ADVANCES®

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FEATURES

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Moyers PBS Series Looks at Dying in America

America, notes Judith Davidson Moyers, is a great country to be sick in, but not if you're terminally ill. Palliative care in America — focusing on easing pain and making life better for those who are dying — is well behind that of other Western nations. And our aversion to discussing death and dying often leaves families uninformed about the wishes of loved ones.

But six hours of documentary television — four 90-minute episodes airing September 10,11, 12, and 13 during prime time on PBS — along with an extensive community and professional outreach program, aims to stir debate and conversation nationwide.

"On Our Own Terms: Moyers on Dying" is based on two years of research led by award-winning journalists Bill Moyers and Judith Davidson Moyers. The Robert Wood Johnson Foundation has provided $2.75 million toward the $6.25-million project. Other major funders include The Fetzer Institute and The Nathan Cummings Foundation.

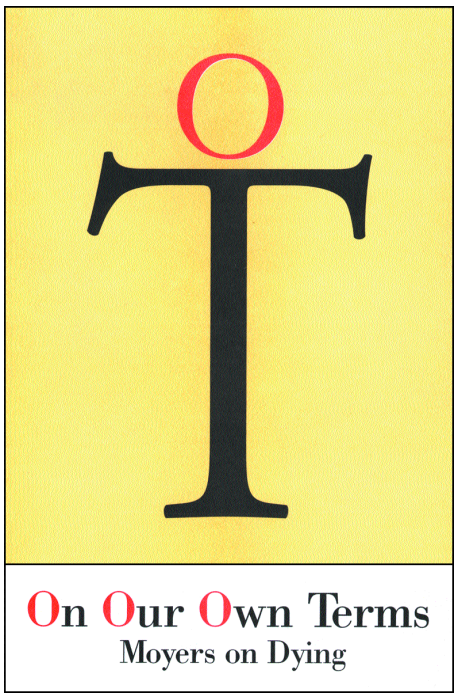
The Moyers team traveled throughout the country, interviewing dying people,their families, caregivers,and others involved in end-of-life decisions. The focal points aren't "horror stories," however. "We're focusing on wonderful models for change," says Judith Moyers.

The first program to air focuses on patients and caregivers talking openly about living with dying. As the process of dying has been prolonged by advances in medical knowledge, Americans now face increasingly complicated choices as individuals and as a society. One patient featured in this segment is Bill Bartholome, MD, a pediatrician who was diagnosed with terminal cancer and decided to forgo what he considered to be excessive treatments. Bartholome outlived his prognosis and found that his life was transformed by his anticipation of dying.

But not all patients are clear on their wishes for treatment. In America's multi-cultural society, the different ethnic, religious, and personal values of patients make it especially challenging for health care providers to understand and respond to their patients' preferences.

The second program looks at palliative care and the need for doctors to examine patients' psychological, emotional, and spiritual well-being. This segment features palliative programs at Memorial Sloan-Kettering Cancer Center and Mount Sinai Medical Center in New York, which use a team approach that stresses continuity of care to address pain, ensures maximum comfort for the patient, and supports the caregivers. It also follows Joyce Kerr, a former math teacher from New Jersey, through her last weeks of life and shows how hospice can support the choice of individuals who want to die at home, surrounded by their loved ones.

The third program discusses "dying well"— that is, how we die and the effect on the dying person, families, institutions, and communities.



This RWJF-funded series airs Sunday, September 10, through Wednesday, September 13, from 9 to 10:30 p.m. on PBS (check local listings).

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Through intimate interviews with a man dying from amyotrophic lateral sclerosis and a woman dying of cancer, it explores the issue of physician-assisted suicide in Oregon, where it is a legal option,and in Louisiana, where it is not. It also raises the issue of terminal sedation, a legal and routine practice in hospitals across the country.

The final program in the series focuses on those who provide palliative care to the poor and others who might otherwise die alone and in pain. One example is Balm of Gilead in Birmingham, Ala., which weaves a safety net under the uninsured and poor by patching together an operating budget from Medicare and Medicaid reimbursements, church donations, foundation grants,and the taxpayer-supported county indigent fund.

Photo Credit: © William Brangham

Bill Bartholome, MD, a pediatrician,began experiencing life differently when faced with a diagnosis of terminal cancer. "If you don't expect to see spring when fall comes, and then are around and get to see spring . . . you experience it as a miracle."

Photo Credit: © Sylvia Plachy

Cancer patient **Joyce Kerr** (above, center front with family) chose to live her final weeks at home, with coordinated support provided by her family, her doctor, and hospice.

Over the four nights, the programs raise questions such as these: What options are available for the terminally ill? Why aren't we dying in comfort? How can we alleviate some of the financial and emotional burdens on loved ones? Why aren't more physicians trained to deal with end-of-life care?

With respect to paying for these services, Judith Moyers says: "The experts interviewed say that we don't necessarily need more money for the health care system; we need to allocate it differently. It's easier for doctors to get patients into intensive care than to get a meal delivered to them at home, or get relief for their regular caregiver for half a day. None of that's included in our present [health care] scheme."

While the topic of end-of-life care may seem daunting, if not depressing, Judith Moyers relates quite a different story. One cameraman told her that he felt like the angel of death; everywhere he went,someone died. "Then later he said,'I'm so exhilarated by this process,'" Moyers recounts. "He said,'I'm learning how incredible the human spirit is. In the worst of times, it's possible for the human spirit to sail to new heights.'"

Outreach programs connected to the series parallel the goals of RWJF's Last Acts coalition, a national program to improve end-of-life care. The Moyers series has a campaign encouraging dialogue and action among the public, health care professionals,institutions, and organizations. Public television stations are encouraged to address these questions in their communities; a discussion guide is available for individuals, families, and groups; and a leadership guide outlines how to form coalitions to achieve community goals. More than 200 communities have coalitions forming to address local end-of-life issues raised by the series.

"We want people to feel more comfortable having conversations about death and dying within the family and expressing what they want at the community level," explains Victoria Weisfeld, MPH, RWJF senior communications officer. "We need to create higher expectations in the community when it comes to care for the dying. 'On Our Own Terms' can build on the networks that Last Acts has established, and Last Acts will build on the community networks that 'On Our Own Terms' has established."

The "On Our Own Terms" Web site <www.pbs.org/onourownterms> contains information about the series, activities in conjunction with the series, and downloadable publications, including the Discussion Guide and Leadership Guide.

The Last Acts Web site <www.lastacts.org> contains recent news stories, activities,an electronic newsletter, media center, and many other resources related to improving end-of-life care.

— ANNE STEIN

Increasing Social Support: An Evolving Approach to Better Health

Everyone knows that isolation can be painful. It's also unhealthy. Over the past few years,studies have demonstrated that social isolation is associated with an increased risk for everything from heart disease to substance abuse to overall mortality. What's less well understood is exactly how isolation increases health risks — and what can be done about it.

"The more we look at the research, the more we realize the prevalence of isolation and its implications for health status," says Paul Jellinek, program vice president and leader of The Robert Wood Johnson Foundation's Community Health Program Management Team, which is looking at the problem of social isolation. "This is an opportunity to help define the problem and develop solutions that will really help people."

A big challenge in combating isolation is the scope and complexity of the problem. The causes, characteristics,and outcomes of isolation vary widely from group to group and from individual to individual. For a young mother, the isolation brought on by a lack of transportation and childcare may result in depression and child neglect. For an adolescent, a lack of a nurturing school and positive after-school environment may lead to delinquency, substance abuse, and early sexual activity.

The Community Health Team currently is researching the process through which social support and connectedness can improve health. But it is building on a history of programming. Over the years, RWJF-funded programs have targeted three groups particularly vulnerable to social isolation — adolescents at risk,low-income families with children, and the elderly. The programs share a common element — all can help to minimize the impact of isolation by fostering relationships between and among people.

Youth challenge

Social connectedness is loosely defined as the amount and quality of interaction an individual has with family, community, school,and workplace, as well as individual perceptions of how much support they have and how much influence they have over their environment. Strengthening social ties and competence holds particular promise for improving health status for adolescents now and throughout their lives.

Prosocial schooling is one proven way of improving health by increasing the social involvement of primary school students and their parents. "Our focus is on creating a sense of connectedness, belonging, and a sense of community in the school," says Eric Schaps, PhD, director of the Prosocial Schooling in Primary Prevention program.

That's done by having children help develop classroom rules and behavior norms,pairing up older and younger children, and emphasizing group assignments over individual competition. Parents are brought in through activities such as science fairs, in which they are asked to develop projects with their children.

RWJF now is supporting an effort to expand prosocial schooling to 190 schools across the country.

After-school time can be just as important for children,says Julie Sandorf, project director for the RWJF after-school pilot program. "I don't know how we can teach children to join the community if we don't teach them to join clubs or other activities. But in many cities the opportunities just aren't there in poorer neighborhoods."

The after-school pilot program aims to build close relationships among children and responsible adults through their participation in constructive activities after school, including sports,arts, and dance.

The Foundation also is looking to new technology to fight isolation. TeenCentral.net is a Web site on which teens chat about problems they face,from school bullies to coping with teen pregnancy. Trained professionals monitor incoming mail and refer children to local support services as necessary. Stories — about 4,000 each month — also are posted, giving other teens an opportunity to respond with support and encouragement. "This is the positive side of peer pressure," says James H. Feldman,national director of public education for KidsPeace. "Kids are overwhelmingly supportive of each other."

Family focus

Another major RWJF-sponsored effort is Family Support America, which promotes family sufficiency by building on family strengths. The program has helped community family support centers in eight states develop networks for sharing information and expertise to help families with day care, counseling, and home visits.

"The evaluations we've seen show an increase in connectedness,an increase in access to help services, and decreases in social isolation," says Terrance Keenan,special program consultant at the Foundation, and a member of the Community Health Team.

These programs are just the beginning, says Floyd Morris, a senior program officer with the Community Health Team. If they succeed, addressing social isolation could become an even larger Foundation priority.

"Our work is in its early stages," Morris says. "But we believe we can help make real improvements in people's lives and their health."

— Howard Larkin

William D. Novelli (right), associate executive director for public affairs of AARP, the nation's leading organization for people 50 years of age and older, is presented the **Campaign for Tobacco-Free Kids' Champion Award** by **John Seffrin** (left),CEO of the American Cancer Society, at a recent gala celebration. The award is given annually to someone who has made a significant,lasting impact in the field of tobacco control. As a founder of the Campaign and its president from 1996 to 1999,Novelli shaped its strategic outreach programs and guided its communications and advocacy efforts during such landmark struggles in the "tobacco wars"as Congress's effort to pass broad tobacco reform legislation,the legal battle between the states and the tobacco companies, and the resulting state-by-state initiatives to earmark settlement funds for tobacco use prevention,as well as the emergence of youth-driven tobacco prevention campaigns nationwide.

No man (or woman) is an island — at least, no healthy man. Increasingly, researchers are finding that social networks play a critical role in maintaining health. As a social epidemiologist, Lisa Berkman, PhD, who chairs Harvard University's Center for Society and Health, is uncovering how families, friends, and acquaintances help to keep us well — and why isolation tends to endanger our health and shorten our lives. In this interview with *ADVANCES*, Berkman talks about what we can do to strengthen the ties that bind people together — to improve both the physical and social health of our communities.

How do social networks promote health?

BERKMAN — The first studies of social networks found that social "disconnection" was related to mortality risk from almost every cause of death, but they left wide open the question of what mechanisms could link something outside the body to such a broad array of outcomes. While the answer is still incomplete, we now know that a number of pathways link social networks to health outcomes. One is health behaviors: People who are isolated tend to smoke more and be more overweight and less physically active. But when you control for all those factors,they only account for a very small portion of the risk that isolation poses to health. It now appears that social isolation — the feeling of disconnection, of not belonging — is a chronically stressful experience that has a direct biological effect on the body.

Most Americans live in densely populated cities and suburbs. How can someone who lives in the middle of a busy community be socially isolated?

BERKMAN — Social isolation has to do with living in a society that's disintegrating. Immigrants in very tight families may feel alienated from the larger community. Even married people can feel very isolated if they don't have many contacts with friends and relatives. We need more than one person in our world to make things work. People need to feel embedded in the social environment, and take responsibility for others. We need to think about the degree to which we're disconnected. The United States ranks in the bottom third of developed countries for life expectancy. The countries that are very high in life expectancy place a much higher value on social cohesion and collective responsibility. All our health care dollars are not buying us health. There has to be a larger sense of "we" that guides us.

Not all social networks promote health. How do you encourage people to surround themselves with friends who encourage healthy choices?

BERKMAN — Networks can affect health through four pathways: social support, social engagement,social influence, and even person-to-person transmission of infectious diseases. Obviously, they don't always work together to promote health. If you're in a network where everybody smokes, you're likely to smoke. We don't yet understand how to change a network's unhealthy behaviors without destroying its supportive functions. But my experience is that networks don't form around something unhealthful. They join to provide friendship, security, and a lot of the good aspects of being connected.

How can we encourage the formation of strong, intimate networks among the elderly, who may be losing their closest ties through illness and death?

BERKMAN — As people age, they do experience losses. But many older people are resilient and find ways to make new contacts. We need to find some new options, such as part-time work and volunteer work, to help older people remain productive and engaged in society. While the data aren't all in, many of us are very reluctant to see the Sun City version of retirement as the answer for all older people. It takes them so much out of the mainstream. I think there are great benefits to living in a community where it's not all about support, but also about what individuals are able to give, well into old age.

How does the idea of unhealthy isolation fit with adolescents' need to separate from their families?

BERKMAN — I don't think adolescent isolation is par for the course. Certainly adolescents have to become independent, but this idea that kids have to be isolated to become successful adults is a myth. It's part of the American character, which puts incredible value on independence and self-reliance instead of community and connectedness.

There are a number of promising programs aimed at easing the isolation of at-risk youths by pairing them with responsible adult volunteers. But are there really enough adults willing to commit to the kind of long-term volunteer relationships needed to help those children?

BERKMAN — It's a step in the right direction, but in the end it depends on whether it becomes a natural part of somebody's life. Right now, one type of intervention tries to mobilize naturally occurring contacts, to make them more effective. The second kind of intervention, for people who don't have a natural community that can be strengthened, is to create an artificial community along the lines of Alcoholics Anonymous. Those communities may be very effective in the short run. For example, widow-to-widow programs may be what people need to get through the first six months. We know that some of those artificial communities are powerful and sustainable. But my gut feeling is that we should try to build on networks that happen naturally because people live together in a community.

How can social service agencies reach out to the isolated and still respect an individual's desire to choose and maintain his own intimate network?

BERKMAN — The task of social services, and social policies in the larger sense, is not to be the most important element in someone's life, but to enable that person to reconnect with the people lurking in their network who would like more intimacy and communication. We also need to realize that, while people need love and a sense of belonging, they need all kinds of relationships. We want to rely on neighbors to borrow a cup of sugar, even if they don't meet our most intimate emotional needs. When the man at the local grocery is friendly and knows who I am, I feel embedded and integrated — and that's a wonderful feeling.

— INTERVIEW BY ELIZABETH AUSTIN

Can the Chronically Ill Get Adequate Insurance Coverage?

Adequate health insurance coverage is vital for persons with chronic illness. Without it, they face the prospect of staggering medical expenses. Unfortunately, common insurance industry practices work against them by basing the price of premiums on their health status and limiting coverage for pre-existing conditions.

To help remove some of the barriers to obtaining insurance coverage, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1997. HIPAA prevents insurers from charging higher premiums to sicker individuals and limits insurers' ability to permanently exclude preexisting conditions from coverage.

To understand the effect that being seriously ill may have on an individual's probability of obtaining adequate health insurance coverage,investigators examined the health insurance coverage of both healthy and sick individuals in 1994 in Indiana. They categorized people as adequately insured, underinsured, or uninsured. The researchers defined underinsured as having "coverage that could not prevent a medical event from becoming financially catastrophic, requiring substantial out-of-pocket expenditures." Policy characteristics that might result in significant out-of-pocket expenses include permanent preexisting condition exclusions;no annual limit on out-of-pocket expenditures; a lifetime maximum payout of $50,000; and a large degree of cost sharing in the form of high deductibles, exclusion of coverage for particular services, and high co-payments for particular services. These characteristics were used by the investigators to distinguish between adequate and inadequate coverage among the study participants.

The study used data from Indiana because the state has an uninsurance rate lower than the national average, a well-established high-risk pool that provides health insurance coverage to individuals unable to obtain insurance in the private market, and, in 1994, had limits on insurance underwriting practices that were similar to those of HIPAA in 1997. In addition, by focusing the study on a single state, the authors sought to avoid the confusion of coverage differences related to differing insurance regulatory environments.

Two groups of policyholders were included in the study: a random sample of 242 individuals from the greater South Bend metropolitan statistical area (the South Bend sample) and a sample of 174 women with breast cancer and 41 men with testicular cancer. In the South Bend sample, 106 individuals were categorized as healthy and 136 as chronically ill. All participants were surveyed by phone and asked about their health insurance benefits, work history, age, health,income, education,and other demographic characteristics.

The results show that chronically ill persons were less likely to have adequate health insurance coverage than healthy persons. In general, adequate insurance coverage was more common among married individuals, those with more education, individuals working in large firms, persons employed full-time, and individuals who are not self-employed. For married individuals,health status did not have an effect on coverage adequacy. In contrast, among single persons — who typically have fewer alternative sources of insurance coverage — health status significantly affected the level of insurance coverage.

The authors suggest that rigorous state enforcement of HIPAA has the potential to improve access to adequate health insurance coverage for persons with chronic illnesses, provided the insurance industry does not adopt new underwriting practices that raise premiums or limit lifetime payouts. Unfortunately, they add, HIPAA can do nothing for the uninsured.

Stroupe KT, Kinney ED, and Kniesner TJ. Does Chronic Illness Affect the Adequacy of Health Insurance Coverage? *Journal of Health Politics, Policy and Law* 25 (April): 309–341,2000.

Handheld Computer Use with Asthma Practice Guidelines

In 1994, the American Academy of Pediatrics (AAP) published its practice guidelines for the office management of acute asthma in children. Practice guidelines are intended to influence how physicians practice medicine in order to reduce variability in patient care, control costs, and improve patient outcomes. Generally the guidelines are developed by an expert committee that reviews the evidence in the medical literature before making its recommendations. In order for guidelines to have an impact, though, physicians have to use them in their medical practices.

One way of bringing practice guidelines closer to the site of patient care is to load them on computer systems available in the physician's office. Recently, researchers tested the use of an even more convenient method, a handheld computerized decision support system containing the AAP guidelines. They wanted to see whether this device, which processes patient data immediately and offers advice, could change how physicians managed these patients.

The device they tested,called AsthMonitor, consists of a handheld computer with pen stylus, specialized software,and a printer. It shows a reminder to measure peak expiratory flow rates and oxygen saturation,as specified

in the guidelines, at the top of a window in which the physician is supposed to document the physical findings. It recommends oxygen administration, use of nebulizers, and corticosteroids when such use is triggered by the findings. The device also prints out a summary of the office visit and any medications prescribed.

The investigators enrolled 9 community-based physicians in the study from 1996 to 1998 and evaluated their adherence to the guidelines both before (91 patients) and after (74 patients) using the AsthMonitor. They also evaluated the children's outcomes at the time of the visit, in terms of improvement in the severity of their attack, and 1 week later, as measured by such factors as the number of emergency department visits and days missed from school.

The results showed that when the physicians used the AsthMonitor, their adherence to the AAP guidelines increased. They measured peak expiratory flow rates and oxygen saturation more frequently, they administered nebulizations more often, and they tended to prescribe corticosteroids and β-agonists more frequently. The only guideline they did not follow more closely was administration of oxygen, because they disagreed with it.

The more extensive patient work-up increased the length of the office visit, with twice as many visits as before lasting more than 1 hour. Costs rose, too, from an average of $103 to $145 per visit.

Despite the additional office procedures, the children's outcomes were the same. The care recommended through the AsthMonitor did not reduce the number of return visits to the physician or the number of days missed from school. As paradoxical as these findings seem, the authors explain them by noting that the AAP recommendations were not truly evidence-based. Many of them were not supported by specific evidence from the medical literature.

This fact aside, the authors conclude that "implementation of guidelines using handheld computers seems to be an effective mechanism for influencing physicians' behavior." This is the first evaluation of a computer-based support system for childhood asthma.

Because the AAP guidelines lacked specific evidence,the authors advise physicians to apply computer-mediated recommendations "wisely and responsibly." They caution them "not [to] accept statements on faith, even when the guideline is described as evidence-based." They feel that both policymakers and physicians would be better served if guideline developers would "annotate each recommendation with an indicator of evidence quality and/or strength of expert opinion"— which the AAP subsequently did.

Shiffman RN et al. A Guideline Implementation System Using Handheld Computers for Office Management of Asthma: Effects on Adherence and Patient Outcomes. *Pediatrics* 105 (April): 767–773,2000.

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

Hysterectomies Inappropriately Recommended

Hysterectomy is the second most common operation performed in women, a fact that has raised concerns that it may be overused. In recent years, guidelines have been developed to assist physicians in determining whether hysterectomy is appropriate for a particular patient. Among them are a set developed for the Women's Health and Hysterectomy Project and the criteria from the American College of Obstetricians and Gynecologists (ACOG).

In a study of 497 women who underwent hysterectomies in one of 9 California managed care organizations between 1993 and 1995 — before the guidelines were issued — researchers wanted to know how many of these recommendations would be considered appropriate according to today's guidelines.

The Women's Health and Hysterectomy Project criteria were developed by an expert committee's collective judgment rather than a literature review because few published studies on hysterectomy outcomes exist. The ACOG criteria were designed to identify cases that should be reviewed by other physicians when the criteria for hysterectomy are not met. The investigators used both of these sets of guidelines in their study.

The investigators reviewed each patient's chart and interviewed each woman by telephone. They assigned each patient to a specific diagnostic category, which a computer algorithm then used to classify the patients as appropriate or inappropriate candidates for hysterectomy, based on the guidelines.

Overall, the investigators found that about 70% of the recommendations for hysterectomy were inappropriate. In the case of leiomyomata (benign uterine tumors), the most common reason for a hysterectomy recommendation, only one-fifth of those cases were considered justified. Most of the inappropriate recommendations were from physicians' failure to use diagnostic procedures or therapeutic alternatives before resorting to surgery. For example, about three-quarters of women with pelvic pain did not undergo laparoscopy or laparotomy before being advised to have surgery, and almost half of those with uterine bleeding did not first have an endometrial biopsy.

Because of the high rate of inappropriate hysterectomies in this study, the investigators concluded that the women received suboptimal care.

Is it possible that the criteria are too strict? The investigators think not, since in their opinion the expert panel used a reliable method to devise them. More likely, the relative safety and curative potential of hysterectomy favor its widespread use, as do the higher reimbursement policies for surgical rather than medical interventions. However, the authors cite the paucity of published research on hysterectomy as one important reason that physicians may have difficulty making sound decisions about recommending this procedure.

One helpful result from this study was the revelation that diagnostic procedures and treatment alternatives preliminary to hysterectomy were underused. Thus, investigations of this type can serve as a quality control measure for patient care.

Broder MS et al. The Appropriateness of Recommendations for Hysterectomy. *Obstetrics & Gynecology* 95 (February): 199–205,2000.

Heart Attacks and Managed Care: Are Patients Getting Quality Care?

Over the past decade, many state Medicaid programs have shifted their enrollees from traditional fee-for-service care into managed care plans. The overriding goal was to cut costs — without simultaneously reducing quality. In this study, the researchers examined the impact of TennCare, Tennessee's sweeping Medicaid managed care program implemented on January 1, 1994, on the quality of care provided to patients hospitalized for acute myocardial infarctions, commonly known as heart attacks.

Under TennCare, Tennessee's Medicaid program channeled all Medicaid-eligible persons into managed care organizations

(MCOs). This was a major change because less than 6% of the state's population was enrolled in MCOs prior to 1994. TennCare also expanded the state's Medicaid program, opening the rolls to individuals without health insurance either because of uninsurable health conditions or ineligibility for employer- or government-sponsored plans. These rapid and large-scale changes raised concerns about potential changes in patient outcomes, especially for individuals hospitalized for a significant acute event, like a heart attack.

The researchers surveyed heart attack patients under age 65 who were hospitalized in a Tennessee hospital. Neighboring North Carolina — which is demographically similar to Tennessee — served as a control state for the study in order to isolate the changes directly related to TennCare. The investigators asked patients whether they had a revascularization procedure — either coronary artery bypass graft (CABG) or percutaneous coronary artery angioplasty (PTCA) — within 30 days after their heart attack. Both CABG and PTCA are standard therapies for patients with blocked arteries. Patients also reported on their health status before and after the hospitalization and their ability to undertake a number of activities of daily living, such as walking, bathing, eating, and dressing.

Some 58% of patients underwent revascularization after their heart attack; of them,69% received PTCA. TennCare patients were just as likely as privately insured patients to undergo revascularization. In contrast, traditional Medicaid patients and the uninsured were significantly less likely to have a revascularization procedure. CABG surgeries were more common than PTCA among both TennCare and Medicaid patients than among the privately insured. Regardless of insurance coverage, patients in excellent health prior to their heart attack were much more likely to undergo PTCA (rather than CABG) than were patients in good, fair, or poor health. At the time of the survey, Medicaid patients reported significantly poorer mental health, general health, physical functioning, and capacity to work — as well as more pain — than all other patients. In contrast, TennCare patients had about the same health outcomes as the privately insured.

The authors contend that "TennCare brought patients who otherwise would have been uninsured or enrolled in Medicaid into the medical mainstream, measured both in terms of utilization of services and their health and functional status. . . . The patients . . . appear to be as well off or better off than they were before TennCare implementation."

Sloan FA et al. Medicaid, Managed Care, and the Care of Patients Hospitalized for Acute Myocardial Infarction. *American Heart Journal* 139 (April): 567–576,2000.

Cigarette Marketing Influences Teen Smoking

There are many reasons why adolescents start smoking. Is advertising and promotion by the tobacco companies one of them? Although prior studies have shown a link between tobacco marketing and smoking initiation, there has always been the old "chicken and egg" problem. Because of the snapshot nature of studies — which look at smoking rates and marketing during a single time period — it's not possible to determine which came first: the smoking or the receptivity to cigarette marketing.

In this study, the investigators used a longitudinal study to examine the link between marketing and teen smoking. According to the researchers, this is one of just two longitudinal studies conducted in the United States that addresses this issue.

In 1993, the study team surveyed more than 1,000 Massachusetts teens about their smoking habits. The adolescents were also asked whether they owned clothing, hats, bags, or other items promoting a tobacco company; and to identify the cigarette brand advertising that most attracted their attention. Teens were classified as highly, moderately, or not very receptive to tobacco marketing based on their responses. Adolescents also provided interviewers with demographic information, told them how many of their friends smoke, and answered a number of questions that gauged their rebelliousness. Information about whether the adults in their household smoke was available from an earlier household interview with an adult family member.

In 1997,the investigators re-surveyed more than 500 teens who had reported being non-smokers in the 1993 survey. Over the 4-year period, 21% of the adolescents had become established smokers, defined as smoking 100 or more cigarettes during the period. Among teens ranked as highly receptive to tobacco marketing in the 1993 survey, 46% had become established smokers. In contrast,18% and 14% of teens with moderate or low receptivity to tobacco marketing, respectively, had become smokers. Although adolescents with smoking friends and family members, those who scored high in rebelliousness, and teens who had experimented with smoking once were more likely to become smokers, receptivity to tobacco marketing by itself was an accurate predictor of progressing from non-smoker to smoker status. Even among teens who had never taken a puff of a cigarette, 29% of those highly receptive to tobacco marketing became smokers over the 4-year period.

The authors conclude: "Because these images hold the power to influence adolescent behavior, a more comprehensive restriction on image advertising is warranted."

Biener L and Siegel M. Tobacco Marketing and Adolescent Smoking: More Support for a Causal Inference. *American Journal of Public Health* 90 (March): 407–411,2000.

Characteristics of Youths by Receptivity to Tobacco Marketing and Progression to Smoking

	Receptivity to Tobacco Marketing in 1993			Became Established Smoker by 1997		
	Low (n=121)	Medium (n=342)	High (n=66)	Yes (n=110)	No (n=419)	Total (n=529)
Household income $						
≤50,000	42.3%	42.2%	35.3%	40.7%	41.5%	41.3%
>50,000	57.7	57.8	64.7	59.3	58.5	58.7
At least 1 adult smoker in household						
Yes	29.8%	36.8%	51.5%	50.0%	33.7%	37.1%
No	70.2	63.2	48.5	50.0	66.3	62.9
At least 1 close friend who smokes						
Yes	51.2%	60.5%	78.8%	79.1%	55.8%	60.7%
No	48.8	39.5	21.2	20.9	44.2	39.3
Baseline smoking status						
Confirmed nonsmoker	64.5%	54.0%	42.4%	31.2%	61.1%	54.9%
Ambivalent nonsmoker	24.0	21.1	15.2	18.3	21.7	21.0
Early experimenter	11.6	24.9	42..4	50.5	17.2	24.1
Rebelliousness						
Low	66.7%	47.4%	27.7%	32.1%	53.8%	49.3%
High	33.3	52.6	72.3	67.9	46.2	50.7

Stopping Tobacco Sales to Minors: The Vital Components of an Enforcement Program

Today, it is illegal for anyone under 18 to buy cigarettes or other tobacco products in all 50 states. Over the past decade, to avoid losing federal funds,states have enacted legislation prohibiting tobacco sales to minors, conducted annual compliance checks of tobacco vendors, and levied penalties against violators.

The intended outcome of strict enforcement of youth access laws is a decrease in smoking rates among pre-teens and young adolescents. In this study, investigators gathered information on the components necessary for a program to adequately enforce these laws. They mailed a 10-page questionnaire to 20 experts not employed by a governmental agency who had administered or evaluated a youth access enforcement program. Of those individuals, 17 completed and returned the questionnaire.

The questionnaire was divided into three sections. The first section asked respondents about the ideal structure for compliance checks; the second asked them about penalty structures; and the third queried respondents on the potential impact of youth access laws on youth smoking rates. Using their expertise, respondents were asked to answer the questions based on how they feel enforcement should be designed and carried out — and not be limited by how enforcement is currently conducted in their particular geographic area.

Overall, the survey respondents felt that at least 90% of merchants who sell tobacco products must comply with youth access laws in order for these laws to have an impact on smoking rates among teens. To achieve 90% compliance requires a strong enforcement program. Participants generally agreed that some of the components vital to such a program include:

- Checkers — the youths who enter stores to attempt to purchase tobacco in order to monitor vendor compliance — should be at least 16 years old, include both males and females, represent the community's ethnicity, and "look like the typical buyer."
- Checker training programs that provide instruction on safety, role-play on approaching a clerk, and background on the purpose of the program.
- For safety and feedback purposes, checker teams of two, including one adult.
- Compliance checks at least twice a year of all stores that sell tobacco products.
- More frequent compliance checks of violators and those establishments where youths are more likely to purchase cigarettes, such as convenience stores, small independent stores, and gas stations.
- A penalty structure that includes increasing fines for each subsequent violation and license suspension or revocation after 3 or 4 fines.
- Publicity using newspaper, television, and radio to increase merchants' awareness of the laws, the compliance checks, and the penalties for violations.
- An education program to teach merchants how to check IDs and train their employees.

According to the authors, "A recurring theme in the responses was the tradeoff between balancing effective compliance . . . with the political realities of community backlash, the need for community support, and the safety of the youth checker." A need for other public policies, such as taxes and media campaigns, also was expressed.

Levy DT, Chaloupka F, and Slater S. Expert Opinions on Optimal Enforcement of Minimum Purchase Age Laws for Tobacco. *Journal of Public Health Management Practice* 6 (May): 107–114,2000.

Ethnic Differences in HIV Survival Not Easily Explained

Death rates from HIV disease are higher among minority groups than in whites, possibly because of poorer access to medical care. This study looked at 6-year survival among 200 patients of different ethnic groups who were hospitalized for an HIV-related illness between 1992 and 1998 in the Los Angeles area. The researchers specifically wanted to examine if blacks' and Hispanics' survival was shorter than whites', and if access to care played a role in survival differences.

They measured access to general care by five criteria: insurance status (private, public, Veterans Administration, or uninsured); having a regular physician or clinic for routine care; the patient's rating of difficulty or ease in obtaining medical care; hospital type (public, Veterans Administration, or private); and utilization of services (number of outpatient visits recalled in the past year and number of prior hospitalizations).

The researchers defined AIDS-specific treatment as the use of any one of the antiretroviral medications available in 1992, combination antiretroviral medication, or preventive medications for *Pneumocystis carinii pneumonia*. They also measured the severity of the HIV disease and recorded CD4 cell counts.

In this study, 95% of the patients were men; 21% were black and 18% were Hispanic. Median survival was 23 months. The 6-year survival rates for blacks and whites were not significantly different, but median survival in Hispanics was at least 8 months shorter than in whites and less than half of blacks' median survival time.

Factors related to access to care did not seem to account for these results — not the AIDS-specific treatment Hispanics received before they were hospitalized nor the type of hospital in which the Hispanic patients were treated.

Hispanics may experience culturally based barriers to care, the researchers suggest, that "may be more subtle and complex than the more traditional concepts of access to care, such as insurance status, that were measured in this study." California Proposition 187 (denying medical care to undocumented immigrants), outright discrimination, and lack of appropriate treatment following hospitalization may also have played a role.

"The poor outcomes for Hispanics with HIV disease are alarming," the researchers wrote. They call for better efforts to extend the benefits of new advances in AIDS treatment to all patients.

Cunningham WE et al. Ethnic and Racial Differences in Long-Term Survival from Hospitalization for HIV Infection. *Journal of Health Care for the Poor and Underserved* 11 (2): 163–178,2000.

OB/GYNs Join Anti-Smoking Fight

Smoking remains the single most significant modifiable cause of poor pregnancy outcomes in the United States. It accounts for 20% of low-birthweight deliveries, 8% of pre-term births, and 5% of prenatal deaths. Yet at least 20% of pregnant women smoke, according to *The Health Benefits of Smoking Cessation: A Report of the Surgeon General, 1990.*

The Robert Wood Johnson Foundation is hoping to improve on that record with a new grant to the American College of Obstetricians and Gynecologists (ACOG). As part of a strategy to reduce the number of pregnant women who smoke, the program, administered through the *Smoke-Free Families* National Dissemination Office, will give obstetricians the tools they need to make smoking cessation counseling and follow-up a routine part of prenatal treatment for all their patients who smoke.

At the core of the ACOG program are pregnancy-specific "best practice" guidelines for counseling patients on smoking cessation, as well as materials and strategies to help pregnant smokers quit. The guidelines were developed over the last 15 years with support from *Smoke-Free Families* and other agencies.

Universal adoption of the program could triple success rates for smoking cessation among pregnant women, according to Cathy L. Melvin, PhD, MPH, director of the dissemination office, which is based at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.

In tests, this best-practice intervention has achieved quit rates of 14 to 16%, compared with 5 to 6% using other methods. The guidelines call for clear, personalized messages about the impact of smoking on mother and fetus. Equally important, the guidelines call for physicians' offices to provide social support and self-help materials to help women stick with their decisions to quit.

ACOG was chosen to disseminate the guidelines for two reasons. First, ACOG has unparalleled reach among medical professionals who provide services to pregnant women. Its members include about 95% of OB/GYNs, 72% of whom practice obstetrics. Obstetricians conduct about 85% of US births.

Second, educating OB/GYNs on standards of care is a major part of ACOG's mission. "We are recognized by our members as a credible source of information. When they get something from us, they look at it. That's one of the reasons we requested funding for this project," says Luella Klein, MD, vice president of ACOG's Division of Women's Health Issues.

ACOG is developing materials and strategies including policy statements, issue briefs, a training manual, office materials for patients and providers, partnerships with other organizations, education programs, and recommendations for medical school curricula and board exams. The goal is for half of OB/GYNs to be using the best-practice intervention routinely by 2003. A survey of ACOG members will be conducted to determine how effective the program is in promoting guideline use.

"Now that the best practices exist, this program will help get them in use," Melvin says. "We're hoping it will help create demand for smoking cessation services among providers and patients."

— HOWARD LARKIN

The 2000 Robert Wood Johnson Community Health Leaders are pictured below, from left to right.

seated:

Melva Jones, RN, runs a successful grass-roots drug intervention program in partnership with local faith leaders in order to get people treatment,housing,food, and job referrals in Baltimore.

Ho'oipo Decambra, head of a drug rehabilitation center, overcame strong staff resistance and bridged cultures to incorporate traditional Hawaiian healing practices into her center's treatment program.

Sharon Rohrbach,RN, created a program to send skilled neonatal nurses into the homes of St.Louis's poorest families to curb preventable infant deaths.

Jocelia Adams, RN, created the first free training program for San Franciscans struggling to provide home care for gravely ill loved ones.

standing:

Timothy Flanigan,MD, set up a care system for at-risk Rhode Island prison inmates;and launched an education project for children of incarcerated and drug-addicted women,and a prison medicine program at Brown University's Miriam Hospital.

Reverend Michael Elliott, MSW, MDiv., forged a partnership among Savannah,Ga., area shelters, hospitals, and government agencies to create shelter-based clinics, a respite care center, and an HIV/AIDS facility.

Sheila J. Webb, RN, MS, the first African American and non-physician to head the New Orleans Health Department, revitalized the city's neighborhood health clinics by working to restore federal funding.

Brenda Butler Hamlett, a heart transplant recipient in Roxbury, Mass.,shares her own experience in outreach efforts to increase organ donations among minorities.

Jose Vargas-Vidot,MD, started a clinic that has grown into one of the most recognized health services in Puerto Rico, offering free health care, housing,and AIDS prevention services.

F. Amos Bailey, MD, mobilized the Birmingham,Ala.,medical community to develop a compassionate end-of-life care facility for disadvantaged residents with terminal illnesses.

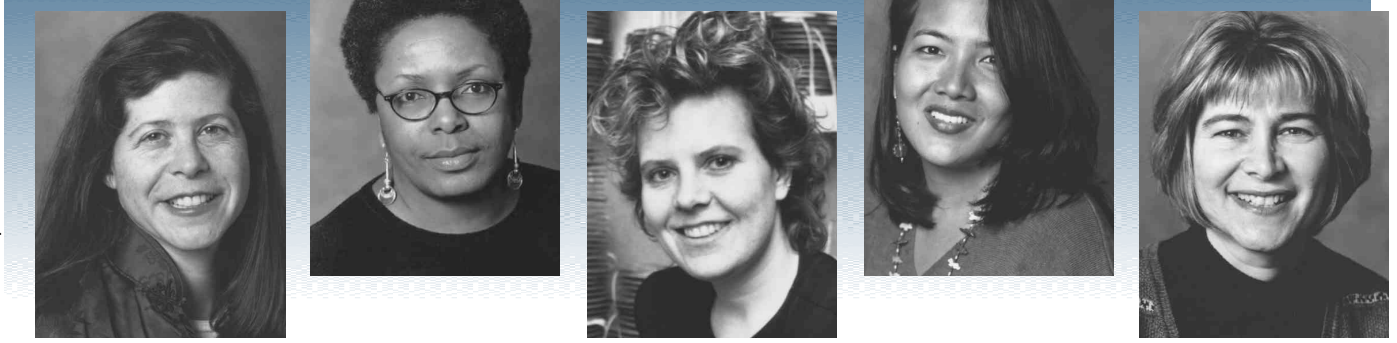
NPR on the Air and on the Web: Extending the Reach of Health Reporting

The American health care system. Its problems. Its challenges. How it's changing and what these changes mean for ordinary Americans. Getting accurate, well-balanced,thought-provoking information to the public about the health system is a daunting task. But it is one that National Public Radio does exceptionally well.

"NPR's effort to reach out and tell the story of how changes in health and health care affect everyday people at the community level is extraordinary," says Victoria Weisfeld, MPH,senior communications officer at The Robert Wood Johnson Foundation."Instead of just doing inside-the-beltway health stories, NPR shows what is happening in communities and to individual people. This philosophy is very much in line with our concerns."

RWJF has supported NPR since 1986. A recent RWJF grant (1996-99) helped to establish NPR's health and health care coverage via the Web <www.npr.org>. Now, a new three-year, $3-million grant will further extend the reach of its health reporting on the Web. It also will enable NPR to reorganize its health and health care coverage so that individual reporters can specialize on a specific beat. One group of reporters will look at a topic from a behavioral/social perspective, another group will examine the health policy and biomedical aspects of the same issue, while another will delve into the actual practice of medicine (such as doctors' dissatisfaction with clinical practice, erosion of trust in health systems, or doctors as business people).

"We have always put a lot of thought and focus on who's getting health care, how they're getting it, what it's like. And also who's not [getting care]," says Anne Gudenkauf, senior editor of NPR's science desk. "Our goal has always been to integrate the coverage of health policy and biomedical research with the way consumers actually experience health care. Many news organizations tend to isolate biomedical research from health care policy, or health care policy from consumers' experiences. Very few — and we have a tough time, too — actually spend much time reporting on consumers' actual experiences with the health care system."



Among NPR's health reporters are, from left to right:Joanne Silberner, Brenda Wilson, Patricia Neighmond, Vicky Que, and Wendy Schmelzer.

"It's very easy, in a journalism or news format, to talk about new research or new legislation," she continues. "But it's very difficult to spend time in a news program chronicling how things are working. It's a less obvious formula for a news story."

Less obvious. But obviously effective.

For example, on a segment of "Morning Edition," NPR's Joanne Silberner took a look at the Navajo Nation's attempts to establish its own health care system. She reported on how the Indian Health Service currently directs how tribe members receive care. Then she spoke to Navajos themselves, who said they would like more control over their health care but are uneasy about change and worried about whether the tribe could afford to employ qualified medical personnel.

"The [multidimensional] approach is critical in giving well-balanced stories," says Gudenkauf. "Over the years, our audience has grown to trust what we're reporting. And that's unusual in the media today. We've achieved a reputation that brings listeners to us with an open and trusting ear. And, in turn, we have to make good on that — tell them what's happening, perfectly accurately."

Apparently the broadcasting industry concurs on the quality of their work. NPR health reporting has won the Alfred I. duPont–Columbia University Award and three Peabody awards for excellence in broadcast journalism.

— SHARI MYCEK

***Critical Condition*, a three-** hour PBS broadcast produced by Pulitzer Prize-winning journalist Hedrick Smith,will air on October 18,8-11 p.m.ET. With principal funding from The Robert Wood Johnson Foundation,the report delivers a patient's report card on the quality, affordability, and availability of health care in the United States. Smith consulted with more than 100 medical experts across the country on a wide range of health issues and offers compelling personal stories from patients of treatment received — and denied — and the lessons to be learned.

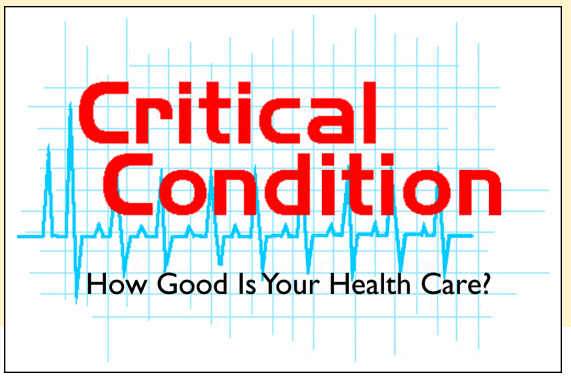
The broadcast special is divided into four segments:

Chronic Care — Can people with chronic illnesses get quality care from a cost-conscious system more oriented to acute care?

Integrated Care — Is managed care delivering on its promise to be more effective at coordinating preventive and long-term care than the old,fragmented fee-for-service system?

The Uninsured — How are their needs being met?

The Hunt for Quality — Is there a serious shortfall between best practice and the care most people get?



A companion Web page, <www.pbs.org/criticalcondition>, will be available beginning September 5.

SELECTED GRANTS

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

- For advancing tobacco control in physician networks, $475,001 to Alliance of Community Health Plans, New Brunswick, N.J.
- For surveying youth smoking cessation needs and practices, $348,759 to Health Research, Buffalo, N.Y.
- For promoting tobacco cessation through managed care dental providers, $315,240 to Oregon Pacific Research Institute, Eugene, Ore.
- For surveying state Medicaid programs' coverage of tobacco dependence treatments, a renewal award of $230,719 to University of California, Berkeley, School of Public Health.
- *Developing Leadership in Reducing Substance Abuse.* Award of $2.7 million to the Foundation of the University of Medicine and Dentistry of New Jersey, Newark.
- *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol.* Renewal awards to two sites, San Antonio, Texas, and Vallejo, Calif., totaling $2 million.
- *Innovators Combating Substance Abuse* and *Developing Leadership in Reducing Substance Abuse.* For communications activities for the programs, $339,150 to the Foundation of the University of Medicine and Dentistry of New Jersey, Newark.
- *Partners in Tobacco-Use Research: A Transdisciplinary Approach to Advance Science and Policy Studies.* Awards to six sites, totaling $992,325.
- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy.* For the Smoke-Free Families National Dissemination Office, a renewal award of $1.2 million to University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
- *SmokeLess States: Statewide Tobacco Prevention and Control Initiatives.* Renewal awards to three sites, totaling $474,605.

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

- For monitoring the uninsured: the states' perspective, $4 million to University of Minnesota School of Public Health, Minneapolis.
- For the Medical Access Card pilot program, $198,360 to L.A. Care Health Plan, Los Angeles.
- For consumer information on access to coverage, a renewal award of $749,966 to Georgetown University Medical Center, Washington, D.C.
- *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children.* One award of $599,972 to South Dakota, Community HealthCare Association, Sioux Falls.
- *Southern Rural Access Program.* Renewal awards to two sites, totaling $1.9 million.

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

- For preparing the monthly *Journal of the American Medical Association* series on chronic illness, "Clinical Crossroads," $759,014 to Beth Israel Deaconess Medical Center, Boston.
- For producing a Fred Friendly seminar on chronic care, $1.2 million to Fred Friendly Seminars, New York, N.Y.
- For analyzing quality of care under varying features of managed care organizations, $529,726 to University of California, Los Angeles.
- For promoting evidence-based clinical and supportive services for persons with serious mental illness, $150,000 to Dartmouth Medical School, Hanover, N.H.
- For examining the validity and usefulness of the Internet as a tool for collecting and providing health information, $394,584 to FACCT, Portland, Ore.
- For studying community service organizations' programs for older adults, $220,577 to National Council on the Aging, Washington, D.C.
- For assessing patient perceptions of behavioral health services in New Jersey HMOs, $229,387 to State of New Jersey Department of Health and Senior Services, Trenton.
- For medical decision-making for contemporary practice: a national faculty development program, $741,472 to Stanford University School of Medicine, Stanford, Calif.
- *Strengthening the Patient-Provider Relationship in a Changing Health Care Environment.* Award of two grants, totaling $509,374.
- *Targeted End-of-Life Projects Initiative.* Award of two grants, totaling $1.2 million.

Other Programs and Those That Cut Across Foundation Goals

- For evaluating the long-term effects of the Child Health Initiative in Monroe County, $278,191 to University of California, Los Angeles, School of Public Health.
- For predicting and preventing child neglect, $750,000 to University of Notre Dame, Notre Dame, Ind.
- For evaluating a model program for mentoring high-risk children, $298,200 to Public Private Ventures, Philadelphia.
- For the Newark (N.J.) Violence Prevention Project, $200,000 to Rutgers, The State University, School of Criminal Justice.
- For developing a model abstinence-based, health-risk prevention program for young teen girls, $600,000 to Best Friends Foundation, Washington, D.C.
- For the Interfaith Health Program — Phase III, $449,999 to Emory University, The Rollins School of Public Health, Atlanta.
- For evaluating a program to prevent teenage pregnancy and promote youth development, $500,000 to Girls Incorporated, Indianapolis.
- For a campaign to mobilize the community to address the needs of children, $500,000 to The Greater Kansas City Community Foundation, Kansas City, Mo.
- *Turning Point: Collaborating for a New Century in Public Health.* Awards to seven sites, totaling $1.7 million.
- For mapping and disseminating micro-systems in health care, $488,809 to Dartmouth-Hitchcock Medical Center, Hanover, N.H.
- For expanding and evaluating "Genetics and Your Practice" curriculum, $746,656 to March of Dimes Birth Defects Foundation, White Plains, N.Y.
- For expanding the new genetics: interactive courseware for physicians, $193,003 to Stanford University Center for Biomedical Ethics.
- For Marketplace radio's Health Desk on health and health care issues, $744,998 to WGBH Educational Foundation, Boston.
- For New Jersey policy forums on health and medical care, a renewal award of $648,858 to The Forums Institute for Public Policy, Princeton, N.J.
- *Generalist Physician Faculty Scholars Program.* Awards to 15 sites, totaling $3.5 million.
- *Health Tracking.* For a study of physician organizations and the management of chronic illness, a renewal award of $2.1 million to University of California, Berkeley, School of Public Health.
- *Investigator Awards in Health Policy Research.* Awards to seven sites, totaling $1.7 million.
- *Multistate Initiative to Help Build a Health Information Infrastructure.* Award of $1.7 million to Foundation for Health Care Quality, Seattle.
- *Changes in Health Care Financing and Organization.* Awards to eight sites, totaling $3.5 million.
- *Minority Medical Education Program.* Awards to three sites, totaling $4.5 million.
- *Minority Medical Faculty Development Program.* Awards to six sites, totaling $2.2 million.
- *The Robert Wood Johnson Clinical Scholars Program.* Renewal awards to seven sites to support the 2000-2002 cohort of Scholars, totaling $4.7 million.
- *Robert Wood Johnson Health Policy Fellowships Program.* Awards to five sites, totaling $430,943.
- For studying the public health consequences of Hurricane Floyd, $411,267 to State of North Carolina Department of Health and Human Services, Raleigh.
- For promoting synergy among local grantees, $287,702 George Washington University Medical Center, Washington, D.C.
- For a camping program for health-impaired children, a renewal award of $322,170 to Middlesex County Recreation Council (John E. Toolan Kiddie Keep Well Camp), Edison, N.J.
- For a revitalization program for the city of New Brunswick, N.J., a renewal award of $300,000.

New Grant Results Reports Posted on RWJF Web Site

Thirty-five new Grant Results Reports and two new National Program Reports have been posted on the RWJF Web site <www.rwjf.org> under *Grant Outcomes & Related Publications.* These include:

- Program to Monitor the Effects of AIDS on Hospitals. The National Public Health and Hospital Institute (NPHHI) in Washington, D.C., conducted six surveys of US hospitals that documented the impact of HIV/AIDS on the nation's hospitals,especially safety-net providers,from 1985 to 1993. The Foundation made three grants to NPHHI that totaled $1.1 million and ran between January 1988 and December 1997. The surveys provided the first national profile of hospital services used by AIDS patients, and the cost and financing of these services,including regional variances.

  A 1987 *Journal of the American Medical Association* article on the survey by the project director concluded: "Our results portend possibly catastrophic effects on both government and private payers as health care costs of AIDS escalate. . . . The nation's major teaching hospitals and large city public institutions bear a disproportionate burden of care for cases of AIDS." The 1987 survey revealed that fewer than 5% of hospitals treated more than 50% of the identified AIDS cases. Public hospitals in the Northeast and South lost the most — more than $600,000 per facility. For public hospitals, revenues covered only 14% of outpatient costs. Since 1989, however, the surveys showed decreasing hospital utilization rates for HIV patients, that the federal sector was paying for an increasing portion of the cost of care, and that hospitals had reduced their losses per patient.

  In 1988 and 1989, the principal investigator presented testimony before the National Commission on the HIV Epidemic, which decided to use the project's figures on the hospital cost-per-day for HIV/AIDS care as the national figure. In 1991, he was asked by congressional staff to discuss the burden of inpatient care for HIV/AIDS on hospitals and the potential value of setting up a way to spread the responsibility into the community. The Ryan White Emergency Care Act of 1992 provided a federal mechanism to fund community-based HIV/AIDS care.
  Contact: Dennis P. Andrulis, PhD, (718) 270-7726, dandrulis @netmail.hscbklyn.edu.

- Study to Identify Modifiable Workplace Factors Affecting Alcohol Abuse and Disseminate the Results. Researchers at Harvard University School of Public Health examined a broad array of policy, work culture,job design, and psychosocial variables that affect employees' use and abuse of alcohol. A Foundation grant of $1.1 million,from September 1991 through June 1996, supported this study, which confirmed the growing consensus among social scientists and others that the workplace offers a priority site for efforts to prevent alcohol problems. Seven Fortune 500 companies with 114 work sites participated in the study, which was co-funded by the National Institute on Alcohol Abuse and Alcoholism.

  The study's findings contradicted some beliefs widely held by corporate executives and senior managers concerning alcohol issues in their companies. These include beliefs that: alcohol-related work performance problems are caused mostly by a few alcohol-dependent employees; work performance suffers only among employees who drink on the job;hourly workers are more likely to drink during work hours than managers or supervisors;current policies that deal with alcohol-dependent drinkers are effective; companies have little influence on the drinking behavior of employees away from work; and workers perceive additional company interventions regarding alcohol behaviors as intrusive.

  In contrast, the study found that 60% of alcohol-related work performance problems are associated with nondependent drinkers — people who occasionally drink too much and constitute 80% of all drinkers; drinking immediately before or during working hours and heavy drinking the night before contribute significantly to work performance problems;upper-level managers are more likely to drink during the workday than first-line supervisors or hourly workers;managers and supervisors report a variety of organizational,interpersonal,and individual barriers to implementing corporate alcohol policies and procedures; workplace culture has the potential to influence drinking behavior both at work and beyond the workplace; and there is broad support among managers, supervisors,and hourly workers for assisting employees whose drinking behavior causes problems for themselves,their co-workers, or the company.
  Contact: Marianne Lee,MPA (617) 525-2732 or Thomas W. Mangione, PhD (617) 482-9485.

These new postings bring the total available on the Web to 282 Grant Results Reports and 15 National Program Reports, covering 689 grants.

— **Molly McKaughan**

People

Welcome

Carol Chang, MPA, MPH, joined the Foundation in July as a program associate in the Research and Evaluation Unit. Prior to joining RWJF, Chang was an analyst at Merck Medco in Parsippany, N.J.

Jean J. Lim, MPP, began working at the Foundation in June as a program associate in the Program Office. Before coming to RWJF, Lim held the position of policy analyst at the National Center for Education in Maternal & Child Health, Arlington, Va.

Kristin Schubert, MPH, joined RWJF in June as a program associate in the Program Office. Prior to coming to the Foundation, she was a health policy analyst for the Yale-Griffin Prevention Research Center, Derby, Conn., while obtaining her MPH from Yale University School of Public Health.

Farewell

Elize M. Brown, JD, a program officer in the Program Office, left the Foundation in August to pursue her doctorate in public health at the University of California at Berkeley, School of Public Health. Brown also was awarded a postdoctoral fellowship by the Behavioral Factors in Epidemiology Training program, funded by the National Institutes of Health.