ADVANCES®
The Robert Wood Johnson Foundation Quarterly Newsletter

INSIDE THIS ISSUE

Promoting Exercise to California Seniors PAGE 4

2001 RWJ Community Health Leaders Named PAGE 9

Excellence In End-of-Life Care Honored PAGE 10

FEATURES

ISSUE 3, 2001

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

America, Get Moving: A Call to Action

Taking a walk in many communities in the United States can be a challenge these days — sidewalks are rare or nonexistent and wide suburban roads are difficult to navigate on foot. To compound matters, stores, movie theaters, and restaurants often are specifically designed to be reached by car and not by walking.

"In the past fifty years or so, we've essentially engineered physical activity out of our daily lives," says Michael McGinnis, MD, senior vice president of The Robert Wood Johnson Foundation and director of its Health Group. "From the way buildings and communities are designed to the dependence on the car for transportation to the advent of television and computers, we've become more passive than active in the way we live."

Indeed, statistics show that few Americans make physical activity a regular part of their lives. More than 60% of adults are inactive or underactive. (See chart at right.) Nearly half of America's youth aged 12 to 21 are not vigorously active on a regular basis. This inactivity is believed to be a precursor to serious health problems such as obesity and diabetes, which have reached epidemic proportions among adults and children. And a growing body of scientific evidence shows that regular physical activity can have a protective effect, reducing the risk of developing and mediating secondary disease complications associated with diabetes, high blood pressure, cardiovascular disease, and colon cancer. Physical activity also can reduce feelings of depression and anxiety, help control weight, maintain healthy bones and muscles, and promote psychological well-being, according to the US Surgeon General's report, *Physical Activity and Health* <www.cdc.gov/nccdphp/sgr/sgr.htm>.

This growing evidence is the reason why RWJF, for the first time, is developing programs aimed at improving health through physical activity. (See also story *Fourth RWJF Goal*, page 3.)

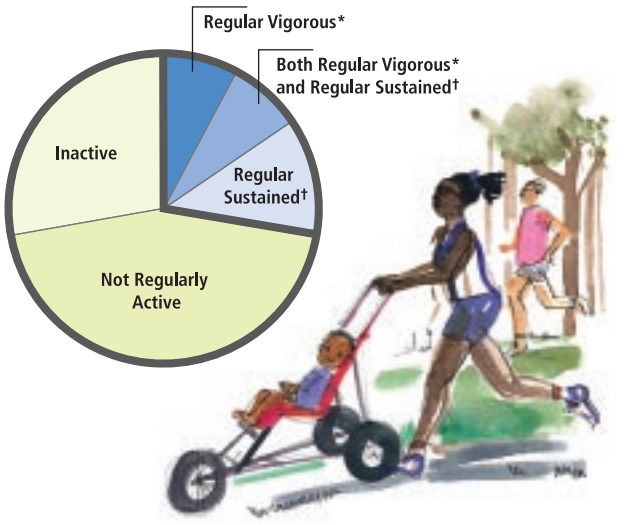
"The Foundation has focused on the behavioral determinants of health for over a decade through its major efforts in tobacco, alcohol, and drug use," says Tracy Orleans, PhD, RWJF senior scientist and head of the Health and Behavior Program Management Team. "Now we can apply similar approaches to promoting physical activity, spurred by new science showing that even 30 minutes of moderate activity a day — like walking, gardening, or taking the stairs instead of the elevator — can bring dramatic health benefits throughout the life span."

The team's goals are to:

- Increase the number of communities with programs, policies, and environments that promote active lifestyles.
- Increase physical activity levels of sedentary adults age 50 and older.
- Integrate health behavior counseling into routine medical care.

See **Physical Activity** — page 2

Adults and Physical Activity



* Regular Vigorous — 20 minutes 3 times per week of vigorous intensity
† Regular Sustained — 30 minutes 5 times per week of any intensity
Source: *Physical Activity and Health: A Report of the Surgeon General*, 1996

ADVANCES®

PRESIDENT
Steven A. Schroeder, MD

EXECUTIVE VICE PRESIDENT
Lewis G. Sandy, MD

VICE PRESIDENT FOR COMMUNICATIONS
Frank Karel

EXECUTIVE EDITOR
Paul Tarini

MANAGING EDITOR
Trish Krotowski

ASSISTANT MANAGING EDITOR
Hedda Colossi

PRODUCTION ASSOCIATE
Joan Barlow

WRITERS, *ABridge*
Barbara Bekiesz
Karin Gillespie

DESIGN
DBA Design
Cambridge, MA
www.dbadesign.com

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

THE ROBERT WOOD JOHNSON FOUNDATION®

From **Physical Activity** — page 1

"These strategies require developing programs and partnerships both within and outside the health care sector," says Orleans. "Our focus on broad determinants of physical activity — environmental and individual — is designed to complement and add value to the important work of other funders and public health leaders."

In the year 2000, the effort's first year, the Foundation committed about $17 million to the three strategies. In 2001, RWJF plans to invest more than $50 million, launching national programs under each of the three objectives. Annual budgets for future years may range from $30 million to $60 million.

"We're making a major commitment because this issue is so important to the health of Americans," says McGinnis. "This is not an easy task, but consider that 35 years ago, some people thought getting people to stop smoking would be nearly impossible. We have a fair distance to go with tobacco control, but we've made much progress."

The three strategies of the Foundation's physical activity efforts are outlined below.

CREATING ACTIVITY-FRIENDLY COMMUNITIES AND PHYSICAL ENVIRONMENTS

The places in which we live, work, and play have significant impact on our health and on our ability to engage in routine moderate physical activity. Therefore, community leaders and professionals must be engaged in any attempt to work with health professionals to encourage and develop activity-friendly communities, says Marla Hollander, RWJF program associate.

To that end, a national seminar program is planned to bring together professionals from architecture, transportation, community planning, and public health, to build new cross-sector awareness of the relationship between community design and health outcomes.

A four-year, $12.5-million national program, to be launched in October 2001 and based at San Diego State University, will support research to identify creative policy and environmental approaches to engineering activity back into our everyday lives, from making communities safer for walking and bicycling, to requiring larger amounts of physical education in schools.

Another component of this strategy is a five-year, $16.5-million national program, authorized in July 2001, to develop model programs in a diverse group of communities, including low-income housing projects, to increase population-wide activity levels. This program will build health-based initiatives into ongoing community design efforts (Smart Growth, Livable Communities), leveraging the growing momentum and financial support these movements have created. It also builds on lessons learned from a number of RWJF-funded pilot programs, including two community redesign and activity-promoting initiatives in Wray, Colo., and Durham, N.C., explain Kate Kraft, PhD, and Karen Gerlach, PhD, RWJF senior program officers.

INCREASING PHYSICAL ACTIVITY LEVELS OF ADULTS 50-PLUS

With one baby boomer turning 50 every 8 seconds, there is a great need for programs aimed at mid-life and older adults who are among the least active Americans. The Foundation, along with five partner agencies, has developed the *National Blueprint on Physical Activity Among Adults Age 50 and Older* for organizations, associations, and agencies to plan strategies to help adults 50 and older increase their physical activity. (See <www.rwjf.org>, click on Publications and Links, then choose Other Publications.)

Another component of this strategy is a four-year, $17-million national program, authorized April 2001, in partnership with Texas A & M University's School of Rural Public Health and AARP, to encourage older adults to increase physical activity and to expand research-based programs into diverse real-world settings.

"Many small studies show the benefits of certain structured physical activity programs and policies on midlife and older adults" says Robin Mockenhaupt, PhD, RWJF program officer. "But much of this research has not been translated into the real world — to senior or community centers — or expanded to include minority populations. And there are many senior centers running physical activity programs that have not been tested to see if they are effective," says Mockenhaupt. "We're trying to bring these two pieces together: To translate proven activity programs into the community setting and to study untested programs that are already out there."

INTEGRATING HEALTH BEHAVIOR COUNSELING INTO ROUTINE MEDICAL CARE

RWJF is funding a number of programs aimed at helping providers incorporate evidence-based health behavior counseling into routine primary care, explains Susan Hassmiller, RN, PhD, RWJF senior program officer.

Among the projects are model programs that address lack of physical activity along with other behavioral health risks, such as a two-year demonstration project in which physicians, nurses, and others give personalized exercise, diet, and tobacco prescriptions to the low-income populations served by the Hope and Healing Center in Memphis, Tenn. Another, a demonstration project at Brown University's Miriam Hospital, is testing a novel computer-based prevention system addressing both physical activity and tobacco cessation.

"It's become clear in recent years how essential physical activity is to maintaining good health," says McGinnis. "Given the magnitude of the issue, we thought it made sense for the Foundation to provide strong, ongoing leadership in this area."

— LAURIE JONES

Changing the Environment: Binge Drinking at College

Two out of five college students (44%) are binge drinkers (drinking five or more drinks in a row for a male; four or more for a female at least once in a two-week period), according to the 1999 Harvard College Alcohol Study. Binge drinkers are more likely than other students to experience alcohol-related problems, including driving after drinking (40% versus 19%), getting hurt or injured (11% versus 4%), or getting behind in school (26% versus 10%). And it is not just the drinkers themselves that are hurt. Binge drinking's secondhand effects include assault, sexual assault, and property damage, among others.

In 1995, The Robert Wood Johnson Foundation began action to reduce binge drinking and its consequences with authorization of its national program *A Matter of Degree: Reducing High-Risk Drinking Among College Students* (*AMOD*). But more remains to be done and learned. To renew its commitment, the RWJF Board of Trustees has approved three major grants in this area.

The first, a $7.5-million renewal, offers up to four more years of funding to further implement the prevention models developed by the ten *AMOD* sites (the Universities of Colorado at Boulder, Delaware, Iowa, Nebraska at Lincoln, Vermont, and Wisconsin at Madison; Florida State University; Georgia Institute of Technology; Lehigh University; and Louisiana State University).

"We have seen the universities start to think of themselves as agents of change," says Richard Yoast, PhD, director of the *AMOD* National Program Office at the American Medical Association in Chicago. "But we were overly optimistic about how quickly all of this change would occur."

A second grant, $2.4 million to Harvard University School of Public Health, will allow researchers to continue evaluating the *AMOD* program's efforts.

A third grant, $5.1 million to the Higher Education Center for Alcohol and Other Drug Prevention (Newton, Mass.), will be used to bring schools together through statewide coalitions that encourage campus-community cooperation to change local environments and deter binge drinking.

AMOD leaders believe in a broad approach that includes changing those factors in students' environments that enable or encourage binge drinking, including widespread availability of alcohol and a lack of alcohol-free activities. It is an approach that involves both the campus and its surrounding community. The University of Iowa, for example, supported a $300 underage possession fine and the University of Wisconsin negotiated terms with a new blues bar in town that

See **Binge Drinking** — page 12

Fourth RWJF Goal Added

The Foundation has broadened its grantmaking focus to include a new goal: to promote healthy communities and lifestyles. When the Foundation first organized itself into two groups — health and health care in 1999 — the health group focused largely on substance abuse issues; today, the group more broadly includes initiatives that promote physical activity and social interaction.

"Our health behaviors and the circumstances in which we live — whether we exercise, eat healthy foods, drink to excess, or smoke, for example, and the degree to which we're connected with others — have the greatest influence on our health status — whether we are healthy or ill," says Steven A. Schroeder, MD, RWJF president and CEO. "Mindful of the Foundation's mission 'to improve the health and health care of all Americans,' we feel that it's important to widen our net in addressing the non-medical factors that affect health."

In addition to its new goal to promote healthy communities and lifestyles, the Foundation continues its commitment to improve access to care, to improve care and support for people with chronic health conditions, and to reduce the harms caused by substance abuse.

RWJF President to Retire in 2002

The Robert Wood Johnson Foundation has formed a search committee to identify a new president to replace Steven A. Schroeder, MD, who intends to retire at the end of 2002. Schroeder announced his retirement plans at the July meeting of the RWJF Board of Trustees.

"Filling Steve's shoes will be a tremendous challenge," says Robert E. Campbell, board chairman, who will lead the search committee. "Under Steve's leadership, we've strengthened the anti-tobacco movement, for example, and we've fostered substantial progress on end-of-life care and health insurance for children. We're very excited about our new involvement in behavioral health — not only substance abuse, but also exercise and the other behavior changes that will help Americans live longer, healthier, and better lives."

Schroeder came to RWJF from the University of California, San Francisco, where he was a professor of medicine and chief of the division of general internal medicine. He plans to return to the UCSF faculty.

"Leading the Foundation has been exhilarating from day one," Schroeder says. "First of all, we try to tackle big ideas, important problems. And we are able to work with the very best people in the country. Foundations don't solve problems by themselves. We identify promising approaches, and we focus attention on issues. But other people — many others — do the heavy lifting. Helping them in their endeavors over the past 11 years has been a privilege for me."

Steven Hooker, PhD

While the image of California fitness may be of hard bodies playing beach volleyball, more than 50% of Californians are actually couch potatoes. The state's Department of Health Services estimates that a sedentary lifestyle causes more than 25,000 deaths each year, with older residents at especially high risk. To get Californians over age 50 off their couches and on their feet, RWJF is funding the Active Aging Community Task Force Project, a joint effort of the California Department of Health Services and the University of California, San Francisco, Institute for Health and Aging. In this interview with *Advances*, project coordinator Steven Hooker, PhD, talks about finding new, effec-tive ways to get seniors moving again.

Even the young and fit can find it difficult to stick to an organized exercise program over the long haul. How do you promote this kind of basic, long-term behavior change in individuals who may have been sedentary for decades?

Hooker — People have to have fun. You need to recognize birthdays and throw holiday tea parties. The physical activity becomes almost secondary to the social aspect, older adults being together and sharing. You've also got to give them ongoing support, education, and encouragement. That could come from a support buddy or mentor, or it could come from the person who is running the program and keeps track of who's there and who's not. You have to work with them for a year or so. Then you hope that, over time, people will be with you long enough to feel confident and have the skills to do it on their own.

Your program gives participants a goal of at least 30 minutes of moderate activity most days of the week. Is that really enough to provide true physical fitness?

Hooker — It's enough to improve health. Too many people have that all-or-nothing philosophy: "If I'm not able to put in the time and effort to be sleek and firm and tan, then it's not worth it." But more and more research suggests that moderate levels of activity may have significant health benefits for most individuals. With seniors, we're talking about attaining some very simple physical goals. I get cards and letters from program participants who simply talk about how much better they feel about waking up every morning. They're able to walk more confidently. They feel like going out and being social more often. There are a lot of psychosocial benefits, beyond strictly "physical fitness."

What are some of the most common barriers to physical activity for seniors?

Hooker — I think they've heard some of the myths, like "No pain, no gain." We have to work to communicate the potential benefits of moderate physical activity and make it very applicable to their real-life situation. For example, if we ask a group of older adults, "What are some things you used to be able to do that you don't do now?" they'll come up with a host of responses: "I can't carry things in from my car . . . I can't get upstairs as easily as I used to . . . I can't pick something up off the floor." Then we show them how exercise will improve their ability to do those daily functional tasks. In our research, we've found that seniors want to know what's in it for them. They strongly state that being active so they'll live longer for their kids or grandkids is not a motivating factor. They want to know, "How is this going to benefit me emotionally, socially, and functionally?"

Can you really persuade people that you're never too old to be active, even if you haven't exercised for years?

Hooker — It's not easy. These people may have very low self-esteem, low self-confidence. We really need to fit the program to the person; one size doesn't fit all. We also need to give a lot of support and encouragement, to help them overcome their specific emotional and social barriers. Most programs don't offer that. They're having aerobics class on Monday, Wednesday, and Friday at 10, and if you go, and have the right clothes, and know the steps, you're going to feel comfortable. That approach is not going to meet the needs of most people.

What types of exercise programs are most important for seniors?

Hooker — We're really focusing on strength-training programs. A lot of other programs involve cardiovascular activity and a flexibility and stretching component, but they don't always incorporate the strength-training aspect. But it's important because when people are not active, they lose both bone and muscle mass. By incorporating strength training, we're able to address that de-conditioning. You can see some pretty dramatic improvements in strength, even if you train just twice a week.

What role does peer support from other seniors play in these programs?

Hooker — It's great if you have some champions in the community. I'm talking about people who look like you and dress like you, yet who have found a way to integrate physical activity into their lives. With a peer, there's a natural connection, a lot more in common to joke about and talk about and share. But in some of our programs, high school students have served very successfully as support buddies for seniors. It's all based on a person's interests and enthusiasm and personality.

The elderly who most need these programs, those who are isolated or housebound, are also those most difficult to reach. How do community-based programs find and serve those individuals?

Hooker — At the local level, we work with our aging network, those who go into homes and provide services to the isolated. They might invite them to attend a class, or provide home-based resources, such as a videotape, with follow-up, support, and encouragement. Sometimes the person who goes into the home helps to find transportation to get to the program, if that's a barrier. They act as troubleshooters, to find solutions to those barriers.

— Interview by Elizabeth Austin

Providing Quality Diabetes Care in Community Health Centers

Many of the 10 million patients with diabetes in this country receive inadequate health care, which leads to complications and high medical costs. This is true across a variety of settings, from academic health centers and health maintenance organizations to community health centers (CHCs). This study examined the barriers to providing quality chronic disease management for diabetic patients in CHCs, which typically serve a more economically disadvantaged and less educated population.

According to the authors, "managing vulnerable patients with chronic disease longitudinally in the outpatient setting is one of the most fundamental and difficult challenges for health centers and, indeed, for much of primary care."

The management of diabetes is particularly demanding because it requires a working partnership between patient and provider — to coordinate specialist care, monitor changes in glucose levels, screen for eye and foot complications, and check for early signs of kidney disease. While physicians monitor the vicissitudes of diabetes on a routine but more sporadic basis during regular checkups, patients must monitor their glucose levels daily, maintain a balanced diet, exercise, and take their medications to prevent further complications from the disease. With education about the nature of their disease and its treatment, patients can manage their diabetes more effectively.

Do CHCs face unique challenges in delivering quality diabetes care because of the population they serve? Using a mailed questionnaire, researchers posed this question to clinicians and administrators in 42 CHCs that care for indigent patients in 10 Midwestern states. Several years before the survey, this particular CHC network had identified diabetes as their top priority for quality improvement. Clinicians implemented annual chart audits of patients with diabetes and disseminated practice guidelines of the American Diabetes Association (ADA). The questionnaire focused on 6 processes of care identified in the ADA standards as quality markers: regular home monitoring of glucose levels, tests measuring hemoglobin A1c changes, comprehensive eye exams, foot exams, diet monitoring, and exercise.

The 279 survey respondents included 204 providers (87 physicians, 108 other care providers, and 9 dieticians) and 75 other CHC personnel (administrators, health educators, etc.). Respondents said that all of the processes of care were "very" or "extremely" important in quality diabetes management; however, they felt that patients would rate the importance of these care processes significantly lower. Providers acknowledged their responsibility for routinely performing these care processes and are confident of their ability to do so — with the exception of comprehensive eye exams, which are typically referred to an ophthalmologist. Providers also reported that they feel comfortable instructing patients about diet and exercise but are less confident in their ability to help patients make changes in these areas.

Affordability can be a barrier for home glucose monitoring and comprehensive eye exams, the respondents believe. Also, the time it takes to teach patients how to monitor their glucose at home was considered a barrier. Time constraints additionally may result in care omissions, and providers sometimes forget to order eye exams or examine patients' feet. Many providers reported that language and cultural differences frequently get in the way of educating patients about diabetes and its management. Although providers in urban health centers were more often confronted with language and cultural barriers, they also appear to be more confident of their ability to deal with these barriers.

The authors point to the "discordance" between the importance providers place on diabetes care processes and their perception that patients consider them less crucial as a potential barrier to establishing a solid patient–provider partnership for managing the disease. They suggest that "quality improvement of diabetes care in health centers probably requires a multifactorial approach emphasizing patient education, improved training in behavioral change for providers, and enhanced delivery systems."

Chin MH et al. Barriers to Providing Diabetes Care in Community Health Centers. *Diabetes Care* 24(2): 268–274, 2001.

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

Computers in the ED: Patients Learn While They Wait

Computers allow us to communicate in real time. They can solve complex problems and forecast rainstorms or recessions. But can they get us to work toward changing risky behaviors?

These investigators placed a computer loaded with risk-assessment software in an urban emergency department (ED) — a setting where patients often face long waiting times. The computer program asked patients about their personal health and health-related risks that could be modified by changes in their behavior or lifestyle.

Research assistants stationed in the ED recruited non-urgent, English-speaking adult patients and alternately assigned them to the computer or a control group that received usual care. The 248 patients on the computer used their waiting time to answer 80 to 100 questions, volunteering information on smoking, hypertension, drug use, drinking habits, sexual

behavior, depression, and other health risks. The assessment took approximately 15 minutes to complete.

Patients subsequently received computer-generated, personalized health recommendations and other information they requested. The computer program also created a one-page summary of the patient's health risks and demographic information for the physician.

Most of the patients in the prevention group disclosed at least one significant behavioral risk factor (see table at right). The risk factors disclosed most frequently by patients included suicidal thoughts, smoking, unsafe sex, and inconsistent seat belt use. In addition, almost all of the patients requested information on specific health topics, such as exercise, reducing the risk of a heart attack, decreasing uterine and cervical cancer risks, and early detection of breast cancer.

Research assistants telephoned patients in the study group one week after their ED visit. More than 60% of the patients who used the computer reported receiving advice on how they could improve their health, compared to only 27% of the control group.

These outcomes — the significant number of patients who requested and remembered receiving health information — are encouraging, the authors contend, and "lend support for the use of computer-based technology for screening and health promotion as an adjunct to usual acute care." In addition, the investigators suggest that "the ED setting is conducive to providing a teachable moment for preventive health messages."

Rhodes KV et al. Better Health While You Wait: A Controlled Trial of a Computer-Based Intervention for Screening and Health Promotion in the Emergency Department. *Annals of Emergency Medicine* 37(3): 284–291, 2001.

Dr. Rhodes is a Robert Wood Johnson Clinical Scholar.

Patients Disclosing Behavioral Risks On Computer Questionnaire

Topics and Definitions of Risk Factors	Percent Disclosing*
Overall disclosure of at least 1 behavioral risk factor*	**85**
Use of street drugs†	**13**
Use of street drugs in last 4 weeks	12
History of intravenous drug use	3
Problem drinking†	**19**
Sometimes >4 drinks per day and drinking at least 3 times per week (or)	15
At least 1 positive response to CAGE (test for alcoholism)	16
Cardiovascular behavioral risks†	**37**
Smokes cigarettes	32
History of hypertension and not taking blood pressure medication	13
Major depression†	**35**
Depressed >2 weeks in row in past 12 months	33
Suicidal ideation in last 12 months	13
High-risk sexual behavior†	**33**
Nonuse of condoms *and* at least 1 of the following:	55
History of sexually transmitted disease in past 5 years	23
Partner with sexually transmitted disease in past year	13
>1 sexual partner in past year	19
History of or sexual exposure to prostitution	5
Other injury-prone behaviors†	**62**
Driving within 4 hours of drinking ≥2 alcoholic drinks	11
Does not always use seat belt	40
Does not have/has not checked smoke detector in past year	17
Has handgun in home or car	11
History of witnessing or participating in knife/gun violence	22

* A disclosure was defined as a response of "Yes" to the question but also included "Not sure" responses only in the areas of patient disclosure of suicidal ideation and "No" to questions about taking medication for hypertension or having a smoke detector that has been checked by someone in the past year.

† Summaries.

Assisted Living vs. Nursing Homes: Different Settings but Similar Outcomes

In the 1990s, Oregon established a model for assisted-living facilities that emphasized a full range of services in private, apartment-style accommodations. It was designed as an alternative to nursing home care. Because state regulations can vary greatly in the levels of service and staffing required at assisted-living facilities, this model has raised concerns about quality of care and patient outcomes.

In an effort to compare assisted-living facilities with nursing homes, investigators evaluated residents' pain and discomfort, psychological well-being, and performance of everyday tasks such as eating, dressing, and toileting. A total of 38 assisted-living facilities (605 residents) and 31 nursing homes (610 residents) participated. The investigators interviewed residents or their proxies at baseline, 6 months later, and 1 year later.

In their statistical calculations, the researchers considered factors such as general health, eyesight, and the presence of a serious illness, which could affect the results. They also accounted for the residents' age and how long they had been in the facility.

The investigators reported that while residents in the assisted-living facilities were less disabled than those in the nursing homes, the type of facility did not affect their outcomes over the study year. In both settings, the residents' ability to perform everyday tasks declined at approximately the same rates. Setting did not account for any significant difference in the residents' psychological well-being.

Similarly, although the residents experienced increasing pain and discomfort over the course of the study, neither their initial level nor

the rate of increase was related to the type of facility. On average, women had more pain and discomfort than men at the beginning of the study, and the greatest increase occurred in residents who had a stroke.

Many people might consider nursing homes better at managing pain and discomfort than assisted-living facilities, but this study did not support that opinion. The principal finding was simply that the type of facility had no impact on whether residents improved or deteriorated.

This study's focus on outcomes provides a different perspective on assisted living as an alternative to nursing home care. Even though the residents in assisted living were in better health from the start, the results suggest that a broad range of nursing home patients might receive appropriate care in assisted-living programs.

Frytak JR et al. Outcome Trajectories for Assisted Living and Nursing Facility Residents in Oregon. *Health Services Research* 36(1 Part I): 91–111, 2001.

Can Computers Help Us Eat Better?

"You are what you eat." Most children and adults have heard this mantra from well-meaning relatives, friends, and physicians. And it's a fact: The kinds of foods we eat affect our overall health and our risk of developing a variety of chronic diseases. Unfortunately, many Americans choose to ignore the proven link between nutrition and health. Their diets are high in red meats and saturated fats, and lacking in fruits and vegetables.

Some physicians counsel their patients on altering eating habits, although a lack of training in behavior-change techniques and limited time for office visits conspire against it. Television, radio, and magazine reports encourage adults to eat better and exercise more. Even interactive computer programs offer patients individualized nutritional information and "nonjudgmental feedback." Many researchers have examined the effectiveness of these messages and messengers at improving nutrition. In this recent study, investigators looked at the effectiveness of an interactive, computer-based system with a twist: A "talking computer" delivered information and feedback to adults over the telephone during a 6-month period.

The investigators recruited nearly 300 sedentary adults with poor diets from a multispecialty group practice. Half of the participants were assigned to the talking-computer intervention and half were assigned to a control group. Both groups used the Telephone-Linked Communications (TLC) system, employing computer-mediated, digitized human speech over the phone to ask questions, monitor behavior, and provide education and dietary counseling. Researchers made a home visit to participants to train them on the TLC and instruct them to call the system once a week during the study. The control group used the same TLC system, but the interactions focused on increasing physical activity rather than changing eating habits.

At the start of the study — and again at the 3- and 6-month marks — the researchers assessed patients' eating habits using a detailed questionnaire that took up to 30 minutes to complete and a shorter version that could be completed in 5 minutes. Based on participants' responses, the investigators measured changes in consumption of fruits, vegetables, red and processed meats, whole fat dairy foods, and whole grain foods, and calculated a "global diet quality score" — with 0 being the worst and 100 the best.

Over the 6-month period, the adults in the dietary intervention group increased their fruit consumption by about 1 serving per day. They also ate slightly more vegetables and slightly less red and processed meats, and whole dairy foods. In addition, their global diet quality score was about 9 points better than the control group's score. On average, participants called the TLC system once a month during the study period. Adults who made more calls to the TLC system were more successful in increasing their fruit and dietary fiber consumption and decreasing their intake of saturated fat.

The investigators suggest that an interactive, computer-based telecommunications system may be a cost-effective medium for providing large numbers of people with health education and counseling. They recommend that health plans and providers consider its use as they make "difficult policy decisions . . . concerning the allocation of finite resources for health care."

Delichatsios HK, Friedman RH, Glanz K, Tennstedt S, Smigelski C, Pinto BM, Kelley H, and Gillman MW. Randomized Trial of a "Talking Computer" to Improve Adults' Eating Habits. *American Journal of Health Promotion* 15(4): 215–224, 2001.

Dr. Gillman was a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar at the time of this research.

Patients Unstable at Discharge Most Likely To Be Readmitted to ICU

As intensive care units (ICUs) become more expensive, one approach to controlling their cost is to understand why some patients, once discharged, need to return. If ICU staff could more accurately predict which patients are likely to be readmitted, they might be able to operate the units more effectively.

In this prospective study, researchers examined 4,684 consecutive medical ICU admissions from 1994 to 1998 at a large university hospital. Concentrating on patients who were discharged alive from their first ICU admission, they looked at several aspects of readmission.

The researchers tracked whether readmissions were reoccurrences of the initial disease or new problems, and whether readmissions had occurred within 24, 48, or 72 hours of discharge. Investigators considered the severity of illness at admission and at discharge, and if patients were actively treated in the ICU or only monitored. Finally, they evaluated length of stay and the hospital and ICU mortality rates.

Among the 3,310 patients evaluated, 9.6% were readmitted to the ICU at least once during their hospital stay. About half of the readmissions occurred within 72 hours. Patients who had transferred from another hospital or from a general medical ward were more likely to be readmitted than those who came from the emergency department or ambulatory clinic. Because prior treatments may have failed in these patients, the authors suggested that physicians need better ways to measure response to therapy. Readmitted patients were more likely to need active treatment in the ICU, and they were much sicker and less stable upon admission and at discharge. Some 41% of readmissions were due to a reoccurrence of the initial problem. Overall, the patients who were readmitted fared worse than those who were not: They stayed twice as long in the hospital and had a mortality rate 11 times higher. Mortality was higher when readmission was for the original medical problem.

The patient's severity of illness at the time of the initial ICU discharge was the most important predictor of readmission. The authors observed that "diseases, or disease categories, are not especially helpful for predicting readmission."

While this study does not address the matter, readmission as an indicator of quality is a hotly debated issue. Some standards now in use interpret a readmission within 48 hours as poor-quality care, while others regard it as a sign of aggressive and excellent care.

Rosenberg AL et al. Who Bounces Back? Physiologic and Other Predictors of Intensive Care Unit Readmission. *Critical Care Medicine* 29(3): 511–518, 2001.

Dr. Rosenberg was a Robert Wood Johnson Clinical Scholar at the time of this research.

Maternal Smoking Increases the Risk of Sudden Infant Death Syndrome

Over the past decade, deaths from sudden infant death syndrome (SIDS) have dropped sharply. Nevertheless, SIDS remains the leading cause of post-neonatal infant mortality in the United States. Public health campaigns that encourage parents to put their babies to sleep on their backs and discourage pregnant women from smoking can likely take credit for helping to reduce SIDS rates. This study examined the latter — the relationship between maternal smoking and the incidence of SIDS.

The investigator looked at US births in 1995 of all single infants weighing more than 500 grams. Data were taken from the 1995 and 1996 Perinatal Mortality Files, which include detailed information for almost every infant born in the United States in 1995. For statistical analysis, each infant who died from SIDS was matched by a number of characteristics with a control group infant who survived at least one year.

Using self-reported smoking information from birth certificates, researchers found that nearly 24% of the SIDS deaths during 1995 appeared to be linked to maternal smoking during pregnancy. Moreover, after categorizing the mothers of the more than 2,500 infants who died from SIDS and the control group infants as nonsmokers, light smokers (1 to 10 cigarettes per day), moderate smokers (11 to 20 per day), or heavy smokers (21 or more per day), the investigator found that even light smoking by pregnant women more than doubles the risk of SIDS.

According to the study's author, if all pregnant smokers were enrolled in smoking cessation programs and quit, the United States could reduce the number of annual SIDS deaths by 108 at a cost of $210,500 per life saved. This is highly cost-effective when compared to other widely accepted interventions to improve or extend human life. "Expanded access to prenatal smoking cessation programs should remain an important policy goal," he concludes.

Pollack HA. Sudden Infant Death Syndrome, Maternal Smoking During Pregnancy, and the Cost-Effectiveness of Smoking Cessation Intervention. *American Journal of Public Health* 91(3): 432–436, 2001.

College Students and Smoking: Where You Live Matters

With cigarette smoking on the rise among college students, campuses are a prime setting for interventions to reduce smoking rates among young adults. Little is known about what works; however, analysis of the 1999 Harvard School of Public Health College Alcohol Study sheds some light on one measure being tried by some colleges and universities — smoke-free dormitories that curtail smoking by limiting the places and times students can smoke as well as their interaction with smoking peers.

The researchers looked at students' responses to several questions about their tobacco use. They compared the responses of students living in smoke-free, on-campus housing to those living in unrestricted, on-campus housing. Among the nearly 4,500 respondents who lived in on-campus housing, significantly fewer students living in smoke-free dorms — regardless of their gender, age, class year, or type of college — reported smoking in the 30 days prior to the survey than their peers living in dorms that allowed smoking.

The preventive effect of smoke-free housing appears to hold among students who were not regular smokers before reaching age 19, but not among those who were regular smokers before that age. A disappointing finding was that smokers living in smoke-free dorms did not smoke fewer cigarettes than their peers living in unrestricted housing.

The authors conclude that "smoke-free dorms help those who are not regular smokers before college avoid taking up tobacco during college." They urge college administrators to continue the practice of offering smoke-free dormitories to students to "keep them from joining the ranks of smokers."

Wechsler H, Lee JE, and Rigotti NA. Cigarette Use by College Students in Smoke-Free Housing: Results of a National Study. *American Journal of Preventive Medicine* 20(3): 202–207, 2001.

Few People Self-Refer Out of Point-of-Service Plans

One of the restrictions of managed health care plans that consumers and primary care physicians seem most opposed to is the lack of freedom in obtaining specialty care. Managed care plans with fewer restrictions — typically point-of-service plans — are growing in popularity, since they allow access to out-of-network physicians.

This charge gives rise to new questions: To what extent do members actually use their option to refer themselves to specialty care? What types of patients are most likely to do this, and why? Are they satisfied with the outcome?

Using 1996 data from 3 point-of-service plans in the Northeast, Middle Atlantic, and Midwest, investigators tackled these issues. All of the plans were triple-option types (use gatekeeper-approved service, self-refer within the network, or self-refer out of the network). The Northeastern and Middle Atlantic plans had designations that showed whether self-referral was within or outside the provider network. For the Midwestern plan, researchers telephoned members who had seen a specialist, determining whether they were self-referred or referred by a physician, and recorded their answers verbatim.

Overall rates of self-referral ranged from 8.8% in the Midwest to 17.3% in the Middle Atlantic. Self-referrals were made most commonly to orthopedic surgeons and dermatologists. Fewer than 2% of patients self-referred to out-of-network specialists. Self-referrals ranged from 9 to 16% of total charges.

Patients who had unstable chronic conditions, allergies, orthopedic problems, and injuries were the most likely to self-refer. Those who had an ongoing relationship with their primary physician and who made small or no co-payments tended not to self-refer.

Most patients self-referred to "save time" or to "choose their own specialist." Others did so because their primary care physician refused to make the referral or because they already had an established relationship with the specialist. They were generally satisfied with their outcome, having felt dissatisfied with the specialists offered by their plan.

Even though members pay about $600 more per year for the right to seek specialist care outside of their plan's network, few of them use the option. Just having the option seems to be enough. "For those concerned that loosening gatekeeper restrictions will lead to uncontrolled utilization," the authors note, "our findings suggest that this is unlikely to materialize."

Forrest CB et al. Self-Referral in Point-of-Service Health Plans. *The Journal of the American Medical Association* 285(17): 2223–2231, 2001.

Research Says Taxes Discourage Youth Smoking

If an alliance of health and tobacco-control groups has its way, cigarettes will be more expensive to buy in six states across New England. The groups there are trying to get the cigarette tax raised a minimum of 50 cents a pack by getting bills introduced in legislatures across the region. Fueling their efforts is a new study from University of Illinois at Chicago researchers demonstrating a strong link between cigarettes' price and teenagers' smoking rates.

The study is part of *Bridging the Gap: Research Informing Practice for Healthy Youth Behavior*, a five-year, $20.5-million national program of The Robert Wood Johnson Foundation designed to examine the role of policy and environmental factors in youth substance abuse. (To read the paper, "The Effect of Cigarette Prices on Youth Smoking," go to <www.uic.edu/orgs/impacteen/pub_fs.htm>.) This grant program is one of many research and public education efforts the Foundation funds that inform tobacco policy.

The new research is the first longitudinal study on the effect of tobacco price increases on youth and provides important new information about the impact of cigarette prices on eighth and tenth graders as they first begin to smoke. Teen smoking rates, which had dropped in the later 1970s and 1980s, rose dramatically in the 1990s, even though federal excise taxes increased. Why? The "real price" for cigarettes — factoring in inflation and cigarette manufacturers' price reductions — actually fell for brands popular with youth.

The study found that a 10% increase in the price of cigarettes decreases the probability of an adolescent starting smoking between 3% and 10%, depending on what type of initiation was looked at — initiation of any smoking, initiation of daily smoking, or initiation of smoking at least a half pack a day. Kids, after all, have limited resources, so it comes as little surprise that higher taxes can dampen their enthusiasm for buying a pack of smokes.

"Other studies have shown that higher cigarette taxes reduce the prevalence of youth smoking," says Frank Chaloupka, PhD, professor of economics, University of Illinois at Chicago, and the study's lead author. "What this particular study does is look closely at smoking initiation and the transition to regular smoking. Higher taxes have some effect on [preventing] experimentation, but the big impact is that they block the transition to regular smoking. It shows that higher taxes are an effective way to prevent youths from becoming addicted smokers. It's the strongest evidence yet."

Health and tobacco-control groups across New England are using the new information in their fight to raise taxes as a means to deter youth smoking. Chaloupka recently testified before the Rhode Island legislature, which is considering a 50-cent increase in the cigarette tax, raising it to $1.21 a pack.

One of the challenges facing New England, however, is that in order for higher cigarette taxes to work, states likely will have to act in tandem. That is, if only one or two states raise taxes, smokers will likely cross state lines and purchase cigarettes elsewhere. In a region where state pride and independence run strong, tobacco-control groups are finding at least a certain measure of cooperation on this issue.

"This is the first time that all six New England states have joined together in a legislative campaign," says Lorie Fresina, director of the American Cancer Society's SmokeFree New England. "We share common media markets; we share hospitals. There are many reasons for us to work together."

There are a number of other hurdles to overcome. The Massachusetts governor has said he will veto any cigarette tax increase, forcing health and tobacco-control coalitions to hope for a legislative override. In Connecticut, tobacco is a major cash crop and therefore political dynamite. But Fresina and others remain undaunted, saying the fight has just begun.

— Sean Mehegan

Each year, the Robert Wood Johnson Community Health Leadership Program

honors 10 outstanding individuals who have overcome daunting odds to expand access to health care and social services to underserved and isolated populations in communities across the United States. For complete information see <www.communityhealthleaders.org>. The 2001 Community Health Leaders are pictured at right.

Seated, left to right:

Victor Joseph, director, recovery camp, Tanana Chiefs Conference, Fairbanks, Alaska, designed a program that reintroduces Athabascan Indians and other Alaskan Natives suffering from alcohol and substance abuse to traditional native values and strengths.

Alvin Jackson, MD, medical director, Community Health Services, Fremont, Ohio, created a mobile clinic to reach thousands of migrant farm workers and their families.

Connie Bremner, director, Blackfeet Eagle Shield Senior Citizens Center, Browning, Mont., transformed the struggling senior facility into a model health and wellness center for the reservation's elders.

Arneatha Martin, MN, ARNP, co-president and CEO, Center for Health and Wellness, Wichita, Kan., established a state-of-the-art health center for low-income African Americans focusing on prevention and education.

Standing, left to right:

Susan Chasson, JD, MSN, founder and board president, Children's Justice Center, Provo, Utah, created the center to provide a homelike environment to help child victims of physical abuse and sexual assault.

Mary Fleming, coordinator, agricultural health, Grady Memorial Hospital, Delaware, Ohio, created programs to educate and raise awareness about farming safety.

David Kalke, MDiv, program developer, Central City Lutheran Mission, San Bernardino, Calif., started a "safe zone" to provide teen health and education programs in an area marked by rampant gang violence.

Steven Schroeder, MD, RWJF president.

Charlotte Keys, founder and executive director, Jesus People Against Pollution, Columbia, Miss., mobilized her community to demand health and environmental justice.

Gina Upchurch, RPh, MPH, founder and executive director, Senior PharmAssist, Durham, N.C., created a model assistance program that helps older adults on limited incomes purchase expensive medications.

Luis Centeno, founder, Proclaimers of Hope Ministries, Philadelphia, created a faith-based recovery and addiction prevention program in the city's West Kensington neighborhood.

— Hedda Colossi

Newspaper Series Addresses Dying in America

When Al Haggar of Pinehurst, N.C., was dying of cancer, a friend sent him the book *Dying Well: Peace and Possibilities at the End of Life,* by Ira Byock, MD.

"I read the book in one day," says Al's widow, Mary. "And when I was finished, I called the bookstore and ordered five more copies for our children. The book made the [dying] process so much simpler for all of us. Everyone in the family read it. It was a how-to primer — how to help somebody. I'd read parts to Al."

The Robert Wood Johnson Foundation — through its *Last Acts*® national coalition and Partnership for Caring — is hopeful that an in-depth newspaper series and accompanying community outreach efforts will help thousands of other families in the same way Byock's book helped the Haggars.

RWJF has awarded $300,000 to help fund a 15-part newspaper series called "Finding Our Way: Living With Dying in America." The articles, which will run September 10 through the end of the year, are being distributed by Knight-Ridder Tribune News Service to every newspaper in the country (not just Knight-Ridder News Service subscribers). Photos, graphics, and "how-tos" for readers are included, and editors can access the series via Knight-Ridder's Web site, <www.krtdirect.com>. The series also is supported by the Fan Fox and Leslie R. Samuels Foundation and the Charitable Leadership Foundation, Clifton Park, N.Y.

Daniel Tobin, MD, project director and member of the Partnership for Caring board, says that "Finding Our Way" seeks to inform citizens on various aspects of death and dying in America.

"America is ready to talk," says Tobin. "Without talking we will not die the way we want. Without preparation, we deny ourselves dignity and pain control at the end of life."

The articles are being written by national leaders in the fields of medicine, sociology, theology, and culture and will explore issues facing seriously ill Americans, their families, caregivers, and communities.

"Death and dying is a topic that has not always been treated well in the media — or at least not as well as it could be," says Mike Duggan, director of Knight-Ridder Tribune News Service. "Certainly, a lot of progress has been made. AIDS, Alzheimer's disease, and cancer have taken the issue of death and dying out of the background. Grandma no longer dies in the hospital with no one around. Now, there are hospice efforts and community groups that help. The 'Finding Our Way' series gives us an opportunity to move the [death and dying] initiative one step further."

— SHARI MYCEK

"Finding Our Way: Living With Dying in America" Topics

- Death and Dying in America
- Living with Dying in America
- Aging Well and Widowhood
- Palliative Care
- Planning for Care at the End of Life
- Culture and Diversity
- Spirituality and Faith
- Last Rites
- Caring for Aging Parents and Partners
- Hospice
- Conversations at the End of Life
- When a Child Is Dying
- Unexpected Violence and Death
- Living with Loss
- A Vision for the Future

Circle of Life Awards Recipients of the American Hospital Association's second annual *Circle of Life Award: Celebrating Innovation in End-of-Life Care* were honored at a ceremony July 31 in San Diego. Pictured from left to right are **Russell Portnoy, MD**, chairman of the Department of Pain Medicine and Palliative Care, Beth Israel Medical Center, New York; **Sister Michelle Reho,** administrator of St. Joseph's Manor, Trumbull, Conn.; and **Dorothy Pitner,** president and CEO, Palliative CareCenter and Hospice of the North Shore, Evanston, Ill.

The awards recognize programs that respect patient goals and preferences, provide comprehensive care, address the family's concerns and needs, and incorporate support to ensure that the programs continue.

The three organizations were selected from among 115 nominees for their contributions to improving care at the end of life.

- **Beth Israel's Department of Pain Medicine and Palliative Care** (New York) helps families and patients with muscular dystrophy, multiple sclerosis, AIDS, and sickle cell anemia by providing spiritual support as well as specialized pain and symptom management.
- **St. Joseph's Manor** (Trumbull, Conn.) uses monthly focus group meetings to discuss small steps it can take — from changing the color of patients' bed sheets to holding memorial services — to make meaningful improvements for patients, families, and staff as they deal with end-of-life issues.
- **Palliative CareCenter and Hospice of the North Shore** (Evanston, Ill.) is a community-based organization that, in addition to housing an inpatient hospice unit, offers bereavement support for families, educational programs on palliative care for the medical community, and special care programs for children who have lost a loved one or who themselves are nearing the end of life.

For more information about the award, visit <www.aha.org/circleoflife>.

SELECTED GRANTS

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

- For establishment of the Institute for Advocacy on Environmental Tobacco Smoke, $971,114 to American Nonsmokers' Rights Foundation, Berkeley, Calif.
- For evaluation of a portable adolescent treatment model for the juvenile justice system, $900,000 to Vera Institute of Justice, New York.
- For establishment of a national campaign to raise awareness of the disease of alcohol and drug addiction, $499,863 to Legal Action Center of the City of New York.
- For embedding prevention in state policy and practice, $420,340 to National Crime Prevention Council, Washington.
- For continuation of a longitudinal study of substance-abusing youthful offenders, $750,000 to Northwestern University Medical School, Chicago.
- For evaluation of CASAWORKS for Families, $561,326 to Treatment Research Institute, Philadelphia.
- For assessment of the cost-effectiveness of alcohol interventions in emergency departments and trauma centers, $190,536 to University of Washington School of Medicine, Seattle.
- For production of a NOVA documentary on the science and policy implications of modified tobacco products, $194,034 to WGBH Educational Foundation, Boston.
- For expanding outreach to policymakers to advance public health and medical approaches to drug policy, a renewal award of $448,096 to Brown University Center for Alcohol and Addiction Studies, Providence, R.I.
- *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* Awards to 18 sites, totaling $1 million.
- *Partners with Tobacco Use Research Centers: Advancing Transdisciplinary Science and Policy Studies.* Renewal awards to four sites for communications, totaling $1.6 million.
- *SmokeLess States: National Tobacco Policy Initiative.* Awards to 24 sites, totaling $19 million.
- *Voices in the Debate: Minority Action for Tobacco Policy Change.* One award of $2.5 million to Latino Council on Alcohol and Tobacco, Washington.
- *After School: Connecting Children at Risk With Responsible Adults to Help Reduce Youth Substance Abuse and Other Health-Compromising Behaviors.* One award of $5 million to After School Matters, Chicago.

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

- For studying medically related bankruptcies, $296,325 to Cambridge Medical Care Foundation, Cambridge, Mass.
- For Health Coverage 2001: National satellite town meetings, $428,500 to Families USA Foundation, Washington.
- For development of a communications campaign for oral health parity, $388,930 to Oral Health America, America's Fund for Dental Health, Chicago.
- *Southern Rural Access Program.* A renewal award of $1 million to The Pennsylvania State University College of Medicine, Hershey, for the 21st Century Challenge Fund.
- *State Coverage Initiatives.* Awards to two sites, totaling $300,000.

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

- For improving support for consumer-directed, long-term care services, $1.5 million to National Association of State Units on Aging, Washington.
- For improving quality performance in home health care, $1.5 million to Visiting Nurse Service of New York.
- For conducting and analyzing the 2001 Annual Industry Survey of managed care plans, a renewal award of $288,908 to AAHP Foundation, Washington.
- For expansion of a senior wellness program, $749,793 to Senior Services of Seattle-King County, Seattle.
- *Coming Home: Affordable Assisted Living*. Award of $220,623 to Commonwealth of Massachusetts Executive Office of Elder Affairs, Boston, to serve as a mentor state for the program.
- *Faith in Action II.* Awards to 42 sites, totaling $1.5 million.
- *Improving Chronic Illness Care.* Awards to two sites, totaling $999,972.
- *Last Acts.* One award of $638,035 to Partnership for Caring, Washington, for continuing education for nurses and creation of a story bank and interactive Web site.
- *Targeted End-of-Life Projects Initiative.* Award of three program grants, totaling $1 million.

Other Programs and Those That Cut Across Foundation Goals

- For promoting philanthropy in professional sports to improve community health, $2.9 million to Institute for Civil Society, Newton, Mass.
- For building support for prevention and public health research, $5.6 million to Research America, Washington.
- For a follow-up study of adolescents who participated in the *Infant Health and Development Program,* $3.5 million to Harvard University School of Public Health, Boston.
- For development of a public television series on physical activity, $350,000 to Connecticut Public Broadcasting, Hartford.
- For defining common core elements of effective primary care health behavior change counseling, $320,112 to Kaiser Foundation Hospitals, Kaiser Foundation Research Institute, Oakland, Calif.
- For educating public health professionals for the 21st century, $711,959 to National Academy of Sciences –Institute of Medicine, Washington.
- For advancing the debate on disease prevention and health promotion policy under Medicare, $387,153 to Partnership for Prevention, Washington.
- For improving collaborative efforts on determinants of health, $746,593 to Princeton University, Princeton, N.J.
- For the New England Regional Public Health and Managed Care Collaborative, $399,221 to Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, Mass.
- For a neighborhood family support center in the District of Columbia, $674,706 to The District of Columbia Developing Families Center.
- *Turning Point: Collaborating for a New Century in Public Health.* Renewal awards to six sites, totaling $2.9 million.
- For a seminar on the practical and ethical challenges of advances in genetic technology, $747,300 to Fred Friendly Seminars, New York.
- For building understanding and state capacity to address patient safety, a renewal award of $284,466 to The Center for Health Policy Development, Portland, Maine.
- *Generalist Physician Faculty Scholars Program.* Awards to 14 sites, totaling $4.2 million.
- *Investigator Awards in Health Policy Research.* Awards to four sites, totaling $994,861.
- *Multistate Initiative to Help Build a Health Information Infrastructure — Phase III.* One award of $351,143 to Foundation for Health Care Quality, Seattle.
- *Changes in Health Care Financing and Organization.* Awards to four sites, totaling $1.4 million.
- *Minority Medical Faculty Development Program.* Awards to 11 sites, totaling $4 million.
- *The Robert Wood Johnson Clinical Scholars Program.* Core renewal awards to seven sites, totaling $12.8 million. Cohort renewal awards to seven sites to support the 2001–2003 Scholars, totaling $4.8 million.
- *Robert Wood Johnson Health Policy Fellowships Program.* Awards to five sites, totaling $467,941.
- For a camping program for health-impaired children, $339,180 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., $400,000 to New Brunswick Development Corporation.
- Support for the 2000–2001 annual campaign, $600,000 to The United Way of Central Jersey, Milltown, N.J.

The Foundation's Web site contains a searchable database of all active grants. Go to <www.rwjf.org>, *click on* **ABOUT OUR GRANTEES** *on the top navigation bar, choose* **Active Grants** *at left, then go to bottom of page for* **Search RWJF Active Grants.**

From **Binge Drinking** — page 3

included an alcohol-free student music night.

While many *AMOD* strategies seem effective, they need to be evaluated, according to Henry Wechsler, PhD, director of the Harvard College Alcohol Study and principal investigator for the *AMOD* evaluation. "To be cost-effective, you want to do the minimum amount that will get you the most results," Yoast adds. "That is part of what the evaluation will address."

Though the formal evaluation will not have final results for another three years, much has already been learned and there is a demand for information in the higher education community. The Higher Education Center will help share these interim findings with other schools across the country.

"The time is right to share the experiences and leadership of *AMOD* and what has been learned to date from its evaluation," says Joan Hollendonner, the RWJF officer in charge of the program. "The Higher Education Center can facilitate this and provide assistance to schools ready to act. All of the elements are present to build a national movement."

It will take some time, however, to achieve sustained reductions in high-risk drinking rates, Wechsler cautions, just as the smoking-prevention movement took decades to achieve results. "This level of drinking has been present on campuses probably since colonial days," he says. "It's not something that is going to disappear overnight, or even in a year or two."

— Melissa Knopper

New Grant Results Reports Posted on RWJF Web Site

In April 2001, 25 new Grant Results Reports and 2 National Program Reports were posted, to <www.rwjf.org>. Reports on closed grants are organized by topic area. An accompanying search engine allows a full-text search.

These newly added reports include:

- **Technical assistance for hospital sponsored school-based health centers**. VHA Health Foundation produced a 314-page workbook, *Making the Healthy Connection: Establishing and Sustaining the Hospital Sponsored School-Based Health Center.* It synthesizes pre-existing material and offers benchmarks and guidelines for developing such health centers, information on funding and evaluating them, and guidance for building community support. For a copy of the book, call (877) 847-1450; or contact Laura Murphy, lmurphy@vha.com. The cost is $5 for shipping and handling.
- **Volunteer training manuals and seminars for Court Visitors and Conservators.** Sage Services of Connecticut prepared the *Court Visitor Training Manual* and *Conservator of the Person Training Manual* for use in states wishing to replicate Connecticut's programs. Court Visitors provide personal contact, and social and mental stimulation through regular one-on-one visits to elderly individuals who have had a Conservator of the Person appointed through the judicial process. Conservators oversee the basic needs of vulnerable elderly persons with no family or friends to take on the role. Seminars presented by Sage and manuals costing $10 to $20 (depending on format), are available by contacting Marsha Ziebell at (203) 777-7401, sageservices@snet.net.
- **Drug prevention Web site.** Partnership for a Drug-Free America offers a Web site targeted to parents and kids, <www.drugfreeamerica.org>. The site provides detailed information about different drugs and their negative effects, and answers frequently asked questions. Related television, radio, and print ads also can be viewed.

These new postings bring the total to more than 451 Grant Results Reports available on the RWJF Web site. They cover some 1,067 grants.

— Marian Bass

People

Larry Blumenthal, MA, joined the Foundation in May as a senior communications officer in the Communications Department. Blumenthal played a leading role in the development of several major health Web sites, including InteliHealth.com and Discoveryhealth.com. Prior to coming to the Foundation, he was vice president of interactive content for The Network Connection in Philadelphia.

Kim Lochner, ScD, began working at the Foundation in July as a program officer on the Community Health and Population Health Science and Policy Teams. Formerly, Lochner was a research fellow with the Harvard Center for Society and Health. She earned her master's and doctoral degrees in health and social behavior from the Harvard School of Public Health in Boston.

Wendy Yallowitz, MSW, came to the Foundation in July as a program associate with the Supportive Services Team in the Health Care Group. Prior to joining RWJF, Yallowitz held the position of geriatric social worker for Jewish Family and Children's Service in Princeton. She earned her masters in social work from Rutgers University.

Congratulations

Sallie Anne Petrucci, MPH, was promoted to program associate for the Health Group's Tobacco Team in May. Petrucci, who has been working on tobacco-control issues, spent the previous two years coordinating the program planning team for the RWJF-sponsored 11th World Conference on Tobacco OR Health (August 2000) and served on the conference's executive committee. She received her master's degree in public health in sociomedical sciences from Columbia University in May.