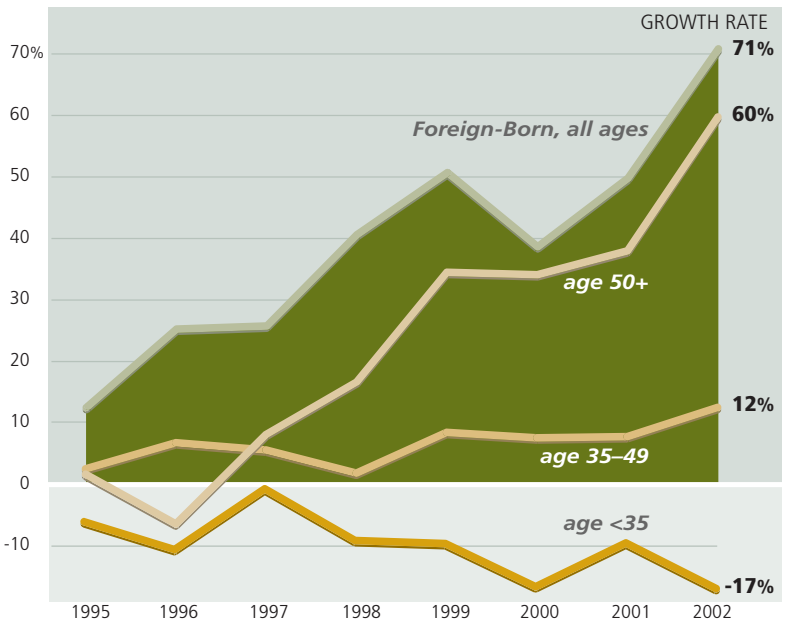
The jump in employment in 2002 suggests that many hospitals filled vacant RN positions. But where did the huge increase in hospital RN employment come from?

The authors found that approximately two-thirds of the 2002 increase in hospital RN employment was accounted for by RNs over age 50, and the remaining one-third by foreign-born RNs. Between 2001 and 2002, employment growth of RNs age 50 and older increased by nearly 16 percent (approximately 63,000 RNs nationwide). At the same time, the number of employed middle-aged RNs (age 35–49) increased by 39,000 and employment of younger RNs (under age 35) fell by 36,000, effectively canceling each other out.

The authors indicate that as large numbers of older RNs begin to retire after 2010 and demand for RNs increases as the large baby boom generation requires more health care, future shortages of RNs are all but certain to develop and become much more severe than the current shortage.

The researchers urge policymakers, workplace planners, Congress and professional associations to take action now to address this challenge.

Employment Growth Among RNs by Age and Foreign-Born Status



Buerhaus PI, Staiger DO and Auerbach DI. "Is the Current Shortage of Hospital Nurses Ending?" *Health Affairs*, 22(6): 191–198, 2003.

Buerhaus P, Staiger D and Auerbach D. "Implications of a Rapidly Aging Registered Nurse Workforce." *Journal of the American Medical Association*, 283(22): 2948–2954, 2000.

For more information on this research, visit *www.rwjf.org/special/nurseshortage.*

Physician Counsel on Eating and Exercise Habits: Missed Opportunities

Poor eating habits and lack of exercise have contributed to the rise in obesity in the United States, and the concomitant increase in heart disease, hypertension, diabetes and other chronic illnesses. Physicians, through their recommendations and counsel, can encourage patients to adopt healthier behaviors. In fact, because a majority of Americans visit their primary care doctor at least once a year, these "encounters are a golden opportunity for counseling on dietary habits and physical activity."

Researchers in this study looked at whether physicians are seizing this opportunity. Trained medical students observed 4,344 patient visits to 38 primary care physician practices, documenting diet and exercise discussions as well as patient, physician and physician-office characteristics.

The researchers found that, overall, physicians do not counsel patients on diet and exercise as often as they could. Although this type of preventive counseling should be a routine part of a nonacute office visit, based on the results of this study it does not appear to be so. The medical students observed dietary and exercise counseling in just 25 percent and 20 percent, respectively, of visits. Physicians who counseled patients on diet were more likely to also counsel them on exercise, and vice versa, indicating that "physicians who counsel patients are likely to counsel on multiple health promotion topics." Although physicians were two to three times more likely to initiate a discussion of diet or exercise than patients, still no discussion took place in the majority of visits.

Physicians more frequently provided both dietary and exercise counsel to new patients and dietary counsel alone to older patients. In addition, physicians in offices with brochures on dietary habits and exercise were more likely to counsel their patients on their eating habits but not on exercise. Neither patient gender nor smoking habits were related to the provision of dietary or exercise counseling.

"Failing to address patient health behaviors with established patients is a missed opportunity," according to the authors. "Once a doctor–patient relationship becomes established, it is important to continue to promote healthy habits and disease prevention. Physician education and reminder systems, possibly like those used with new patients, are vital tools for prompting physicians to ask about eating and exercise habits.

Anis NA et al. "Direct Observation of Physician Counseling on Dietary Habits and Exercise: Patient, Physician, and Office Correlates." *Preventive Medicine*, 38: 198–202, 2004.

For more information on this research, visit *www.rwjf.org/special/physiciancounsel*.

Examining the Link Between Substance Abuse and Health Problems

Primary care physicians and hospital emergency departments alike treat many patients with hypertension, stroke, liver disease, psychiatric disorders and other medical conditions who also have a history of substance abuse. In fact, previous research indicates that numerous health conditions are associated with alcohol or drug use. However, most of these studies examined patients with publicly funded health insurance coverage, like Medicaid; few examined privately insured populations or individuals in managed care. This recent study looked at medical and psychiatric conditions among patients in alcohol and drug treatment programs in Northern California Kaiser Permanente, a large group-model health maintenance organization with approximately 3 million members. That represents about 33 percent of the commercially insured population in the region. Kaiser's membership is diverse in terms of both professions represented and socioeconomic levels.

The investigators collected information from 747 adult patients who entered alcohol and drug treatment between April 1997 and December 1998 on the severity of their alcohol or drug problem, employment status, ethnicity and other demographics. They also examined 3,690 individuals from the general Kaiser Permanente population who were matched with substance abuse patients based on age, sex and length of enrollment in the health plan. Using records from the health plan's clinical database, the investigators then looked at diagnoses and treatments during the 12 months prior to entry into the treatment program for substance abuse patients and during that same 12-month period for the 3,690 matched controls.

Of the 23 common medical and psychiatric conditions the investigators examined, one-third were "significantly more prevalent among the treatment cases than among their matched controls." More than 25 percent of the substance abuse patients suffered an injury or overdose during the year prior to treatment compared with just 12 percent of the individuals from the general population who were of the same age and sex. Substance abuse patients also had higher rates of hypertension, congestive heart failure (in alcohol-dependent patients), pneumonia (in painkiller-dependent patients) and ischemic heart disease (among older patients), which along with injuries and overdoses were among the health plan's top six direct medical expenses in a one-year period. The investigators also found that substance abuse patients had significantly higher rates of three pain-related conditions—lower back pain, headaches and arthritis—than the general health plan population. These three medical conditions were especially prevalent among patients who abused narcotic painkillers. In addition, substance abuse patients had significantly higher rates of psychiatric conditions, including depression, anxiety and psychosis.

According to the authors, "understanding the prevalence and patterns of medical conditions . . . of individuals with alcohol and drug disorders might be of great clinical utility. . . . The optimal treatment of many common medical conditions may require identification, intervention, and treatment of an underlying substance use disorder."

Mertens JR et al. "Medical and Psychiatric Conditions of Alcohol and Drug Treatment Patients in an HMO: Comparison with Matched Controls." *Archives of Internal Medicine*, 163(20): 2511–2517, 2003.

For more information on this research, visit *www.rwjf.org/special/abuseandhealth*.

Study Finds End-of-Life Care in Institutions Woefully Inadequate

Too many Americans dying in institutions receive inadequate pain treatment, emotional support and respect, and not enough communication from their physicians, according to a national study on the quality of end-of-life care.

Researchers interviewed bereaved family members of 1,578 people across 22 states who had died from chronic illness or old age. The study aimed to compare the quality of end-of-life care between home and institutional settings. The study was designed to represent the experiences of the nearly 2 million Americans who die each year from nontraumatic causes.

About 67 percent of the study group had died in an institution—either a hospital or a nursing home. The others died at home, either with home hospice care, no nursing care, or, least often, with home health care services.

While researchers found that improvements were needed in all settings, reform was most needed in institutions. The study found that one in four people who died did not receive adequate pain treatment. Poor pain management was 1.6 times more likely to be reported for nursing homes than for home hospice care. Also, half of the family members stated their relative did not receive enough emotional support. This was 1.3 times more likely to be the case in an institution.

One-quarter of respondents said their relatives did not receive enough input from physicians about treatment decisions; this rate was the same across all settings. Finally, 21 percent complained that the dying person was not always treated with respect. Compared with a home setting, disrespectful care was reported more than twice as often with a nursing home and three times as often with a hospital.

Respondents whose relatives received hospice care at home were the most satisfied. More than 70 percent rated hospice care as excellent. Less than 50 percent gave that grade to nursing homes, hospitals or home health services.

Teno JM et al. "Family Perspectives on End-of-Life Care at the Last Place of Care." *Journal of the American Medical Association*, 291(1): 88–93, 2004.

For more information on this research, visit *www.rwjf.org/special/eolcarestudy*.

Adult Cigarette Smoking Prevalence: Declining as Expected (Not as Desired)
While the prevalence of adult smoking fell steadily from 1970 to 1990, the rates held steady during the 1990s. These authors compared observed smoking prevalence data for 1995–2002 with predictions derived from a previously published population dynamics model to determine whether the recent trend in smoking prevalence is consistent with the downward pattern they predicted. The observed data fit their projections closely. Consistent with the logic underlying the model, they conclude that adult smoking prevalence will continue to fall for the foreseeable future, although at a rate approximately half that of the decline experienced during the 1970s and 1980s.

Mendez D and Warner KE. *American Journal of Public Health*, 94(2): 251–252, 2004.

Correlates of Rape While Intoxicated in A National Sample of College Women
Binge drinking among college students is a significant social problem, particularly in those situations where the risk of rape rises. Few studies provide detailed information on rapes in college women that occur when they are intoxicated. New research from the Harvard School of Public Health's Center for Alcohol Studies indicates that about one in every 20 female U.S. college students is raped each year. More than 70 percent are raped while they are too intoxicated to give consent, the authors say. Researchers analyzed data drawn from three surveys at 119 colleges. The data were drawn from questions answered by approximately 24,000 female students.

Mohler-Kuo M, Dowdall GW, Koss MP and Wechsler H. *Journal of Studies on Alcohol*, 65: 37–45, February 2004.

Young Adults: Vulnerable New Targets Of Tobacco Marketing
The 1998 Master Settlement Agreement (MSA) included limitations on advertising and promotional activities that were mostly directed at children. Prior research documents the subsequent rise in tobacco marketing towards young adults. In this study, young adult smoking patterns were examined, in addition to their receptivity to cigarette advertising to assess vulnerability to tobacco marketing strategies. Based on data obtained using a telephone survey of 12,072 Massachusetts adults, the study found that smokers aged 18 to 30 years were more likely than older adults to smoke only occasionally and to consume fewer than 10 cigarettes per day. The study also found that these smokers were more receptive to cigarette marketing and were more likely to be frequent patrons of bars and clubs. The findings from the study concluded that many young adult smokers are in the initiation phase of smoking and are likely to undergo a transition to either nonsmoking or heavier smoking. If unimpeded by regulation, tobacco promotion in bars and clubs is likely to lead to increased adult smoking prevalence.

Biener L and Albers AB. *American Journal of Public Health*, 94(2):326–330, 2004.

Communication Differences Exist But Do Not Explain Why Patients Prefer Same-Race Doctors

A growing number of studies find that patients are more satisfied with care they receive from physicians of their same race. For example, surveys have found that black patients are less likely to trust or feel that they are sharing in medical decisions with doctors who are not black. Dutch studies reveal similar findings when patients and physicians are not of the same ethnicity.

Researchers in this study sought to determine whether communication differed between same-race and different-race patient-doctor encounters, and whether any difference might account for the higher satisfaction of patients with same-race doctors. To answer the question, researchers audiotaped 252 primary care visits (142 black patients and 110 white patients) receiving care from 31 doctors (18 black and 13 white) in Washington and Baltimore. They also surveyed patients on how satisfied and involved they were with the visits.

When both patient and doctor were black or when both were white, visits lasted about two minutes longer, both doctor and patient talked more slowly, and patient affect was more positive than when ethnicity differed. However, no differences between same-race and different-race pairs were detected in areas such as questioning patients about their background and symptoms, educating and counseling them about medical problems, and asking whether they understood the information.

Similar to previous studies, the researchers found that patients who saw same-race doctors rated their care as higher and said their doctors were more participatory in decision-making. This was true even after the researchers accounted for differences in the length and emotional tone of same-race and different-race visits. "The association between race concordance and higher patient ratings of care is independent of patient-centered communication, suggesting that other factors, such as patient and physician attitudes, may mediate the relationship," researchers conclude.

The study recommends that until the reasons for the satisfaction ratings are clear, efforts to increase trust and comfort between physicians and patients of different races should be made, and the number of minority physicians should be increased to improve the health care experiences of minority patients.

Cooper L et al. "Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race." *Annals of Internal Medicine*, 139: 907–915, 2003.

Lisa Cooper, M.D., M.P.H., was a fellow in the Harold Amos Medical Faculty Development Program at the time of this research.

For more information on this research, visit *www.rwjf.org/special/samerace.*

Consumer-Directed Care Model Yields Benefit

What happens when users of Medicaid's personal care services are allowed to receive a monthly cash allowance to manage and purchase their own care, instead of having it handled by an agency? One study in Arkansas found that participants had greater access to care and that younger recipients (age 18–64) needed less overall care, perhaps because they were able to live more independently.

Researchers followed a group of 2,008 adults between 1999 and 2002 who applied to participate in the experimental *Cash & Counseling* program called IndependentChoices and were randomly assigned to either the program or traditional agency care. Those in the experimental program were allowed to hire friends or relatives to care for them and to help with household chores and errands. This allowed them to get care outside of typical agency working hours. They also were allowed to spend their allowance on certain kinds of equipment, such as washing machines, to help them live more independently.

The study found that, in terms of total hours of care, nonelderly *Cash & Counseling* recipients received less than the group assigned to agency care over a two-week period—99 hours compared with 120 hours. Total care hours did not differ between elderly recipients. Researchers suggest that younger *Cash & Counseling* users needed fewer hours of care in part because the program allowed them to buy equipment to live more independently and because they could use the hours more efficiently.

A companion paper (Foster et al.) showed that consumers in the *Cash & Counseling* group had fewer unmet needs and were more satisfied with their care than agency-care recipients.

Cash & Counseling users of all ages were more likely than the agency-care group to receive paid care: 95 percent of both elderly and working-age *Cash & Counseling* participants got paid care, compared with 79 percent of elderly, and 68 percent of younger consumers who were supposed to get care from an agency. Even those who did receive agency care were provided only about two-thirds of the help they were eligible for, often because of agency staff shortages.

In terms of Medicaid costs for their care, *Cash & Counseling* participants averaged about twice the cost of those assigned to agency care during the first year. However, by the second year nearly all of this extra cost was offset by savings in nursing home and other long-term care costs.

Dale S et al. "The Effects of *Cash & Counseling* on Personal Care Services and Medicaid Costs in Arkansas." *Health Affairs* (Web Exclusive), November 19, 2003, W3 566–575.

Foster L et al. "Improving the Quality of Medicaid Personal Assistance Through Consumer Direction." *Health Affairs* (Web Exclusive), March 23, 2003, W3 162–175.

For more information on this research, visit *www.rwjf.org/special/consumermodel.*

From **Raising the Standard**—page 4

What are some examples of the Foundation's efforts thus far to improve health care quality?

ROTHMAN—Since 1998, the Foundation has been a major funder of the National Quality Forum, which has the goal of adopting quality of care measures that could be publicly reported or used for improvement.

Under the RWJF national program *Improving Chronic Illness Care (www.improvingchroniccare.org)*, we have developed a template for how physician office practices can be designed to care for people with chronic illnesses. We have a number of initiatives to help providers make those changes.

We have assisted Medicare in policy work to put into place their new chronic care initiatives. There were a lot of technical questions they had to resolve and we provided some assistance through one of our grantees.

We supported a major conference by the Institute of Medicine called the National Summit on the Quality Chasm Report. The goal was to encourage national stakeholders like Medicare, foundations and major provider associations to commit to specific ideas nationally to improve quality of care. That was successful in getting strong national commitments from major organizations.

We are doing some research studies to assess key questions that are necessary for quality. For example, what is the value of getting an electronic medical record in your practice? What does it cost? What is the return on investment?

We also support the Leapfrog Group *(www.leapfroggroup.org)*, a Washington-based national purchasing group of large employers. Leapfrog is aiming to measure quality and provide information to employers who will then offer incentives to encourage providers to improve their quality of care. It is the most successful effort we have seen so far to engage employers in quality incentives. The Leapfrog Group plans to look at measures of electronic prescribing. Does an outpatient practice have a way to check before placing a drug order to make sure it is the appropriate order? Leapfrog is slowly demanding more and more public reporting. Once the National Quality Forum establishes standard quality measures, Leapfrog will encourage providers to publicly report their results on a subset of those measures.

The common goal of all of these programs is to improve the quality of health care for Americans. Dedicated people work in health care. But the work processes and systems do not help them do their work well. So there is this huge loss to society in terms of people dying or not feeling well—and it is getting worse because of the growing numbers of people with chronic conditions. There is definitely urgency to this issue.

—INTERVIEW BY LAURIE JONES

Young Epidemiology Scholars

Teenagers took top honors at the inaugural Young Epidemiology Scholars (YES) Competition held in Washington in April. Each of two first-place winners was awarded a $50,000 scholarship. Ten other students, chosen from nearly 600 entries nationwide, also were honored with scholarships ranging from $15,000 to $35,000. Pictured below, back row, left to right: Eugene Kim, Yuguan Shen, Robert Levine (first-place winner), Benjamin Eidelson (first-place winner), Evan Orenstein, Alanna Hay and Bevin Cohen. Front row, left to right: J. Michael McGinnis, M.D., M.P.P., of The Robert Wood Johnson Foundation; Stephanie Mok; Anna-Katrina Shedletsky; Zarabeth Golden; Katherine Elizabeth Dillon; Victoria Hunt and Andre Bell of the College Board.

The winners were selected by a panel of nine judges that included some of the nation's top epidemiologists, as well as high school teachers and curriculum developers. The students participating in the competition submitted research projects ranging from examinations of smallpox vaccine policies and attitudes toward indoor tanning to hygiene practices in neonatal units. The YES Competition, supported by The Robert Wood Johnson Foundation and administered by the College Board, is designed to spur students' interest in epidemiology, the scientific method used to investigate, analyze and prevent or control a health problem in a population.

During Cover the Uninsured Week

During Cover the Uninsured Week, May 10–16, more than 2,300 events— many organized by grantees of The Robert Wood Johnson Foundation–took place in all 50 states and the District of Columbia. News conferences, health fairs, seminars for small businesses, interfaith activities and campus events all were designed to raise awareness about the need to secure stable, affordable health care coverage for all in America, including the nearly 44 million who are uninsured.

Cover the Uninsured Week 2004 was launched May 5 at the National Press Club in Washington. During the event, Risa Lavizzo-Mourey, M.D., M.B.A., (pictured center) RWJF's president and CEO, released new research from the State Health Access Data Assistance Center, an RWJF grantee, showing that at least 20 million working adults in the United States are uninsured and suffer as a result.

Also participating in the press conference were Senate Majority Leader Bill Frist, R-TN (pictured at left); Sen. Jay Rockefeller, D-WV; Noah Wyle of television's "ER," the campaign's national spokesperson (pictured at right); Bob Ross, M.D., of the California Endowment; former Health & Human Services Secretary Louis Sullivan, M.D.; and two uninsured Americans.

Former Presidents Gerald Ford and Jimmy Carter served as honorary co-chairs; nine former Surgeons General and Secretaries of Health & Human Services also endorsed the week, led by RWJF and a diverse group of national and local organizations, including the California Endowment, W.K. Kellogg Foundation, U.S. Chamber of Commerce and AFL-CIO.

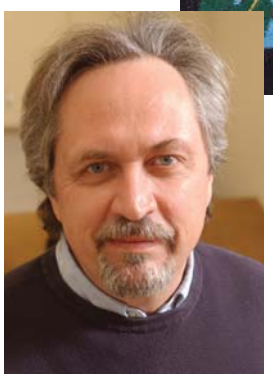
To find research and resources, or to view the webcast of the May 5th launch event, visit *www.CoverTheUninsuredWeek.org*.

—MAUREEN COZINE

For more information on RWJF's coverage efforts, see *www.rwjf.org/coverage*.

A Stitch in Time

On a slip of fabric three inches by two inches, an embroidered image of a butterfly emerges from its cocoon—an apt metaphor to describe the transformation of the artist Ray Materson. Last fall, Materson became the first artist to receive a grant from *Innovators Combating Substance Abuse,* a national program of The Robert Wood Johnson Foundation that recognizes five people each year who are doing innovative work in this field.



Ray Materson

Not that long ago, this now-honored artist, author, father and educator of at-risk youth was, in his own words, "just a common thief, a common criminal." But in prison he turned to God and discovered his art, which ultimately provided him with the inner calm and sense of self-worth that had long eluded him.

Materson's journey into the abyss of substance abuse and back into a life of sobriety was long and, not surprisingly, difficult. By the time he was 10 years old, his family had lived in four states. As soon as he had made friends in one place, he had to leave. His father was an abusive alcoholic. He remembers as a three-year-old hiding behind a chair while his father walked through the house hollering, bottle in hand. For a while, school was his refuge. He was popular, an A student, involved in sports and theater. When his family moved once again, this time to the blue-collar area of Grand Rapids, Mich., things that once were important to him, such as theater and academic activities, weren't cool with the students in his new school. He was picked on constantly. He started smoking at 14 and drugs quickly followed—marijuana and LSD. In the 10th grade he dropped out of school. He took a job as a busboy and dishwasher, went to night school and earned his high school diploma when he was 17. Soon afterward, he entered college, where he started drinking again, smoking marijuana and using cocaine.

He recalls the first experience of cocaine in his book, *Sins and Needles.* "My heart began racing and an electrical storm flooded my brain. Every grand moment of exhilaration that I'd ever known grabbed hold of my senses as I took deep, repeated breaths. . . . It was the most sensual feeling I'd ever experienced compounded a hundred times over." He finally had found something he could count on to make him feel good.

In the early '80s, Materson married and went to graduate school for a year during which he maintained a fragile sobriety. But after he returned to drinking and drug use, his marriage failed and he moved in with his sister and her family in Connecticut. For about a year he remained clean and sober. He began working as a counselor in a halfway house for prisoners coming out of jail as substance abusers and took a second job as a waiter in a restaurant. Going out with the wait staff after work, Materson started drinking again. After that, it became all too easy to slip back into old habits: smoking marijuana in the parking lot, sniffing lines of cocaine in the bathroom. Then he started using heroin.

Materson lost his job at the halfway house and quit the restaurant. Driven by the need to feed his habit, he shoplifted a toy gun and committed a series of robberies. "I was a lousy criminal, but I didn't care. I was desperate. I wanted it to end—probably my life and my drug use—but I didn't know how to do that."

Materson was arrested and sent to jail. Every day was scary. Because he was educated, he found a niche writing letters for inmates to send to their girlfriends, wives or lawyers. His payment took the form of homemade wine and marijuana.

With plenty of spare time to think, Materson recalled better times of his youth, including watching the University of Michigan Wolverines play football. He also remembered his grandmother being able to block out everything around her while she embroidered. One day, he made an unlikely connection. He noticed a pair of tube socks in the Wolverines' yellow and blue hanging in another convict's cell and bartered for them. He pulled them apart thread by thread and taught himself how to embroider a small letter M.

He began embroidering flags and sports logos for fellow inmates. Early in his artistic journey, another convict paid him for his work with three marijuana cigarettes." After I smoked one of them, I realized I couldn't be high and do the artwork. I'm higher doing the artwork than anything artificial has ever gotten me. That was the defining moment when I realized that the doors I prayed would open for me had opened."

In the fall of 1990, Melanie Hohman came into Materson's life. It was at the home of one of Materson's acquaintances that she saw his framed artwork and was swept away by it. When she learned the art was made by a man in prison using sock thread, she asked for his address so she could write to him.

They started out as pen pals and then became friends. Eventually Melanie became Materson's art agent and in 1993 his wife. Materson was released from prison in 1995, and he launched his life as an artist.

In 2002, Jack Henningfield, national director for *Innovators Combating Substance Abuse,* saw Materson's artwork featured at the American Visionary Art Museum in Baltimore.

"His ability to communicate the human side of addiction and recovery was extraordinary and of national significance," says Henningfield. "His art extends the objective scientific understanding of drug addiction with insights that can nurture the compassionate understanding of addiction and recovery. Such an understanding is critical if our nation is to garner support for the research, prevention and treatment programs that are so critical in reducing substance abuse."

Today Materson works at the Berkshire Farm Center and Services for Youth in Canaan, N.Y., where he helps young men who have substance abuse histories develop an alternative identity through their artistic abilities.

"These kids learn they are not crack heads, potheads or juvenile delinquents, but artists and students," says Materson. "I could think of myself as an addict, alcoholic and ex-con but I rarely do that. I am an artist, author, program director and public speaker. I want the kids I work with to think of themselves in a similar way. It's too easy to get hung up on a negative label."

—Hedda Colossi

For more information on *Innovators Combating Substance Abuse,* visit *www.innovatorsawards.org.* For more information on RWJF's addiction prevention and treatment programs, see *www.rwjf.org/addiction.*

Grant Results Reports

The Robert Wood Johnson Foundation generates a Grant Results Report on almost all its independent grants after they are closed, as well as regular reports on its national programs. These reports, organized by topic area, detail the results of the Foundation's work, including the products produced. Since January 2004, four new National Program Reports and 30 new Grants Results Reports have been posted on the RWJF Web site, *www.rwjf.org*. Search the entire database of reports at *www.rwjf.org/grantresults*. Among those posted are reports on projects with specific products that may be of interest to others. Recent reports on such projects include the following:

- **Developing an Internet-Based Directory of Tobacco-Control Professionals and Experts.** In 2002, independent consultant Philippe Boucher developed an online Tobacco Control Directory, *www.tcdirectory.org*, which provides descriptions and contact information for more than 5,000 tobacco-control professionals and organizations in the United States. Users can search the list by name, location or key words. The directory lists initiatives in state and local health departments, national and state nonprofit organizations, state coalitions, university-based groups and specialized Web sites. See the Grant Results Brief at *www.rwjf.org/reports/grr/044742.htm.*
- **Study of Injuries in the United States and the Response of Public and Private Agencies.** The National Academy of Sciences, Institute of Medicine, formed an expert panel of 17 researchers and practitioners to study the problem of injury in America. The committee's 336-page report, *Reducing the Burden of Injury: Advancing Prevention and Treatment*, makes detailed recommendations including greater coordination between public and private agencies; increased national support for trauma care systems at the federal, state and local levels; strengthening the infrastructure of injury programs; preventing and reducing firearms injuries; and increased funding for injury research and training. The report is available for $35.96 through the National Academies Press or at its Web site at *http://books.nap.edu/catalog/6321.html.* See the Grant Results Brief at *www.rwjf.org/reports/grr/030188.htm.*
- **Building a Collaborative to Improve Care for Children with Attention Deficit Hyperactivity Disorder.** The National Initiative for Children's Healthcare Quality developed a learning collaborative designed to improve care for children with Attention-Deficit Hyperactivity Disorder (ADHD). The ADHD learning collaborative involves 26 sites, ranging from small, private medical practices, to community health centers, to academic medical centers in diverse communities. The project's Web site includes a practitioners' toolkit, which can be downloaded at *www.nichq.org/resources/toolkit*. Also included in the toolkit is a booklet for parents from the American Academy of Pediatrics (AAP) entitled *Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder*. This booklet can be ordered separately from AAP. Information on ordering is provided on its Web site at *www.aap.org/bst*. See the Grant Results Brief at *www.rwjf.org/reports/grr/043155.htm.*
- **Developing a Guide to Treatment Programs for Adolescent Substance Abusers.** In January 2003, the nonprofit research institute Drug Strategies published a national guide to drug treatment programs for teens; it also established a companion Web site *www.drugstrategies.org/teens*. The 60-page guide provides parents and caregivers with tangible ways to assess treatment programs. It includes a detailed description of nine elements key to treatment effectiveness, summary profiles of 144 effective adolescent treatment programs, an in-depth look at seven promising programs, 10 important questions to ask a treatment program, and hotline numbers and Web site addresses for teen substance abuse centers in each state. The companion Web site includes a searchable database with profiles of the treatment programs summarized in the guide and research articles on adolescent substance abuse. Copies of the report, *Treating Teens: A Guide to Adolescent Drug Programs,* can be ordered online at *www.merchantamerica.com/ds-store/* for $16.95 plus shipping and handling. Multiple copies are available at a reduced price. For six or more copies, contact Drug Strategies at (202) 289-9070. See the Grant Results Brief at *www.rwjf.org/reports/grr/039051.htm.*
- **Production of Videotapes on Self-Management of Psychiatric Symptoms.** The Mental Illness Education Project has produced two videotapes on self-management of emotional, behavioral or psychiatric challenges. The videotapes, *Wellness Recovery Action Plan* (32 minutes) and *The Wellness Toolbox* (28 minutes), accompany a workbook by Mary Ellen Copeland, M.S., a mental health recovery educator. These videos, along with a third video produced earlier (*Key Concepts for Mental Health*), comprise *The Creating Wellness Series.* The videos can be purchased online at *www.MIEPvideos.org/shop/index.html.* The cost is $39.95 for individuals and $89.95 for institutions. See the Grant Results Brief at *www.rwjf.org/reports/grr/042044.htm.*

—Hedda Colossi

PRISM Awards

Reba McEntire (left) accepted from Hank Saroyan, co-producer of the PRISM awards, the PRISM award for her performance in the comedy series, "Reba."

The awards are presented by the Entertainment Industries Council in partnership with The Robert Wood Johnson Foundation and the National Institute on Drug Abuse, a component of the National Institutes of Health, Department of Health and Human Services. They are presented in recognition of the accurate depiction of drug, alcohol and tobacco use and addiction in film, television and music.

The episode for which McEntire won, "Calling the Pot Brock," deals with the parents of a teenager who are afraid to tell the truth when their daughter asks if they've ever smoked marijuana. The 8th Annual PRISM Awards were announced on April 29, 2004, at the Hollywood Palladium in Los Angeles in a ceremony hosted by Mackenzie Phillips.

PRISM award submissions are put through a rigorous nomination review process, judged by members of the creative community and scientific experts for entertainment value, accessibility of the message and scientific accuracy.

SELECTED GRANTS

Search all active RWJF grants at

www.rwjf.org/grants

RWJF National Programs are denoted by italics.

Active Living, Obesity and Nutrition

- For increasing the number of bicycle-friendly communities in New Jersey, a renewal award of $75,000 to the League of American Bicyclists, Washington.
- *Active for Life: Increasing Physical Activity Levels in Adults Age 50 and Older.* A renewal award of $499,247 to the University of South Carolina Research Foundation, Columbia, for evaluation of the program.
- *Active Living Research.* Awards to two sites, totaling $200,000. Awards of two grants, totaling $127,405.

Alcohol and Drug Addiction Prevention and Treatment

- For a pilot program of research to integrate substance abuse issues into mainstream medicine, $200,000 to the Treatment Research Institute, Philadelphia.
- *A Matter of Degree: Reducing High-Risk Drinking Among College Students.* A supplemental award of $146,637 to the Harvard University School of Public Health, Boston, for the evaluation of *A Matter of Degree:* Collection and analysis of 2004 comparison data from the college alcohol study.
- *Leadership to Keep Children Alcohol Free—Phase III.* A renewal award of $2.2 million to Boston University School of Public Health.
- *Paths to Recovery: Changing the Process of Care for Substance Abuse Treatment.* A supplemental grant of $97,359 to the Oregon Health and Science University, Portland, for evaluation of additional sites participating in the program.
- *Reducing Underage Drinking Through Coalitions.* A renewal award of $747,732 to the University of Minnesota School of Public Health, Minneapolis, for evaluation of the program.
- *Substance Abuse Policy Research Program.* Awards to eight sites, totaling $1.25 million.

Building Human Capital

- *The Harold Amos Medical Faculty Development Program*. Awards for eight fellows, totaling $2.9 million.
- *Innovators Combating Substance Abuse.* Awards to two sites, totaling $600,000.
- *Investigator Awards in Health Policy Research Program.* Awards to three sites, totaling $823,658.
- For improving leadership development programs for health care organizations and universities, $299,000 to the National Center for Healthcare Leadership, Chicago.

Health Insurance Coverage

- *Covering Kids and Families.* An award of $200,000 to the Illinois Maternal and Child Health Coalition, Chicago.
- *State Coverage Initiatives.* An award of $274,990 to the Center for Health Policy Development/ National Academy for State Health Policy, Portland, Maine.

Nursing: Transforming Care at the Bedside

- For studying the impact of nurse/patient ratios on the quality of hospital care, $93,890 to the University of Maryland College of Behavioral and Social Sciences, College Park, Md.
- For studying Foundation and other efforts to identify innovation, $83,940 to Cornell University, Joan and Sanford I. Weill Medical College, Ithaca, N.Y.

Pioneer

- For convening expert panels to develop guidelines, standards and technical solutions for the development of electronic patient records, $375,000 to the Markle Foundation, New York.
- For developing a patient-centered quality calculator, $75,000 to RAND Corp., Santa Monica, Calif.

Public Health Leadership and Capacity

- For developing an operational definition of a local governmental public health agency, $200,000 to the National Association of County and City Health Officials, Washington.
- For building sustainable public health advocacy, a renewal award of $724,737 to Trust for America's Health, Washington.

Quality Health Care

- *Prescription for Health: Promoting Healthy Behaviors in Primary Care Research Networks*. A renewal award of $600,000 to the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, N.J., for an evaluation of the program.

Reducing Racial and Ethnic Disparities in Chronic Care

- For sharpening Medicare's tools for reducing racial and ethnic health disparities, $389,240 to the National Academy of Social Insurance, Washington.
- *Building Community Supports for Diabetes Care.* Renewal awards to three sites, totaling $77,107.
- *Hablamos Juntos: Improving Patient-Provider Communication for Latinos.* One renewal award of $840,061 to the Regional Medical Center at Memphis, Tenn.
- One grant from the Special Opportunities Fund of $70,000 to the Kaiser Foundation Health Plan, Kaiser Permanente, Oakland, Calif., for building health care interpreter capacity: a partnership between health care organizations and educational institutions.

Tobacco Use

- For developing a sustainability plan for the Center for Tobacco Cessation, a renewal award of $399,574 to the American Cancer Society, Atlanta.
- *Helping Young Smokers Quit: Identifying Best Practices for Tobacco Cessation.* An implementation award of $706,277 to the University of Illinois at Chicago School of Public Health.

Vulnerable Populations

- *Southern Rural Access Program.* An award of $600,000 to the South Carolina State Office of Rural Health for planning and developing the Southern Health Improvement Consortium.
- *After School: Connecting Children at Risk with Responsible Adults to Help Reduce Youth Substance Abuse and Other Health-Compromising Behaviors.* A renewal award of $2.25 million to the United Way of Massachusetts Bay, for improving after-school programs for children living in Boston.
- *Community Partnerships for Older Adults.* Renewal awards to eight sites, totaling $6 million.
- *Faith in Action.* Awards to seven sites, totaling $245,000.
- *Improving the Health and Well-Being of Isolated Families and Communities*. A renewal award of $1.2 million to Shreveport-Bossier Community Renewal, Shreveport, La.
- *Urban Health Initiative: Working to Ensure the Health and Safety of Children.* Award of $300,000 to the East Bay Community Foundation, Oakland, Calif., for developing an integrated data system in Oakland to strategically assess and support citywide after-school programs.

Other

- For issue briefings on health policy for policymakers, journalists and national organizations, $1.1 million to the Alliance for Health Reform, Washington.
- For data collection and analysis of the foundation field, $250,000 to the Foundation Center, New York.
- *Changes in Health Care Financing and Organization.* Awards to 13 sites, totaling $2.8 million.
- *State Forums Partnership Program.* An award of $125,000 to the University of North Dakota School of Medicine & Health Sciences, Grand Forks.
- For supportive services to homeless families in Mercer County, $125,000 to Homefront, Lawrenceville, N.J.
- For developing a public/private partnership for New Jersey's Aging Services network, $119,062 to New Jersey Foundation for Aging, Trenton, N.J.
- For an assistance program for indigent people in New Jersey, $175,000 to St. Vincent de Paul Societies, East Brunswick, N.J.
- For assistance to needy and indigent families in New Brunswick, $365,780 to the Salvation Army, New Brunswick, N.J.

People

Najaf Ahmad, M.P.H., began working at the Foundation in April as a communications associate in the Communications Department. Most recently, she was a research analyst at the Rutgers Center for State Health Policy, New Brunswick, N.J. Ahmad received her master's degree in public health from Yale University.

Gerard Lebeda started at the Foundation in April as a program coordinator for the *Health & Society Scholars Program*. Previously, Lebeda was a convention/meeting planner and executive assistant for Medical World Communications, Jamesburg, N.J.

Promotions

Karen Davenport, M.P.A., has been promoted to senior program officer in the Health Care Group. Since coming to the Foundation in 1999, she has developed programs related to covering the uninsured, long-term care and reducing disparities in health care. Davenport manages the *Covering Kids and Families* and *Coming Home* national programs.

Rona Henry, M.P.H., M.B.A., has been appointed director, National Program Affairs. Henry, who has made significant contributions to the work of RWJF National Program Offices through her organizational and leadership activities, will continue to work closely with Peter Goodwin, M.B.A., vice president, National Program Affairs, as he develops the focus and responsibilities of this new office.

Maureen Michael, M.G.A., has been promoted to senior program officer in the Research and Evaluation Unit. Since joining the Foundation in 1996, she has managed the *Health Tracking* initiative, the *Cash & Counseling* national program and led the effort to design and launch *Better Jobs, Better Care: Building a Strong Long-Term Care Workforce*.

New CFO and Treasurer Named

Margaret H. (Peggi) Einhorn, M.B.A., has joined The Robert Wood Johnson Foundation as chief financial officer and treasurer. She comes to RWJF from J. P. Morgan Chase, New York, where she has worked since 1980, most recently as senior vice president, Enterprise MIS/Finance Transformation.

Einhorn has extensive experience in the financial/MIS areas, including serving as the chief financial officer for LabMorgan, the firm's e-commerce department. In addition, she has experience with the nonprofit world through her role as chair of the board of trustees of the Brooklyn Children's Museum. Einhorn received her M.B.A. in marketing and finance from Columbia Graduate School of Business.

As Einhorn assumes her position, Peter Goodwin, M.B.A., officially moves from the position of vice president, treasurer into his new role as vice president, National Program Affairs.

What's New on the RWJF Web Site

Two areas of the RWJF Web site continue to expand their offerings: the Television Health Series and the Research Center.

Several new features have been added to the Television Health Series, including "Smoking in the Workplace," found at *www.rwjf.org/news/worksmoke.* This segment highlights research published in the *Journal of Occupational and Environmental Medicine* and co-authored by Karen K. Gerlach, Ph.D., M.P.H., a senior program officer at RWJF. Roughly three-fourths of the nation's white-collar workers are covered by smoke-free policies, but only 43 percent of the estimated 6.6 million food-preparation, and service workers benefit from this on-the-job protection, according to the study, "Disparities in Smoke-Free Work-place Policies Among Food Service Workers." In addition to a webcast, the feature includes an interview with Gerlach, and key findings and resources.

Other Television Health Series features making their debut:

- "Managing Maternal Depression" at *www.rwjf.org/news/maternaldepression*
- "Getting the Message About Drugs" at *www.rwjf.org/news/pdfa*
- "Binge Drinking and Campus Rape" at *www.rwjf.org/news/campusrape*
- "Keeping Asthmatic Children out of the Hospital" at *www.rwjf.org/news/ahc*

In the Research Center, two new features focus on the RWJF-funded College Alcohol Study.

"Watering Down the Drinks" explores a College Alcohol Study finding suggesting that greater campus diversity leads to lower binge drinking on campus. Henry Wechsler, Ph.D., director of the College Alcohol Study, based at the Harvard School of Public Health, is interviewed. Wechsler suggests that integrating students from high-risk student groups with lower-risk groups might exert a moderating effect on high-risk drinkers. This feature can be found at *www.rwjf.org/news/watereddrinks.*

In the second College Alcohol Study feature, Wechsler is interviewed along with Meichun Kuo, Sc.D., principal researcher for "The Marketing of Alcohol to College Students: The Role of Low Prices and Special Promotions," published in the October 2003 issue of the *American Journal of Preventive Medicine.* This landmark study indicates that drink promotions at bars and liquor stores near college campuses—such as ladies' nights or free beer specials—are linked to high rates of student binge drinking. Visit this feature at *www.rwjf.org/news/drinkspecials.*

In addition to the College Alcohol Study articles, the following new feature was added to the Research Center highlights: "Survey: Gaps in State Medicaid Coverage for Programs to Help Clients Stop Smoking" at *www.rwjf.org/news/medicaidtobacco.* This feature draws on a 2002 survey of states led by researchers at the Center for Health and Public Policy Studies at the University of California, Berkeley, in conjunction with RWJF and the Centers for Disease Control and Prevention. The research suggests that 20 percent of the states fail to offer Medicaid coverage to help people quit tobacco use, and that even in states where Medicaid coverage is provided, Medicaid recipients are not informed about those services.

A special report was posted during Black History Month, "Disparities at the End of Life." Research indicates that African Americans fail to adequately avail themselves of hospice care and other critical services. To shed light on the issue, RWJF hosted a special panel discussion on the subject, moderated by John Lumpkin, M.D., senior vice president and director of the Health Care Group at the Foundation. This webcast is now available for viewing on the RWJF Web site. To see the entire package, visit *www.rwjf.org/news/special/endDisparities.jhtml.*

—Jeffrey Meade