

The
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FEATURES

- Profile 4
- ABridge 5
- Grants 11

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**"Quality
Because of
Choice, Not in
Spite of It"**

PAGE 4



**Four
Organizations
Receive
Circle of Life
Awards**

PAGE 9



**Honoring
Accurate
Depiction of
Substance Abuse
in Entertainment**

PAGE 10



Lavizzo-Mourey to Take Helm of RWJF, Succeeding Schroeder as President

Risa Lavizzo-Mourey, M.D., M.B.A., will become the next president and chief executive officer of The Robert Wood Johnson Foundation, succeeding Steven Schroeder, M.D., who will retire in December 2002. Lavizzo-Mourey currently is senior vice president and director of the Health Care Group at RWJF.

"Risa has a superb record of accomplishment in academic medicine, in her specialty-geriatrics, in government and her most recent stint as senior vice president," said RWJF Chairman Robert E. Campbell. "We know that she will continue the exemplary legacy of leadership and service in improving health and health care for all Americans set forth by Steve Schroeder and his predecessors, and we look forward to Risa's long and successful tenure."

Prior to joining RWJF as senior vice president in 2001, Lavizzo-Mourey served as Sylvan Eisman Professor of Medicine and Health Care Systems at the University of Pennsylvania School of Medicine. She also directed the University's Institute on Aging and was

chief of the Medical School's Division of Geriatric Medicine. From 1992 to 1994, Lavizzo-Mourey was deputy administrator of the federal Agency for Health Care Policy and Research (now Agency for Health Care Quality) while on leave from Penn. She also held faculty appointments at Penn's Wharton School of Finance and the School of Nursing.

A native of Seattle, Lavizzo-Mourey earned her medical

See **Lavizzo-Mourey** — page 3



Medicaid Program Offers Independence to Beneficiaries

A movement is taking shape in America, one that is offering thousands of elderly and disabled people more independence and control over their lives.

Providing choice and autonomy to elderly and disabled Medicaid beneficiaries is the concept behind the *Cash and Counseling Demonstration and Evaluation* program. The program is funded by The Robert Wood Johnson Foundation and the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services.

Launched in 1995, *Cash and Counseling* tests a consumer-directed approach to personal assistance services for people with disabilities, many of whom are seniors.

In each of three participating states — Florida, Arkansas and New Jersey — half of the study participants receive a direct cash allowance, and the other half receive services through a traditional home-care agency. Those who receive the cash allowance may use it to hire friends, neighbors or relatives as personal care assistants. They also may use the money to modify their

See **Choice** — page 2

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From *Autonomy* — page 1

homes or cars or to buy services and items such as taxi rides, microwave ovens or touch lamps that allow them to live more independently.

"We find that people who need help with some basic daily activities want flexibility and a sense of control over how, by whom and when those services are delivered," says Sandra Barrett, director of Independent Choices, the *Cash and Counseling* program in Arkansas. "Unfortunately, the reality is that elderly and younger disabled consumers do not have much choice under the standard Medicaid approach, which essentially limits individuals to using home-care agencies or going into a nursing home."

Cash and Counseling enables each consumer to set up a schedule specific to his or her individual needs, says William Ditto, M.S.W., director of New Jersey's *Cash and Counseling* initiative, Personal Preference.

"Many consumers need help at odd times, such as 6 a.m. or 7 p.m., times that fall outside the usual agency hours," says Ditto.

"Also, there is a shortage of workers in the formal care system and there's a lot of turnover at most agencies," Ditto says. "Many elderly and disabled Medicaid consumers need help with very personal needs, like getting dressed, bathing and getting to the bathroom. It can be stressful and disruptive for them when the aides change every month or so or if there are days when the agency has no one to send.

"Giving the consumer and his or her family control over how to spend the benefits helps the person stay more independent for longer and it increases their functional capacity," according to Ditto.

Consumer response to the *Cash and Counseling* approach has been "remarkable," says Kevin Mahoney, Ph.D., director of the *Cash and Counseling* national program and

an associate professor at the Graduate School of Social Work at Boston College. (See related *Profile*, page 4.)

In Arkansas, where the program has been in operation the longest, preliminary evaluation data show that 93 percent of enrollees would recommend this option to others. Some 82 percent of enrollees said the program has improved their lives.

The Arkansas data also showed that the group enrolled in the traditional agency-provided services failed to receive personal assistance services at some point in almost 40 percent of the months in which they were eligible, compared to 9 percent for clients who received the cash allowance. Early results show that Medicaid costs per recipient per month were virtually identical for agency and cash services groups, in part because nursing home and hospital costs were 18 percent higher for the control group.

The preliminary success of the *Cash and Counseling* model is having a ripple effect. In May, the federal Department of Health and Human Services announced its "Independence Plus" Medicaid waiver templates, which provide guidance to states on how to develop programs to establish cash-allowance consumer-directed care programs for the elderly and the disabled. The templates are based, in large part, on the *Cash and Counseling* approach, as well as other similar demonstration projects taking place in other states, says Ditto.

And *Cash and Counseling* staff members are beginning discussions with federal officials about possibly making the consumer-directed care approach a permanent option for all states under Medicaid, eliminating the need for waivers.

Meanwhile, the Florida Legislature this year passed a law that will make the consumer-directed care approach a statewide

IN MEMORIAM

Robert H. Myers, 84, who served as an RWJF trustee from 1983 until 1992 and chairman of the Board of Trustees from 1986 to 1989, died after a long illness on May 11, 2002, in Chevy Chase, Md. A partner in the Washington law firm of Williams, Myers and Quiggle, he was a trustee of Suburban Hospital in Bethesda, Md., for 35 years and the hospital's president for 13 years. Myers was a graduate of Princeton University and George Washington University School of Law. He is survived by his four children.

option for all eligible elderly and disabled Medicaid recipients. If the state receives the necessary federal approval, the program could begin operating throughout the state sometime in the spring of 2003, says Tom Reimers, director of Consumer-Directed Care, Florida's *Cash and Counseling* program.

Reimers believes the consumer-directed care approach most likely will become more common as baby boomers move into their 70s and 80s.

"We are the most demanding generation ever," he says. "Just as we made demands at every other phase in our lives, we're going to insist on having choices and options for our care as we age."

— LAURIE JONES

See www.inform.umd.edu/HLHP/AGING/CCDemolindex.html for more information on *Cash and Counseling*.

Use of RWJF-Funded Chronic Care Model Growing

The U.S. health system is structured to respond to acute illness — a broken bone, a heart attack, a sore throat. The system is not nearly as well equipped, however, to help the 99 million Americans with chronic conditions, such as asthma, diabetes, heart disease or depression.

Over the last four years, RWJF's national program *Improving Chronic Illness Care (ICIC)* has been helping health care organizations across the country restructure their care processes to dramatically improve care for people with chronic conditions. Recently *ICIC* has made some noticeable strides.

The five-year, \$25-million program is grounded in the Chronic Care Model, developed by *ICIC* National Program Director Edward Wagner, M.D., M.P.H., and colleagues at the W.A. MacColl Institute for Healthcare Innovation at the Group Health Cooperative in Seattle.

The model emphasizes health system leadership; regular, planned patient visits; instant access by clinicians to the latest evidence-based guidelines for

care; use of information technology that tracks patients' health status; goal setting and self-management by patients; and involvement of community resources to keep patients well, involved and active.

When *ICIC* was created in 1998, Wagner partnered with the Boston-based Institute for Healthcare Improvement (IHI) to create national improvement collaboratives based on IHI's well-known Breakthrough Series methodology.

The Breakthrough Series methodology brings groups of health care organizations together in team efforts called collaboratives to work with faculty in tandem for a year to improve all aspects of care surrounding a single condition. To date, nearly 800 health care teams, representing hospitals, HMOs, medical practices and clinics, have participated in national and regional collaboratives for asthma, depression, diabetes, hypertension, rheumatoid arthritis and other chronic conditions. Two rounds of Collaborative Sponsorship grants by *ICIC* have aided the

spread of this improvement method throughout the country.

Perhaps the most striking success of the program is its partnership with the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC). Early on, several of BPHC's federally funded health centers, which provide primary care to medically underserved communities across the country, participated in an improvement collaborative with the aim not only of bettering care in those clinics, but of expanding the model to its other clinics. Included among the 800 teams are some 500 of BPHC's more than 700 federally funded health centers that have completed or are engaged in collaboratives, which it conducts independently, using the Chronic Care Model to improve chronic illnesses and prevention efforts.

Quality improvement data suggest that the results of the year-long collaboratives are impressive: improvements in glycemic control for patients with diabetes; dramatic increases in follow-up for patients with depression; decreases in blood

pressure rates among patients with cardiovascular disease; overwhelming success in providing asthmatic patients with daily preventive medicines; and decreases in health care costs, even with increased patient visits. The RAND Corporation currently is conducting a controlled evaluation of the Chronic Care Model, which will be completed next year.

With federally funded health centers having fully embraced the model, says Tracy Orleans, Ph.D., senior scientist at RWJF, "this has become arguably the largest, most important health care quality improvement initiative in the country. It's exactly what the health care system needs right now — a demonstration that it is possible both to improve care dramatically and even reduce health care costs."

ICIC also has worked with national accrediting bodies to embed elements of the Chronic Care Model in their review tools for chronic care management programs. *ICIC* is actively disseminating the lessons learned from its years of working with systems via its Web site, by national presentations and through a speaker's bureau of experts in system change who can be linked with health care organizations.

As part of *ICIC*'s work, the program will release a Call for Proposals for a second round of research grants to refine the Chronic Care Model later this year. Details about the model, assessment tools, a bibliography, a video and more information can be found on the Web site, www.improvingchroniccare.org.

— RAYMOND RIGLIOSO

From Lavizzo-Mourey — page 1

degree at Harvard Medical School and completed her internship and residency in internal medicine at Brigham and Women's Hospital in Boston. In 1984, she was named a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania and received her M.B.A. in Health Care Administration from Penn's Wharton School in 1986. She was appointed assistant professor in the Section of General Internal Medicine at Penn in 1986,

associate professor in 1992 and Sylvan Eisman Professor of Medicine in 1997.

A member of the Institute of Medicine of the National Academy of Sciences, Lavizzo-Mourey recently served as co-vice chair of the IOM committee on eliminating racial and ethnic disparities in medical care, which recently issued the report "Unequal Treatment". She is a master and former regent of the American College of Physicians and has chaired its ethics and

human rights committee. She has served on the board of directors of the American Board of Internal Medicine and of several corporations. She has lectured and published extensively on issues of health care and health policy.

"Almost 20 years ago, the Foundation identified Risa as an up-and-coming young leader in health care when she was named a Robert Wood Johnson Clinical Scholar," said Schroeder. "Time and experience has only burnished our confidence in her."



When people with disabilities are on Medicaid and need help with eating, taking showers or simply getting in and out of bed, most states require them to call in a home care agency — which may not have enough workers to go around. That doesn't make sense to Kevin J. Mahoney, Ph.D., an associate professor at the Boston College Graduate School of Social Work and national program director for the *Cash and Counseling Demonstration and Evaluation*, a three-state demonstration program. In this interview with *ADVANCES*, Mahoney talks about a new model that lets consumers hire friends and family to provide the personalized care that they need — and deserve.

Don't family members usually provide personal assistance services without being paid?

MAHONEY — Yes, but they can't do it all. In the United States, at least three-quarters of all elderly people who need help with bathing, dressing, eating, toileting and transferring get their care from the informal system, mostly from family members. In my own family, my dad is caring for my mother, who has Alzheimer's disease, and all four of us children are helping out. But there is still a need for formal paid services on top of that, just to hold things

together. Families continue to help out when formal services are provided. The public services care plan is meant to address the *unmet* needs.

How is *Cash and Counseling* different from the traditional model?

MAHONEY — In most states, if you're on Medicaid, you can only get formal help through an agency, where you don't have much say over who helps you, when they'll come and what they can and can't do. With *Cash and Counseling*, you can choose to take responsibility for managing the cash allowance yourself. You can also name a family member or friend to serve as a representative if you need help managing your individualized budget. Let's say your father has dementia and you help him apply for assistance. Someone comes out, assesses the situation, and says, "You're providing great amounts of care already, but you need help with his bathing, and coverage for some hours when you can't be there." So they develop a plan and assign a dollar amount equivalent to what it would cost for an agency to implement it. Then, using that cash, you have total freedom to develop an individual plan to take care of your father's unmet personal needs. Who cares who the provider is?

Can consumers end up getting more assistance than they would under a traditional plan, at the same cost?

MAHONEY — Sometimes it's just amazing what people can do when they have the latitude to stretch that money themselves. In some states, for example, you can only get agency services in blocks of time, with a minimum block of around four hours. Under *Cash and Counseling*, if you only need help for an hour in the morning getting out of bed, and another

hour at night, you can hire someone just for those times. You don't have to pay an agency worker to sit around your house for those extra hours.

So that could leave the consumer extra cash to buy equipment or retrofit an apartment so they could get around more independently?

MAHONEY — One person might decide, "If I could just renovate my home in certain ways, that would mean the most to me." Or a woman with multiple sclerosis might say, "If I could just buy a sofa I could get up from, that would make a big difference in my life."

Are family members trained to provide these services?

MAHONEY — They're not providing medical services. They're helping with shopping, making sure people have taken their medication — the types of things that people who live together do for each other every day. Furthermore, family members are available to sit in on a doctor's visit and get training individualized for their relative.

How does quality of care compare under the two systems?

MAHONEY — There's research showing that when you're able to hire someone who truly cares about you as a person, quality of care is improved in many ways. The people working on the quality management side have developed the mantra, "Quality because of choice, not in spite of it." Many agency workers do provide really good care. However, in earlier research comparing outcomes for people who got care from agencies versus those who were able to select their own caregivers, the consumer-directed model generated significantly better outcomes on 6 of 14 measures of quality and there was never a case where the agencies were better.

How do you deal with insurance issues? Is the program liable if a family member falls down the stairs while providing care?

MAHONEY — Our best example is the state of New Jersey, where they've really pioneered a worker's compensation approach. Consumers can use part of the cash allowance to buy a worker's comp policy, which is available at a very modest charge.

How do you prevent abuse of the system — family members taking the cash without providing the care?

MAHONEY — This may amaze some people, but we've gone three and a half years without any major instances of fraud and abuse. In part, that's because RWJF gave us the money for focus groups and surveys before we started. Consumers made it clear that they didn't want to manage large amounts of cash themselves. They wanted a "fiscal intermediary," a service that does the bookkeeping, tax-paying and check-writing. That turned out to be enormously helpful in controlling fraud and abuse.

Are participants satisfied with these arrangements?

MAHONEY — The majority say this has made their lives *a lot* better. In Arkansas, we talked to one elderly woman who was not able to get out of her chair. She said she liked her eggs prepared a certain way, but when she had strangers coming in, no one would ever pay attention to what she wanted. Now she has someone she can talk to, who will listen to her and cook her eggs the way she likes them. That one small thing has made such a difference to her happiness.

— INTERVIEW BY
ELIZABETH AUSTIN

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Many Patients Who Prefer Comfort to Life-Prolonging Care Don't Receive It

Today, many people will reach a point where aggressive medical treatment can no longer improve their chronic illness — a reality that has prompted consumers to take an active role in deciding their course of end-of-life care. However, numerous studies have found that patients are more ready to accept death than are the physicians who treat them.

A recent study of 1,185 seriously ill patients in five teaching hospitals supports this finding. In this study, more than one-third of the patients who preferred comfort care believed that their medical care was at odds with that desire.

Based on interviews with seriously ill patients and their surrogates, 60 percent of patients preferred that treatment focus on comfort, even if it meant shortening their lives; 40 percent wanted life-extending care. Of those preferring comfort care, only 41 percent reported that their treatment matched their wishes; 35 percent reported that their care was inconsistent with their goal; and

another 24 percent said they were not aware of their treatment goals. In contrast, 86 percent of patients who wanted life-extending care believed they received care that met their wishes.

The study was based on patient care data collected in five medical centers between 1992 and 1994 for the widely known Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). SUPPORT was the first comprehensive study to measure patients' preferences and physicians' practices regarding end-of-life care. The five medical centers were Beth Israel Hospital in Boston; MetroHealth Medical Center in Cleveland; St. Joseph's Hospital in Marshfield, Wis.; the University of California at Los Angeles Medical Center; and Duke University Medical Center in Durham, N.C.

The study results revealed a trade-off for the patients who believed physicians were providing the comfort care they requested. While they thought their wishes were met, these patients were much less likely to survive one year than those who also wanted palliative care, but believed they were instead receiving life-prolonging care (38 percent versus 55 percent).

At the same time, patients who believed they were getting the palliative care they requested had substantially lower one-year medical costs than those who believed they were receiving life-extending treatment against their wishes (\$52,098 versus \$92,442) "Our results suggest that efforts to adapt medical care to patients' treatment goals might substantially lower costs. However, such savings would entail some reduction in survival," according to the study.

The authors caution that their research, based on nearly decade-old data, may no longer characterize physician behavior. Because of greater use of managed care and its focus on cost containment, physicians may be more likely to stop treating a patient aggressively at the end of life. "Indeed, it is quite possible that such economic incentives will result in more patients reporting that medical care is inconsistent with their preference to focus on life extension," the study notes.

Researchers believe their findings raise two concerns that call for further research. First, physicians may not be aware of patients' treatment preferences, or worse, may be "actively ignoring them." Second, patients may be

RESEARCH NOTE

Home as the Place of Death For Chronically Ill Children

More chronically ill children may be dying at home, a trend with important implications for pediatric palliative care.

This study of 31,000 children and young adults who died in Washington state between 1980 and 1998 found that the high proportion of infants who died in the hospital from chronic conditions stayed relatively the same. But after age 1, the proportion of children who died from complex chronic conditions at home doubled, from 21 percent to 43 percent.

Two factors, standard of living and type of disease, greatly influenced the odds that home would be a seriously ill child's location of death. Children from affluent neighborhoods and those who died from congenital, genetic,

neuromuscular, metabolic and non-leukemia cancers were more likely to die at home than children from poorer neighborhoods or those who died of leukemia.

Researchers could not pinpoint specific reasons for their findings. The tendency of children with certain conditions to die at home, they suggest, could be related to the nature of the disease, the medical technology needed to treat it or the practice habits of various pediatric specialists. They also were uncertain if the rise in home deaths among children with complex chronic conditions was deliberate, or whether it was because more medically fragile children, over time, have been cared for at home, raising the odds that they would die there. Finally, the researchers raise the question whether parents residing in poorer neighborhoods would

prefer that their chronically ill children die at home, but cannot afford the necessary home care.

The study notes that if dying at home is a trend found in other parts of the country, "then we will need to ensure that dying at home represents a desired outcome for these children and their families and that sufficient resources are available to care for children who die at home from complex chronic conditions, along with support for their families."

Feudtner C, Silveira MJ and Christakis DM. "Where Do Children with Complex Chronic Conditions Die? Patterns in Washington State, 1980-1998." *Pediatrics* 109(4): 656-660, 2002.

At the time of this research, Drs. Feudtner and Silveira were Robert Wood Johnson Clinical Scholars; Dr. Christakis was a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar.

choosing to forgo lifesaving treatment because their physicians are not relieving their pain, and patients fear that life-extending care would incur more pain. “Given the forced choice presented to them, they would prefer to end the suffering,” the study suggests. Based on their findings, the authors recommend that the health care system use the extent to which end-of-life medical care meets patients’ informed wishes as one marker of quality care.

Teno JM et al. “Medical Care Inconsistent with Patients’ Treatment Goals: Association with 1-Year Medicare Resource Use and Survival.” *Journal of the American Geriatrics Society* 50(3): 496–500, 2002.

Domestic Violence: Improving Detection And Treatment

Domestic violence has become a top-priority public health problem in this country. Estimates of its prevalence are startling. Each year, 2 to 4 million women are battered by their spouses, partners or significant others and up to 55 percent of women experience some kind of domestic abuse over the course of their lives. Yet physicians routinely fail to screen women patients in their practice for domestic violence, and identify as few as one in 20 victims. Patients’ general unwillingness to disclose a history of domestic violence and physicians’ discomfort with the topic both contribute to the low level of detection. A recent study examined other barriers to screening for abuse; a second study describes the development of a tool to educate physicians about domestic violence “from the perspective of those who have lived through it.”

In the first study, researchers surveyed more than 1,000 internists, family practitioners, obstetrician-gynecologists and emergency medicine physicians by mail about the prevalence of domestic violence victims in their state and their practice, the percentage of their female

patients they screened for it, and their training on domestic violence. Although 81 percent of physicians indicated that they “believed they had as much responsibility to address the problem of domestic violence as other clinical problems,” on average, responding physicians screened only about 10 percent of their female patients. Approximately 10 percent of physicians never asked their patients about domestic violence. Obstetrician-gynecologists screened 20 percent of their patients, the highest screening rate among the specialties. Female physicians had higher domestic violence screening rates than male physicians.

Lack of training doesn’t appear to be a barrier to screening; 80 percent of physicians reported that they had received training on domestic violence issues. Nonetheless, less than a third of physicians said they felt “very confident” in their ability to

recognize victims and almost half felt they had inadequate resources to help those victims they did identify.

Two barriers to screening mentioned by a third or more of physicians — concern that asking about domestic violence might offend or anger patients and forgetting to ask patients about domestic violence — are rectifiable with appropriate education. In fact, the investigators suggest that training “should focus on correcting misconceptions about domestic violence and should provide concrete screening tools.”

The second study specifically addresses the issue of physician education, examining a tool to help physicians understand the particular concerns and needs of abused women.

The investigators conducted in-depth interviews with 21 domestic violence victims. Interview participants talked about their personal experiences and interactions with the health care system, and offered advice to

physicians on dealing with victims of abuse. The researchers identified the following common themes across the interviews and used vignettes to create an educational documentary and training guide for physicians:

- Domestic violence can happen to anyone; therefore physicians should discuss it with all their patients.
- It includes verbal abuse as well as physical assaults.
- It is about power and control; batterers may use stalking, social isolation, physical and economic limitations, and the threat of violence as other means to control the victim.
- It affects the victim’s entire family.

Victims emphasized that domestic violence is a “chronic problem.” The help physicians can offer victims depends on which of *five stages* the victim is at in the violent relationship:

RESEARCH NOTE

Timing of Insurance Enrollment Affects Use of Prenatal Care

Low-income women who enrolled in either Medicaid or a private insurance plan during their first trimester of pregnancy were more likely to receive early prenatal care than women who secured coverage later in pregnancy or who entered pregnancy with either public or private coverage.

What is the relationship between timing of insurance coverage and early prenatal care use among low-income women? To answer this question, the authors reexamined a survey conducted in 1994 and 1995 of a statewide representative sample of more than 10,000 postpartum women at 19 California hospitals. The focus here was on 5,455 women with family incomes at or below 200 percent of the federal poverty level, making them eligible for Medicaid prenatal coverage.

The point in their pregnancies at which women secured insurance was strongly associated with whether they received early

prenatal care (during the first trimester, when experts say care should begin), even after control for a wide range of sociodemographic and other characteristics. Low-income women who enrolled in either Medicaid or private coverage during their first trimester had rates of early care comparable to rates observed for higher-income women: 91 percent for Medicaid enrollees and 90 percent for privately insured pregnant women. Rates of early care were lower for low-income women who entered pregnancy with coverage: 61 percent for Medicaid and 84 percent for privately insured enrollees. Women who became insured after their first trimester had the lowest rates of early prenatal care: 34 percent of women on Medicaid and 36 percent for privately insured women.

The study found that nearly all low-income women studied had insurance coverage by the end of their pregnancies. Forty-five percent of the study group entered pregnancy uninsured; 21

percent were uninsured throughout their first trimester. The uninsured rate dropped to 6 percent and 2 percent during the second and third trimesters, respectively, with 69 percent of the group ending up on Medicaid.

The authors speculate that uninsured women who seek coverage early in pregnancy do so expressly to obtain prenatal care. Furthermore, uninsured low-income women who seek care early in their pregnancy are likely to be encouraged by their providers to apply for Medicaid. The findings indicate that timing of prenatal coverage should be considered in research on the relationship between coverage and care use among low-income women. Earlier studies without data on when coverage began may have led to inaccurate inferences about lack of coverage as a barrier to prenatal care.

Egarter S, Braveman P and Marchi K. “Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women.” *American Journal of Public Health* 92(3): 423–427, 2002.

- 1. The patient is not able to recognize the abuse:** Physicians need to ask all patients about specific components of abuse to educate them on what constitutes abuse.
- 2. The patient is not ready or able to disclose the abuse.** Physicians should speak privately with patients, display interest and compassion, and specifically discuss their clinical suspicion of abuse.
- 3. The patient is not ready to leave an abusive relationship.** Physicians should refrain from blaming victims and assure them that they do not deserve this treatment. They should offer resources and referrals, but leave to patients the ultimate decision about terminating the relationship.
- 4. The patient is seeking acute care after an assault.** Physicians should offer support, ensure privacy and carefully document their findings.
- 5. The patient has left an abusive relationship.** Physicians need to understand that it takes a long time to heal and they should not replicate the controlling behavior of the abuser in the patient-physician relationship.

The American College of Physicians–American Society of Internal Medicine is distributing the video. A formal evaluation of its effectiveness in changing physician attitudes and behavior is under way.

Elliott L, Nerney M, Jones T and Friedmann PD. “Barriers to Screening for Domestic Violence.” *Journal of General Internal Medicine* 17: 112–116, 2002.

Nicolaidis C. “The Voices of Survivors Documentary: Using Patient Narrative to Educate Physicians About Domestic Violence.” *Journal of General Internal Medicine* 17: 117–124, 2002.

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

Are Teens Talking to Their Doctors and Vice Versa?

Adolescence is a time of change and frequently also is a time of stress and experimentation with high-risk behaviors like smoking and drug use. While many teens are likely to discuss their problems

whether they thought a provider should discuss sensitive issues with a patient their age and whether they had ever discussed the following topics with a health care professional: drinking, drugs, smoking, eating disorders, sexually transmitted disease and pregnancy prevention, physical or sexual abuse, stress, exercise, weight and family life. The teens also provided

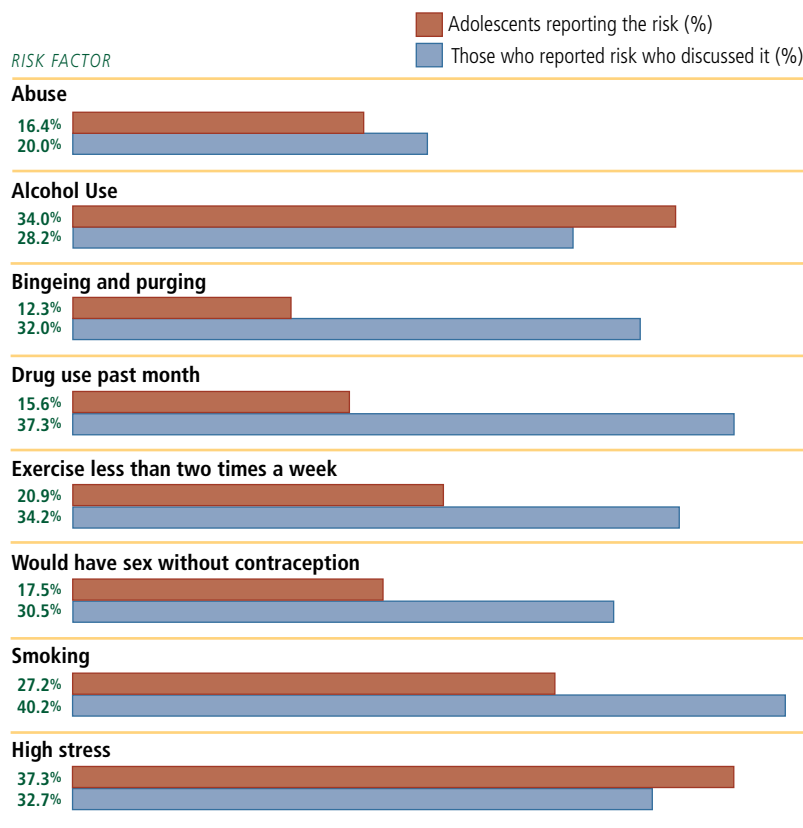
negatively impact their health.” More than a third use alcohol, 27 percent smoke and 18 percent have had unprotected sex. About 37 percent report a high level of stress in their life. Unfortunately, “most adolescents who reported an individual risk factor had not discussed it with their provider.” Adolescents with a female provider and those who had time alone with their provider were more likely to have discussed these risk factors with their provider. Teens who used the television and the Internet to get health information were also more likely to have discussed their risky behaviors with a provider.

According to the authors, their findings reinforce the need for adolescents to speak confidentially with their providers and for providers to use this time to screen for health risks and offer appropriate counseling or referrals. They emphasize the need for local and national advocacy to assure that all teens have access to confidential care. The routine use of screening forms for adolescent care may encourage discussion of the topics teens want and need to have addressed. “Without these system changes,” they contend, “medical care providers will continue to miss opportunities to help adolescents make better decisions about their health.”

Klein JD and Wilson KM. “Delivering Quality Care: Adolescents’ Discussion of Health Risk with Their Providers.” *Journal of Adolescent Health* 30(3): 190–195, 2002.

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

Adolescent Risk Factors and Discussions of Risks



and concerns with parents, they may be more willing to turn to their health care providers for advice on health-related issues — especially if they can do it without a parent present. Are physicians using this valuable opportunity to educate and counsel adolescents? Are teens getting the information they need from their providers? This study looked at data from a survey of nearly 7,000 girls and boys in grades 5 through 12 to answer this question.

The survey questioned adolescents about family socioeconomic status, their health status and regular source of care, and whether they were able to speak privately with their health care provider. In addition, the youths indicated

information on where they most frequently get health information.

The results show that physicians are not maximizing the communication opportunity they have with adolescent patients. Teens want most to talk about drugs, sexually transmitted diseases and smoking, but their clinicians are more likely to ask them about their eating habits, exercise routines and weight. In fact, one-third of the adolescents had not discussed any of the topics they wanted to discuss with their health care provider.

Adolescents’ responses show that they are engaging in high-risk behaviors. “Nearly three-quarters of the adolescents in this nationally representative study reported at least one risk factor that may

Getting Care to Children on Medicaid: Where They Live Matters

From state to state, Medicaid programs differ. For children, who make up more than half of all Medicaid beneficiaries, this means that eligibility, level of coverage and access to care depend in part

on where they live. A recent study looked at differences in health care access and utilization by children in Medicaid programs in 13 states and the nation as a whole, and explored a variety of factors that might account for those differences. Together, these 13 states represent more than half of the nation's Medicaid population. The states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington and Wisconsin.

From the 1997 National Survey of America's Families — a survey of the socioeconomic and health characteristics of nearly 45,000 families across the country — the investigators gathered information

on more than 7,000 children under the age of 17 who were enrolled in Medicaid and whose family incomes were below 200 percent of the federal poverty level. Having a usual source of care was their proxy for access to care. They measured health care use by whether the child had a physician, well-child clinic, dental care, or emergency room visit or a hospital stay over the year prior to the survey.

Overall, about 92 percent of children on Medicaid have a usual source of care and nearly 80 percent saw a physician during the year. By state, however, there are variations in access and use. "In general, access to care tends to be better and use higher among

children on Medicaid . . . in the eastern region of the country and lower in states in the southern region."

Why are there these differences? Health status and educational and economic circumstances certainly play a role. For example, children on Medicaid in Mississippi — which ranks among the lowest states in the nation for both Medicaid coverage and expenditures — are less likely to live in a two-parent family, have spent more time uninsured and have caretakers who are more likely to report being depressed.

Differences in state Medicaid programs also appear to play a role. Children who reside in the states with the lowest Medicaid

spending per low-income child are less likely to have a usual source of care and a well-child visit than children on Medicaid in states with higher Medicaid spending. In contrast, "the local health care environment explains very little of the differences in access and use among children on Medicaid across the states."

The authors conclude: "Our results suggest an association between Medicaid policies and state variation in access and use." They suggest that future research explore how state Medicaid policies promote these differences.

Long SK and Coughlin TA. "Access and Use by Children on Medicaid: Does State Matter?" *Inquiry* 38: 409–422, 2002.

RESEARCH NOTES

Fear of Falling in Older Persons

Many older persons are afraid of falling. Fear of falling may encourage older people to use increased caution in their daily routines and actually protect them against falls. However, some older individuals significantly curtail their day-to-day activities because of this fear and thereby threaten their overall independence.

This study looked at more than 1,000 noninstitutionalized individuals age 72 and older to profile those who were most likely to fear falling — and to act on that fear by restricting their social and physical activities. Trained research nurses asked participants about their fear of falling, history of falls, health status and social support systems; in addition, they assessed, through a series of tests, participants' visual acuity, cognitive and physical functioning, and anxiety and depression levels.

The mean age of participants in the study was 80; 70 percent or more were female, white and lived alone. Nearly 43 percent of the participants reported having a fear of falling. Among these individuals, 44 percent restricted their daily activities. The participants who restricted their activities because of a fear of falling were older, frailer, in poorer health and more likely to show signs of depression than those who reported a fear of falling but no activity restriction. In addition,

individuals with a history of falling and injuring themselves during the year prior to the study were more likely to report that they had restricted their daily activities.

The authors contend that managing the fear of falling among older persons with programs that focus on improving physical skills is not enough. The burden of depression and concurrent chronic conditions should also be addressed. They conclude that "an improved understanding of the important differences among older persons with fear of falling should facilitate the development of targeted interventions based on the specific needs of these distinct subgroups."

Murphy SL, Williams CS and Gill TM. "Characteristics Associated with Fear of Falling and Activity Restriction in Community-Living Older Persons." *Journal of the American Geriatrics Society* 50(3): 516–520, 2002.

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

Doctors Choose Patients' Wishes Over Public Health Interests in Prescribing Antibiotics

Physicians must consider not only issues of efficacy, cost and side effects when prescribing antibiotics. They must also factor in evolution. While modern medicine

is advancing rapidly, bacterial pathogens are keeping pace through the development of antibiotic resistance, rendering modern antibiotics ineffective. But when it comes to balancing the long-term impact of over-prescribing antibiotics against patients' demands for optimal treatment, doctors are deferring to patients' wishes.

This study of 829 physicians — 400 generalists and 429 infectious disease specialists — found that providers were likely to prescribe stronger antibiotics than necessary when dealing with community-acquired pneumonia, according to the guidelines set out by the Infectious Diseases Society of America in 1998.

Physicians appear to understand the implications of overprescribing antibiotics. Of the providers who responded to the study survey, more than 82 percent agreed that resistance to antibiotics is a major concern to public health, and more than 64 percent agreed that by prescribing more potent antibiotics they are likely increasing their patients' risk of acquiring a future drug-resistant bacterial infection. But the majority of respondents also noted that physicians over-prescribe antibiotics because patients demand it. Only 54 percent of respondents said that they consider the long-term societal impacts of administering antibiotics before they do so.

Respondents rated drug resistance the lowest among seven factors they weigh when considering antibiotic use: potential side effects, cost, efficacy, ease of use, knowledge of the drug and illness severity all come first.

In general, infectious disease specialists are more inclined than generalists to consider drug resistance when administering antibiotics. For example, 49 percent of the generalists disagreed with the statement that new drug development would keep pace with the problem of antibiotic resistance, compared to 64 percent of the infectious disease specialists. Also, 42 percent of generalists agreed that they should only consider the needs of their patients when prescribing drugs, compared to 34 percent of infectious-disease specialists.

Researchers conclude that it will take more aggressive efforts than medical guidelines to change physicians' behavior around antibiotic use and choice.

Metlay JP, Shea JA, Crossette LB and Asch DA. "Tensions in Antibiotic Prescribing: Pitting Social Concerns Against the Interests of Individual Patients." *Journal of General Internal Medicine* 17: 87–94, 2002.

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

Study: School Connectedness Protects Adolescent Health

School is the hub of life and learning for most adolescents. It is where they spend a great deal of their time, find friends and begin the exciting, often difficult transition into adulthood. Recent research shows that a favorable school environment could prevent health-risk behaviors such as using alcohol, tobacco or other drugs, and even reduce the likelihood of being involved in pregnancy.

An analysis of results from a national adolescent health study suggests that when adolescents feel connected to their school – that is, when they feel as if they belong to their school and that people there care about them – they are less likely to engage in high-risk health behaviors.

With \$650,000 in support from The Robert Wood Johnson Foundation, Robert Blum, M.D., Ph.D., director of the University of Minnesota's Center for Adolescent Health and Development, analyzed data from the National Longitudinal Study of Adolescent Health, the largest and most extensive research study of adolescents ever conducted in the United States. Blum found that, while the majority of students in most middle or high schools feel "pretty connected" to their school, 31 percent do not. It is this "disengaged" population that is more likely to smoke cigarettes, drink alcohol or use other drugs; engage in sexual activity early; or become involved in weapon-related violence.

"School connectedness is a buffer against or associated with significantly less involvement with every single one of those behaviors," says Blum. "These data contribute to the conversation about what matters in school."

Although Blum's analysis does not explain why students' feeling of school connectedness made them less likely to engage in high-risk health behaviors, the findings

indicate a strong relationship between school connectedness and emotional well-being. The analysis also shows that students' feeling of connectedness depends on classroom management style, types of disciplining actions, relationships with teachers and having a school environment conducive to promoting adolescent development.

For example, middle- and high-school students need opportunities to participate in classroom management, to help establish classroom rules and to make their own decisions, Blum says. They need a school environment where discipline policies are not harsh. They need to feel that teachers

respect and care about them. And they need a school environment where they are encouraged to join extracurricular activities, where they have friends from a variety of social groups and where they won't be lost in a crowd.

Students in Blum's analysis who said they felt connected attended schools with no more than 600 students. "In a smaller school, more people know who you are," Blum says. "In schools that have 900 kids, there are more financial resources for equipment, services, programming and athletics than in schools with 300 to 500 kids, and for academic achievement those resources make a difference."

However, he adds, "Once you get more than 1,200 kids, you have a fallout of both connectedness and learning."

Blum hopes that knowing the ingredients for school connectedness will help schools foster adolescent health. "We pay a fair amount of attention to the content of curricula. This study suggests we need to pay attention to process, to the climate and the environment. It may just be that the environment in which learning takes place is at least as important as the content that is taught."

— ANDREA KOTT

See www.allaboutkids.umn.edu for a copy of the report.

Circle of Life Awards 2002 Pictured below are recipients of the American Hospital Association's annual Circle of Life Award: Celebrating Innovation in End-of-Life Care at the awards ceremony July 26 in San Diego.

Front row, left to right: Liz Sumner, Children's Program of San Diego Hospice and Children's Hospital; Jean Kutner, M.D., Population-Based Palliative Care Research Network, University of Colorado Health Sciences Center; Gretchen Brown, Hospice of the Bluegrass; and Meri Armour and Elizabeth Ford Pitorak, Project Safe Conduct-Ireland Cancer Center at University Hospitals of Cleveland and Hospice of the Western Reserve.

Back row, left to right: David Sine, M.D., Children's Program of San Diego Hospice and Children's Hospital; Sister Mary Roch Rocklage, American Hospital Association; and Stephen Connor, Ph.D., National Hospice and Palliative Care Organization.

The awards, which are funded by The Robert Wood Johnson Foundation, recognize programs that respect patient goals and preferences, provide comprehensive care, address the families' concerns and needs, and collaborate with other organizations to ensure sustainability.

Four organizations, selected from more than 80 nominees, received \$25,000 each in recognition of their contributions to improving care at the end of life:

Children's Program of San Diego Hospice and Children's Hospital. The four-year-old collaboration between San Diego Hospice and Children's Hospital San Diego cares for infants, children and adolescents with life-threatening illnesses, providing clinical, spiritual and physiological support for patients, families, friends and staff.

Hospice of the Bluegrass; Lexington, Ky. Making the community a part of its hospice philosophy, Hospice of the Bluegrass works with area hospitals, community physicians, medical schools and local churches.

Project Safe Conduct-Ireland Cancer Center at University Hospitals of Cleveland and Hospice of the Western Reserve, Cleveland. In a culture traditionally focused on aggressive treatment and cure, Project Safe Conduct has shifted its focus of care to include palliative care in conjunction with therapy and treatment for patients with cancer.

The Population-Based Palliative Care Research Network, University of Colorado Health Sciences Center, Denver. In collaboration with hospices across the nation, this project conducts research on a variety of issues from the role of spirituality in palliative care to staff safety.

For more information about the Circle of Life Award, please visit www.hospitalconnect.com/aha/awards-events/circle_of_life/index.html.

— MAUREEN COZINE



RWJF to Launch "Cover the Uninsured Week" in 2003

The Robert Wood Johnson Foundation, along with a diverse array of other organizations, is planning a week of intensive activities in March 2003 to dramatize the problem of the more than 39 million Americans who have no health insurance.

"Cover the Uninsured Week," slated to take place during the week of March 10, is being sponsored by RWJF and 13 other organizations. These groups have been working together since 2000 on an education and advertising campaign to focus attention on the uninsured.

The all-out effort in March is designed to focus the attention of the nation's leaders on the growing number of uninsured Americans, a problem which is of increasing concern to more people as the economy weakens, says Risa Lavizzo-Mourey, M.D., senior vice president of RWJF. According to a study prepared by Families USA for the campaign, the number of people without health insurance rose by at least 2 million in 2001 as a result of the slowing economy and the layoffs that took place after September 11th. Recent opinion polls conducted by RWJF, the Kaiser Family Foundation and others show increasing concern over this issue. Moreover, recent studies by the Institute of Medicine, funded by RWJF, document that uninsured Americans live sicker and die younger than those with health coverage. The uninsured frequently delay or avoid needed medical care because they cannot afford it. For example, uninsured women who develop breast cancer are twice as likely to die as insured women with the same diagnosis, because uninsured women are often diagnosed at a later stage of their illness.

"In the last year, the situation has grown worse and people feel more vulnerable. We need to get this issue on the front burner," says Lavizzo-Mourey. "Policymakers listen when they get a sense that it is an important issue to their constituents."

The sponsoring organizations are a varied group, including some that rarely collaborate with one another, such as the U.S. Chamber of Commerce and the AFL-CIO, which represent business and labor respectively. In addition to RWJF, the U.S. Chamber and the AFL-CIO, the effort is being supported by the Business Roundtable, Blue Cross/Blue Shield Association, the Service Employees International Union, the American Medical Association, the American Nurses Association, the Health Insurance Association of America, Families USA, the American Hospital Association, the Federation of American Hospitals, the Catholic

Health Association of the United States and AARP. Dozens of national organizations and thousands of individuals have expressed strong interest in joining with these 13 groups and RWJF in building support for "Cover the Uninsured Week." In addition, RWJF grantees working in hundreds of communities across the country are planning to join in the weeklong effort.

Each day of "Cover the Uninsured Week" will highlight the concerns of key constituencies in solving this problem. For example, physicians, nurses, hospitals and clinics are expected to provide free health care screenings to uninsured people at health fairs and to speak out about the need to find more fundamental solutions to this problem. Advocates for children plan to enroll eligible children in Medicaid and the State Children's Health Insurance Program through special events. Medical students

will organize teaching events about the uninsured at medical schools from coast to coast.

Plans also call for elected officials to hold town meetings to explore what could be done to improve access to health care, and for religious leaders to hold interfaith prayer breakfasts and give sermons focused on the moral imperative to solve the problem of the uninsured.

"Cover the Uninsured Week" is the next major effort in a campaign that RWJF has undertaken to bring attention to this problem.

"It's a logical next step to build grassroots support to improve this intolerable situation," Lavizzo-Mourey says. "I hope that out of this week comes a true commitment from thousands and thousands of people across the nation to work toward full coverage for every American."

— SUSAN G. PARKER
See www.coveringtheuninsured.org for more information.

PRISM Awards™ 2002 Amanda Demme (left) accepted from Penelope Cruz the PRISM Award for theatrical feature film on behalf of her late husband, director Ted Demme, for "Blow." The PRISM Awards, which honor the accurate depiction of drug, alcohol and tobacco use in television, film, music and comic books, were created six years ago by The Robert Wood Johnson Foundation, together with the Entertainment Industries Council and the National Institute on Drug Abuse.

On May 9, 2002, some 500 of the entertainment industry's creative community of stars, producers, writers, directors and executives came together for the awards ceremony, which was taped at CBS Television City in Los Angeles. On July 16, the "PRISM Awards" television special premiered on Capitol Hill to a bipartisan congressional audience and leading professionals in health and social issues.

Each year the PRISM Awards receive about 250 submissions from popular TV shows, films and musical performers. These submissions are judged first by experts in health and social issues for their scientific and technical accuracy, and then by a team of entertainment industry members for their quality and entertainment value. Only those submissions that measure up in both categories receive PRISM recognition. See www.rwjf.org for more information on the PRISM Awards.



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

- ⌘ For a dental assistant training program, \$384,900 to Columbia University School of Dental and Oral Surgery, New York.
- ⌘ For improving health insurance coverage options for home care workers, \$350,000 to Service Employees International Union, Washington.
- ⌘ *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children.* Awards to seven sites under *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps*, totaling \$1.8 million.
- ⌘ *Covering Kids and Families.* Awards to 13 sites, totaling \$11.6 million.
- ⌘ For evaluating a program to develop an integrated system of health care for impoverished persons in the Texas border region, \$747,078 to Texas A&M University System Health Science Center Research Foundation, College Station.
- ⌘ *Southern Rural Access Program.* Renewal awards to eight sites, totaling \$7.7 million.

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

- ⌘ *Taking Health Care Home*, \$6 million to the Corporation for Supportive Housing, Oakland, Calif.
- ⌘ For improving chronic disease management in correctional institutions, \$348,019 to National Commission on Correctional Health Care, Chicago.
- ⌘ For developing strategies to address the challenges of America's aging population, \$640,004 to the National Governors' Association Center for Best Practices, Washington.
- ⌘ For developing online measures of health care quality based on consumers' assessment of their own health care, \$388,147 to FACCT, Portland, Ore.
- ⌘ *Faith in Action II.* Awards to 53 sites, totaling \$1.8 million.
- ⌘ *Improving Chronic Illness Care.* Awards to three sites, totaling \$299,964.
- ⌘ *Pursuing Perfection: Raising the Bar for Health Care Performance.* Renewal awards to seven sites, totaling \$13.3 million. One grant of \$1.5 million for an evaluation of the program to Boston University School of Public Health.
- ⌘ *Targeted End-of-Life Projects Initiative.* Award of three program grants, totaling \$653,470.

Projects to Promote Healthy Communities and Lifestyles

- ⌘ For evaluation of physical activity programs for sedentary mid-life and older adults: best principles, practices and programs, \$2.3 million to the National Council on the Aging, Washington.
- ⌘ For developing a flexible screening and brief intervention tool to address multiple behavioral health risks in primary care, \$390,442 to the Bayer Institute for Health Care Communication, West Haven, Conn.
- ⌘ For preventing and treating chronic disease in safety-net populations through a faculty development program, \$375,000 to the Morehouse School of Medicine, Atlanta.

- ⌘ For examining the relationship of local government recreation and park services to the health of older adults, \$321,345 to the Pennsylvania State University College of Health and Human Development, University Park.
- ⌘ For promoting child well-being in home, pediatric health care, and early care and education settings, a renewal award of \$480,000 to the Task Force for Child Survival and Development, Decatur, Ga.
- ⌘ *Active Living By Design.* Award of one grant of \$461,396 for the National Program Office to the University of North Carolina at Chapel Hill Public Health Foundation.
- ⌘ *Leadership for Active Living.* Awards to three sites, totaling \$973,405.
- ⌘ *National Community Development Initiative.* Awards to two sites, totaling \$3 million.
- ⌘ *Turning Point: Collaborating for a New Century in Public Health.* One renewal award of \$400,000 to the Nevada Public Health Foundation, Carson City.

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

- ⌘ For determining whether national-level tobacco policies decrease smoking: A four-country tobacco policy study, \$1.5 million to Health Research, Buffalo, N.Y.
- ⌘ For incorporating substance abuse treatment into welfare reform programs, \$743,000 to the National Center on Addiction and Substance Abuse at Columbia University.
- ⌘ For developing a campaign to engage nurses in tobacco control, \$397,410 to the University of California, Los Angeles, School of Nursing.
- ⌘ For developing a worksite wellness program to reduce tobacco use in New York City, \$400,000 to City of New York Department of Health.
- ⌘ For increasing adolescent substance abuse screening in health care settings, a renewal award of \$749,913 to Children's Hospital Corp., Boston.
- ⌘ For embedding prevention in state policy and practice as the preferred policy for reducing crime, violence and substance abuse, a renewal award of \$350,000 to the National Crime Prevention Council, Washington.
- ⌘ *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol.* One renewal award of \$545,483 to the City of New Haven (Conn.) Office of the Mayor.
- ⌘ *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* Renewal awards to 15 sites, totaling \$3 million.
- ⌘ For the National Center on Addiction and Substance Abuse at Columbia University, a renewal award of \$9 million.
- ⌘ For the National Resource for Community Substance Abuse Initiatives, a renewal award of \$9 million to Boston University School of Public Health.
- ⌘ Policy Advocacy on Tobacco and Health: An Initiative to Build Capacity in Communities of Color for Tobacco Policy Change. One award of \$2.3 million to the Praxis Project, Columbia, Md.
- ⌘ *Smoke-Free Families: Innovations to Stop Smoking*

During and Beyond Pregnancy. For marketing and communications support for the *Smoke-Free Families National Partnership to Help Pregnant Smokers Quit*, \$1.4 million to the University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.

- ⌘ *SmokeLess States™: National Tobacco Policy Initiative.* Awards to six sites, totaling \$4.1 million.
- ⌘ *Substance Abuse Policy Research Program.* Awards to 11 sites, totaling \$3 million.
- ⌘ *Voices in the Debate: Minority Action for Tobacco Policy Change.* One award of \$2.4 million to the National African-American Tobacco Prevention Network, Raleigh, N.C.

Other Programs and Those That Cut Across Foundation Goals

- ⌘ For the Public Health Informatics Institute: *Modifying Information Systems to Improve Bioterrorism Readiness and Laboratory Management*, \$2.9 million to the Task Force for Child Survival and Development.
- ⌘ For improving the education and training of health care executives, \$479,600 to the National Center for Healthcare Leadership, Chicago.
- ⌘ *Colleagues in Caring: Regional Collaboratives for Nursing Work Force Development.* One renewal award of \$309,028 to the American Association of Colleges of Nursing, Washington.
- ⌘ *Generalist Physician Faculty Scholars Program.* Awards for 15 scholars, totaling \$4.5 million.
- ⌘ *Changes in Health Care Financing and Organization.* Awards to four sites, totaling \$383,999.
- ⌘ *Minority Medical Faculty Development Program.* Awards for seven fellows, totaling \$2.6 million.
- ⌘ *The Robert Wood Johnson Clinical Scholars Program.* Renewal awards to seven sites to support the 2002–2004 cohort of scholars, totaling \$4.7 million.
- ⌘ For researching public opinion on RWJF priorities, \$345,000 to Harvard University School of Public Health, Boston.
- ⌘ *Children's Futures.* An award of \$2 million for evaluation of the program to Public Private Ventures, Philadelphia.
- ⌘ *Investigator Awards in Health Policy Research Program.* Awards for four investigators, totaling \$1.1 million.
- ⌘ For expanding a nursing education program, \$425,989 to Middlesex County College Foundation, Edison, N.J.
- ⌘ For a revitalization program for the city of New Brunswick, N.J., \$500,000 to the New Brunswick Development Corp.
- ⌘ For a citywide program to strengthen human services and resources, \$400,000 to New Brunswick Tomorrow, New Brunswick.
- ⌘ Support for the 2001–02 annual campaign drive, \$660,000 to the United Way of Central Jersey, Milltown.

PEOPLE

STEPHEN DOWNS, M.S.,

joined the Foundation in May in the position of senior program officer working with both the Health and Health Care Groups on program initiatives in information technology.

Previously, Downs was director of the Technology Opportunities Program for the U.S. Department of Commerce, Washington. He earned his M.S. in technology and policy from Massachusetts Institute of Technology.

LORI MELICHAR, Ph.D., began working at the Foundation in June as a program officer in the Research and Evaluation Unit. Prior to joining RWJF, Melichar was a social science analyst at



the position of senior program officer working with both the Health and Health Care



the National Institutes of Health. She earned her master's and Ph.D. degrees in economics from the University of Maryland at College Park.



CHINWE ONYEKERE, M.P.H., started at the Foundation in June as a program

associate in the Health Care Group, assigned to the Priority Populations Team. Onyekere most recently worked as a research assistant on projects associated with Weill Medical College of Cornell University and Harvard Medical School. She earned her M.P.H. from Columbia University.

RAMASWAMY SURYANARAYANAN became a permanent member of the RWJF staff in June as a



business applications manager in Information Technology. A consultant to the Foundation since 1993, Suryanarayanan had previously worked for Pentafour Software Solutions in Cerritos, Calif. He holds a B.S. in mathematics.

KRISTEN PELA began working at the Foundation in July as a



technical trainer in Information Technology. Formerly, Pela was a technical training specialist for Software Associates International, Mt. Arlington, N.J.

MEGHAN BENCZE joined the Foundation in July as a



program intern in the Health Group. Before coming to RWJF, she was a program associate at Bass and Howes Inc. in New York City. Bencze currently is pursuing a master of public health degree at Columbia University.

CONGRATULATIONS!

BARBARA MATACERA-BARR

has been promoted to program officer and will continue working with the Coverage Program Management Team.

FAREWELL

MARLA HOLLANDER, program associate, left the Foundation in June to become director of the Leadership for Active Living and Active Living Coordination Center in San Diego, Calif.

JUDY WHANG, senior program officer, left the Foundation in June and now is living in California.

New Grant Results Reports Posted on RWJF Web Site

Since April 2002, 35 new Grant Results Reports and three National Program Reports have been posted at www.rwjf.org. These reports, organized by topic area, detail the results of grants that are now closed. Among the newly posted reports:

- **Education of Policymakers: Tobacco Debate.** The American Council on Science and Health (ACSH), a consortium of more than 350 scientists and physicians dedicated to educating consumers on health issues, has published a paper that presents the views of both sides of the political spectrum on the issue of tobacco policy. The report describes how the political "left"

and "right" interpret scientific findings differently, hold diverse views on youth smoking and advocate that governmental regulation of the tobacco industry should take different directions. The report is available free on the ACSH Web site, www.acsh.org/publications/reports/ideological_Divide.html.

- **Fostering Awareness: Early Brain Development Message.** The book and presentation kit *Rethinking the Brain: New Insights into Early Childhood Brain Development* from the Families and Work Institute (FWI) are meant to raise public awareness of the importance of the first three years of life. An

outreach network is disseminating FWI's findings to families, educators, and governmental, media and faith-based groups. Sixteen states and cities have created legislation based on this research, and the governors of 31 states have conferred to help shape legislation. Both products are available in the publications area of the FWI Web site, www.familiesandwork.org. The book costs \$25. The presentation kit is available in components or as a set: PowerPoint CD-ROM, \$50; hard-copy transparencies, \$150; the set, \$190. The book and presentation kit purchased together cost \$175.

- **Online Self-Care Guides and Information.** Healthwise worked in four Idaho counties, bringing self-care information to public libraries, clinics, worksites and the Web. The goal was to determine if this information might cut down on unnecessary clinic visits. Guides and handbooks aimed at different populations can be obtained at www.healthwise.org. *Healthwise Handbook* (also available in Spanish) is for families; *Healthwise for Life* is geared to older adults. Each handbook costs \$9.95 plus shipping; quantity discounts are available.

— PATTI HIGGINS AND
MARIAN BASS