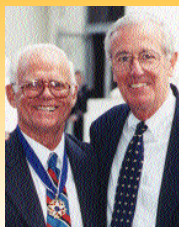


- The
- Robert
- Wood
- Johnson
- Foundation
- Quarterly
- Newsletter

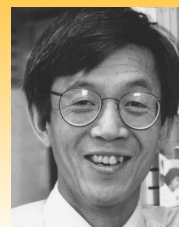
Burke Honored with Presidential Medal

PAGE 3



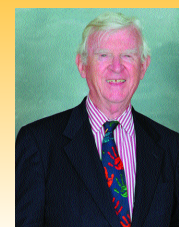
Protecting Confidentiality of Medical Records: What Is at Stake

PAGE 4



Lee Named 15th Recipient of Lienhard Award

PAGE 9



Lessons from Workers' Compensation: DISABILITY PREVENTION AND MANAGEMENT CAN IMPROVE THE QUALITY OF HEALTH CARE

Every year in the United States some seven million individuals suffer from work-related injuries or illnesses. That's about 5% of the working population. Yet until the last few years, very little attention was paid to the quality of medical care provided through the state-regulated workers' compensation systems that cover these cases.

In 1995 The Robert Wood Johnson Foundation pitched in to help change the situation. Amidst growing concerns over the cost, quality, and access to health services for work-related ailments, the *Workers' Compensation Health Initiative* was launched.

"We wanted to encourage some new thinking about ways to organize the system and improve the quality of care and access to care," says James Knickman, PhD, vice president for research and evaluation at RWJF.

Some of that new thinking is being done by employers, health care systems, and labor groups who are reassessing their approaches for providing high-quality medical services to injured employees.

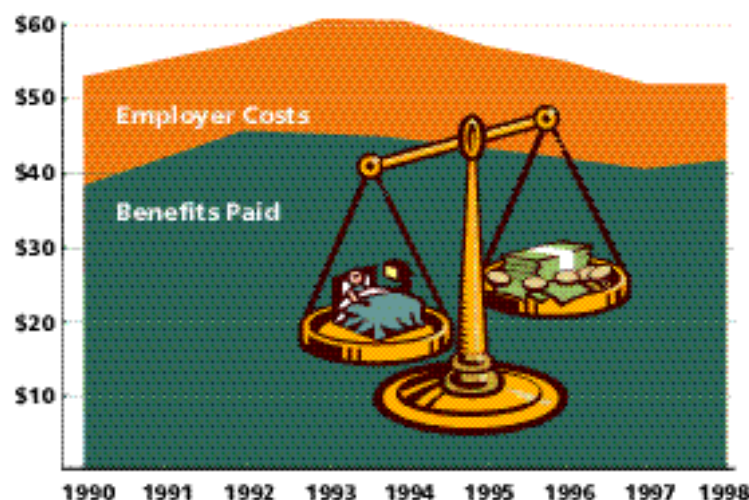
"There is a growing understanding that both occupational injuries and chronic disabilities affect productivity," says Jay Himmelstein, MD, national program director of the *Workers' Compensation Health Initiative*, which is housed at the University of Massachusetts Medical School. "And the result has been an evolution toward enhanced disability management programs."

FEATURES

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

Workers' Compensation Employer Costs and Benefits Paid

(in billions of dollars, not adjusted for inflation)



Employer Costs include costs to employers who purchase insurance from private carriers, state funds, federal programs, and who are self-insured. These costs are the aggregate of benefits paid and administrative expenses.

Benefits Paid are the cash and medical benefits paid to injured workers through employer workers' compensation insurance programs.

Source: *Workers' Compensation: Benefits, Coverage, and Costs, 1997-1998 New Estimates*, National Academy of Social Insurance, Washington, D.C.:May 2000.

A SYSTEM WITH PROBLEMS

One of the biggest problems with the workers' compensation system is that it operates under a set of complex rules that separate it from other forms of health coverage, says Allard Dembe, ScD, the initiative's deputy director. To qualify for workers' compensation coverage, an injury or illness must be determined by a physician to be work-related. The treating physician also decides when and to what kind of job duties an injured worker may return, and what, if any, permanent disability results. The physician's decisions in these matters can affect how much money a worker receives in wage replacement and disability benefits.

The rules are supposed to ensure prompt and appropriate treatment, but often they simply delay or deny care to workers who must wait for rulings by

ISSUE 4, 2000

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

See Lessons — page 2

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

Reproduction of material published in *ADVANCES* is encouraged with the following attribution:

"From *ADVANCES*,

The Robert Wood Johnson Foundation quarterly newsletter."

Printed on recycled paper.



From Lessons — page 1

insurers or administrative judges, Dembe notes. Further complicating the access issue are low statutory fee structures in some states, which some physicians say are inadequate to cover the time they spend treating, documenting, and even testifying in workers' comp cases.

All of this tends to breed an excessively adversarial relationship in which injured workers often consult an attorney before seeing a doctor, says Peter Barth, PhD, of the University of Connecticut, who serves on the National Advisory Council for the initiative. "The presence of an attorney early on can affect the way a worker uses health services. It's not something you run into with regular health insurance."

Quality of care is another issue. "There is less good scientific background on occupational injuries than for the most common general medical problems. We know high blood pressure should be treated a certain way, but there may be significant disagreement among physicians about how to treat work-related back pain," says Liza Greenberg, MPH, of the American Accreditation Health Care Commission (also known as URAC) in Washington, D.C., which received a grant to develop quality measures for workers' compensation managed care plans.

Tracking quality in workers' comp is also complicated by the low volume of cases in a given network relative to general health insurance, she points out.

Not surprisingly, all of this leads to higher costs. Workers' comp in the early 1990s dwarfed even the high overall health care inflation rate. That's what really got employers to focus on it.

AN APPROACH WITH LARGER LESSONS

Some solutions to these problems seem clear. More outcomes research, protocol development, and

best practices dissemination for specific occupational medical care are major goals of the initiative, as is development of mechanisms to eliminate barriers impeding access to timely and appropriate care for injured workers.

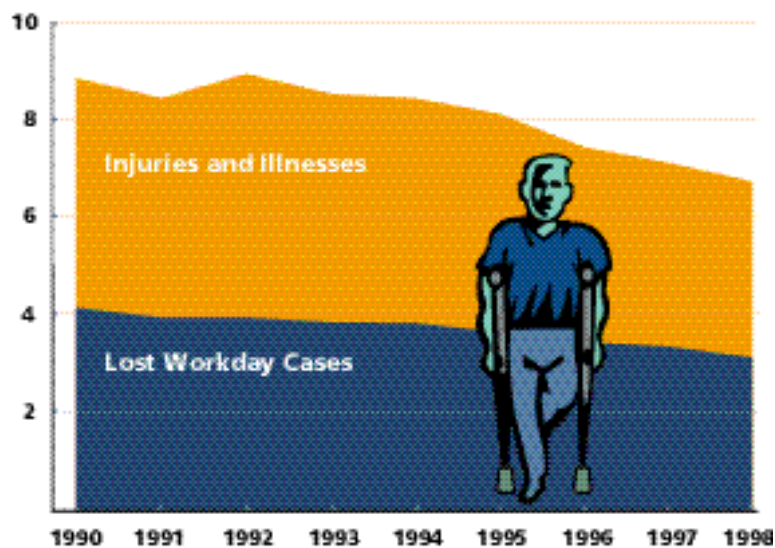
But the solution to workers' comp problems is not to make the system look and act more like the rest of health care. In fact, workers' compensation's focus on returning workers to full function — a process that integrates the health care they receive with an examination of their work requirements, environment, and activity demands — is proving a valuable approach to improving health care generally,

to ask more questions about patients' everyday functioning and to tailor treatment to maximize functioning. For example, an elderly patient might receive therapy to restore mobility lost after an extended illness.

As with many of the initiative's projects, the Minnesota Health Partnership study is not yet complete. But Calasanz says the preliminary data show a significant improvement in functional status among patients who have received the intervention over controls who have not.

The *Workers' Compensation Health Initiative* also is supporting efforts to strengthen the focus

Workplace Nonfatal Injury and Illness Incidence Rates for Private Industry (per 100 full-time workers)



Source: Bureau of Labor Statistics, US Department of Labor.

says Marilou Calasanz of the Minnesota Health Partnership. "General health plans have been good at controlling overall utilization and workers' comp plans have been good at evaluating and reducing disability. We're hoping to benefit both by combining the best of both worlds."

The partnership, a coalition of Minneapolis-area health plans and employers representing about 11,000 workers, is testing a program in which patients at general medical clinics receive disability evaluations and counseling. Physicians are coached

of health care on everyday functionality by developing case management protocols. Under the protocols, nurse managers are trained to go beyond evaluating worker disabilities using standard tests. They go into the workplace to assess what can be done to help injured workers fully recover and prevent future injuries, says Michael Feurerstein, PhD, of Georgetown University.

Nurses look at administrative changes, such as scheduling more breaks or rearranging schedules to

See Lessons — page 9

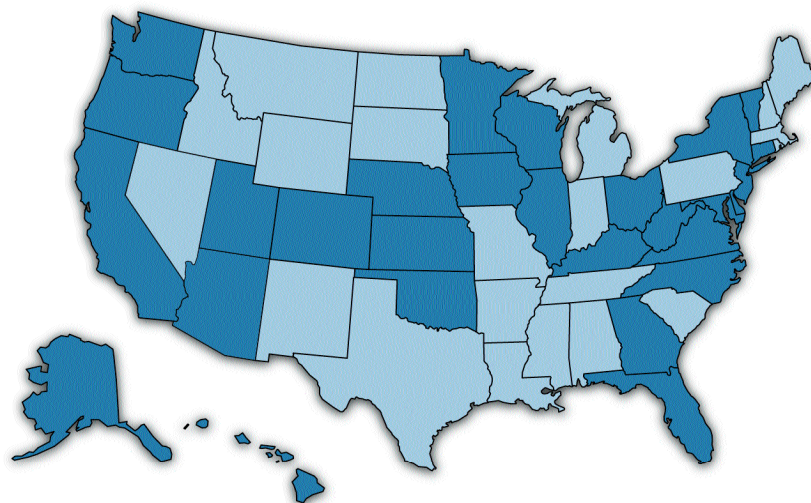
SmokeLess States® Seize Tobacco Settlement Opportunities

In light of recent litigation against the tobacco industry, the prevention landscape has dramatically changed. Suddenly, millions of dollars in settlement money are available, and local organizations have a rare opportunity to advocate using a portion of these funds for tobacco control. Unless tobacco-control groups are effective in raising public awareness, however, much of this money may be spent on other priorities, such as roads or prisons, and an historic opportunity to advance tobacco control may be lost.

“There are people and organizations in all states that are very passionate about this issue. A lot of them just need assistance to get organized,” says Karen Gerlach, PhD, MPH, program officer at The Robert Wood Johnson Foundation. “The *SmokeLess States* National Program Office can help them pull together appropriate groups in the state and formulate a plan to mobilize public opinion in favor of tobacco control.”

The Foundation recently authorized \$52 million over the next three years in renewal of the *SmokeLess States: Statewide Tobacco Prevention and Control Initiatives*, to offer support to more state coalitions to address tobacco policy issues within their states, including the use of settlement funds for prevention and health. The program, which currently includes 27 states and two cities (Tucson and Washington, D.C.), helps local coalitions set up tobacco-control initiatives. To qualify, applicants must be able to mobilize a broad-based statewide coalition, foster public awareness of the issue, and advocate tobacco-control policies within their state. Since 1993, *SmokeLess States* has provided \$39 million to state-level private organizations. Capacity-building and

SmokeLess States Grantees



implementation grants ranged from \$500,000 to \$1.5 million, while smaller grants of \$45,000 to \$60,000 were made for special opportunities.

In areas with *SmokeLess States* projects, a greater percentage of settlement money has been

allocated for tobacco prevention than in states without the program's support. For example, Hawaii allocated 25% of its settlement funds for tobacco control, an estimated \$294 million over 25 years. Similarly, Maryland earmarked \$300 million for

prevention over 10 years. Of the 23 states that have set aside at least \$10 million for tobacco control, 18 have been *SmokeLess States* grantees. Those 18 states have set aside a total of \$3.3 billion for tobacco control, according to the *SmokeLess States* National Program Office.

In Maryland, for example, the *SmokeLess States* program helped grantee Smoke Free Maryland and local groups forge an alliance of tobacco-control advocates that was able to gain credibility and bring a strong, consistent message to the policy debate. *SmokeLess States* staff members helped the Maryland activists anticipate the opposition's public relations strategy and formulate effective responses and media messages. Their work paid off: The Maryland state legislature agreed in December 1999 to set aside \$30 million per year for tobacco prevention over the next decade.

Throughout the campaign, says Kari Appler, project manager for Smoke Free Maryland, they kept focusing public attention on their

See *SmokeLess States* — page 10

Trustee Emeritus Wins Presidential Medal of Freedom

RWJF Trustee Emeritus Jim Burke (left, with Richard Bonnette, president and CEO of the Partnership for a Drug-Free America) was awarded a Presidential Medal of Freedom, the nation's highest civilian honor, by President Bill Clinton at a White House ceremony August 9. Burke, chairman emeritus of Johnson & Johnson and founding chairman of the Partnership for a Drug-Free America, was one of 15 recipients of the award this year.

The common bond among the honorees, a diverse group including Holocaust survivor Simon Wiesenthal and Children's Defense Fund President Marian Wright Edelman, President Clinton said, is that they have all “helped America to achieve freedom . . . to secure the blessings of liberty by acts of bravery, conscience, and creativity.”

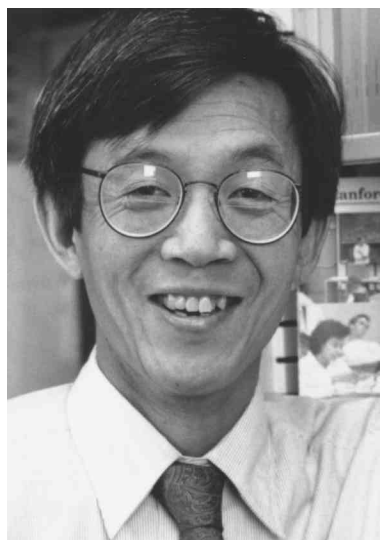
President Clinton commended Burke for his “years and years and years of passionate devotion” to raising awareness about the risks of illegal drug use. Burke's “willingness to make the tough call in times of crisis and to put the public interest above all else has placed a higher premium on candor and corporate citizenship in the business world,” the president said. “In an age when many look only to the bottom line, he draws his values from a deeper well.”

Burke spent 37 years at Johnson & Johnson, where he was named president in 1973 and chairman and CEO in 1976. Upon his retirement in 1989, Burke signed on as chairman of the Partnership for a Drug-Free America, where he continues his work today. Burke was elected to the RWJF Board of Trustees in 1987 and assumed the position of trustee emeritus in January 2000.

President John F. Kennedy established the Presidential Medal of Freedom by executive order in 1963.

— MAUREEN COZINE





At the touch of a key or the click of a mouse, a patient's records can be immediately accessed by an emergency room nurse — or an inappropriately curious records clerk. Too many confidential medical records are left unprotected, says Bernard Lo, MD, an internist and medical ethicist at the University of California–San Francisco School of Medicine. If doctors, health care systems, and hospitals don't move quickly to safeguard private information, they risk losing their patients' trust. Lo is national program director for The Robert Wood Johnson Foundation's *Strengthening the Patient-Provider Relationship in a Changing Health Care Environment*, which is, among other things, examining the Internet's impact on medical care. In this interview with *ADVANCES* he talks about the importance of keeping medical records safe and secure.

How does privacy — or the lack of it — affect the quality of medical care a patient receives?

Lo — Privacy and confidentiality are very important to patients. Patients may talk to their doctors about very sensitive topics, such as drug and alcohol abuse, sexuality, and psychological and emotional issues, which they may not discuss with anyone else. If patients are afraid to talk to doctors about these problems, their health may suffer. On the one hand, if a patient with a sprained ankle doesn't reveal his psychiatric history, the quality of care is unlikely to suffer. On the other hand, if a patient with fever

and headaches doesn't tell the doctor about HIV infection or injection drug use, the doctor could fail to order necessary tests.

Most of us have heard a doctor's office manager go over the details of a patient's bill in a voice loud enough to be overheard by everyone in the waiting room. How can you convince providers and their staffs to respect all aspects of a patient's privacy, both on- and off-line?

Lo — Organizations need to take confidentiality seriously. In our clinic, we have signs saying, "We respect your privacy. Please wait behind the red line," so other patients can't overhear what's being said. Just in the course of explaining where to get a test, confidential information may be passed on. It's not just doctors and nurses who need to think about confidentiality; it's also clerks, secretaries, phlebotomists, and laboratory technicians. These health care workers not only need to keep their voices down, but also need to be vigilant about not giving out their computer passwords, and not using their access to computer information to satisfy their personal curiosity. Health care organizations need to train their workers about the importance of confidentiality, and enforce their confidentiality policies.

Do computer hackers pose a significant threat to the confidentiality of medical records?

Lo — I think most breaches of confidentiality are inside jobs, someone who sees that a friend or neighbor is in the hospital and thinks, "Gee, I wonder why they're here." When a celebrity checks into a hospital, lots of people run to their terminals to find out what's wrong. In the pre-computer days, snooping was harder to do. Even if somebody rummaged through paper medical records, it was only one person at a time, and it was hard to find information. The strength (and the threat) of

computerized records is that you can retrieve large amounts of information on a lot of patients. If I have access to a computerized record system, I can easily download the names of all the people who are on antidepressants, all the people with HIV — unless the computer system is set up to prevent me from doing so.

In an emergency, reliable knowledge about a patient's medical history can be lifesaving. How do you balance the clear medical advantage of an easily accessible records database with the concern that those records might be misused?

Lo — Computerized medical records are terrific in many ways. When I'm on call and a patient phones in at night, having access to medical records from my home allows me to provide better care and advice. However, the computerized records system needs to tailor access to the job description. If I'm a doctor in an emergency room, I have to be able to swiftly access any clinical information on the patient. Whereas if I'm a clerk checking insurance eligibility or sending out bills, I don't need to know clinical details, just what type of service was rendered and on which dates. We have the computer technology to limit access appropriately. Every time someone tries to access information that they do not need for their job tasks, the computer system can generate a message that warns: "If staff access patient information that they do not have a legitimate reason to see, it may be grounds for dismissal." The organization needs to let employees know that it is not acceptable to look at patients' records if that is not necessary to carry out their job.

What do medical organizations need to do to assure patients that their medical information is secure?

Lo — We need to make it just as confidential as making purchases

on the Internet. I conduct a lot of medical transactions with my patients through e-mail. It's more efficient than the telephone. Unfortunately, that e-mail may be vulnerable to interception. We need to put in system-wide encryption programs, so that e-mail is safe. But that's going to cost a lot of money that many organizations don't have. After putting in place those confidentiality protections, health care organizations need to explain them to patients, just as e-commerce companies explain to customers how they keep information secure.

Some consumer advocacy groups have opposed all federal privacy legislation, because none of the proposed bills provide absolute safeguards. What should be done to ease their concerns and win their support?

Lo — Absolute protection is a fruitless goal. We are never going to get there, except at the price of making inaccessible the information that's needed for medical care. The question is: "How can we improve the current situation?" There's got to be something better than what we have now — state-by-state regulations that are inconsistent, piecemeal, and don't provide meaningful penalties. We need comprehensive, sensible federal legislation that protects confidentiality while also allowing access to medical information in ways that improve the quality and efficiency of health care.

— INTERVIEW BY
ELIZABETH AUSTIN

EDITORIAL NOTE: As a condition of its grants, RWJF requires that grantees conducting research involving human subjects certify they have applied the ethical standards and the criteria for approval of grants set forth by the US Department of Health and Human Services, which include measures to protect individual privacy. Further, the Foundation requires that any public use data tapes from funded projects be constructed in a way that assures individual privacy.

- Selected
- Summaries
- of Recently
- Published
- Research by
- RWJF Grantees

The US Nursing Workforce: Aging and Shrinking

More than 2 million strong, registered nurses (RNs) make up the largest group of health care professionals in this country. Because of their numbers and the vital role RNs play in health care delivery, changes in the supply or composition of the nursing workforce are felt throughout the industry. Data from the US Census Bureau's annual Current Population Survey (CPS), a national survey of households that includes employment questions, indicate that America's nurses are getting older. In fact, since the early 1980s, the average age of employed RNs increased by more than 4 years to age 42 and the proportion of the RN workforce under age 30 dropped from approximately 30% to 12%.

Why is the RN workforce aging and what does it mean for US

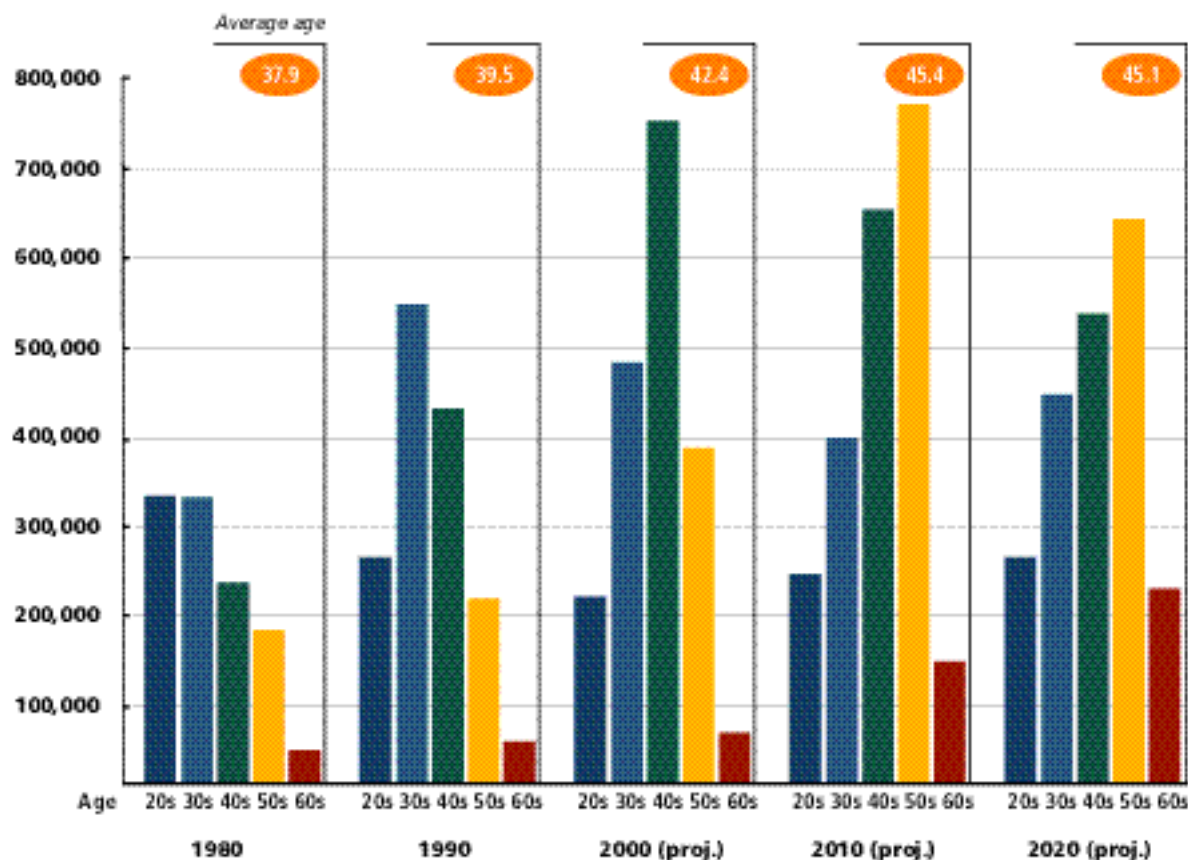
health care? This study identified the factors contributing to the change in the age distribution of the nation's nurses and discussed the implications. The investigators combined employment data from the CPS for the last 25 years with US Bureau of the Census population projections. They examined how changes in the US population and the aging of employed nurses affect the overall composition of the RN workforce.

Looking at the size of the RN workforce that was or will be age 45 in each year, they estimated that the number of 45-year-old RNs would peak around the year 2000, "reflecting both the effects of the baby boom (i.e., a large overall population aged 45 years) and the high propensity of women born around 1955 to choose nursing as a career." After 2000, the estimated number of 45-year-old RNs drops because fewer individuals born after 1955

chose nursing as a career. In 2015, the number of 45-year-old RNs is estimated at about 35% less than in 2000, although there will be about as many individuals age 45 in the population as there are in 2000.

The authors point to important factors that contribute to the aging of the RN workforce. The baby-boom era produced a disproportionately large number of college-age women for nursing schools to tap in the 1960s and 1970s. In succeeding years the number has been smaller. Expanded career opportunities in fields other than nursing also have reduced the pool of potential new nurses. These trends translate into an aging RN workforce in the short term and a shrinking one in the long term. In 2010, more than 40% of RNs are projected to be older than 50. In addition, the investigators' projections show that the number of full-time RNs per capita will peak in 2007 and then decline through 2020. In 2020, the authors estimate that

Registered Nurses (Full-Time Equivalent) by Age Group



Source: US Census Bureau's annual Current Population Surveys.

the RN supply will be nearly 20% less than what is needed to serve the US population.

Because the aging and shrinking of the RN workforce are predicted to coincide with the baby boomers' first wave of retirement and enrollment in the Medicare program, the authors urge "policymakers [to] understand, and develop appropriate responses."

Buerhaus PI, Staiger DO, and Auerbach DI. Implications of an Aging Registered Nurse Workforce. *The Journal of the American Medical Association* 283 (22): 2948-2954, 2000.

Charting the Dying Experience of Cancer Patients

Each year, cancer kills more than 500,000 Americans. Only heart disease takes more lives. Despite cancer's heavy toll, few studies have documented the overall dying experience of people with cancer, focusing instead on more circumscribed aspects of the end of life, like pain. In fact, most of what is known about dying with cancer is anecdotal – contained in stories passed on by word-of-mouth, in newspapers, or in the medical literature.

To improve the quality of care for people dying with cancer, physicians and patients need more accurate information about the dying process. This study examined cancer patients' last 6 months of life to characterize the dying experience.

The researchers collected data from medical charts and interviews of patients enrolled in SUPPORT (Study to Understand Patient Prognoses and Preferences for Outcomes and Risks of Treatments) — 316 people dying with colon cancer and 747 with lung cancer.

(SUPPORT was a study that examined the care preferences and outcomes of seriously ill patients at 5 academic medical centers to improve quality of care and clinical decision-making.) To describe the progression toward death, the investigators separated the last 6 months of life into 4 "observational windows," moving backward from the date of death: 3 days before death; 3 days to 1 month before death; 1 month to 3 months before death; and 3 months to 6 months before death. For each window, they looked at a variety of measures, including days spent in the hospital, prognosis, severity of illness, ability to perform common daily activities such as eating and walking, pain, emotional symptoms, preferences for care, and the financial impact on families. Information about the last 3 days of life was gathered through after-death interviews with patients' families or caregivers.

Within one year after SUPPORT enrollment, 61% of colon cancer patients and 80% of lung cancer patients had died. Over the last 6 months of life, patients with lung cancer spent an increasing percentage of their days in the hospital: 3 to 6 months before death they were hospitalized on average 11% of the time, and spent 27% of the time in the hospital during the last month before death. In contrast, colon cancer patients spent less time in the hospital the closer they came to death.

Until the last month before death, most cancer patients were highly functional — able to use the toilet, walk, move from a sitting to a standing position, and bathe, dress, and feed themselves. During the last month of life, patients' functional capacity dropped precipitously: on

average they could perform only 2 of these activities and by 3 days before death, they could perform none.

Pain and confusion were common complaints among the cancer patients. More than 40% were in severe pain during the last 3 days of life and about 28% of patients experienced severe confusion during this same time period.

Patients' care preferences changed as their health declined. Patients increasingly preferred comfort care to life-extending care. They did not want to be resuscitated — and were more likely to document this in writing — as death approached.

The authors suggest that there are many important opportunities for improving the care of cancer patients at the end of life. "An important first step is using these data to counsel patients about what to expect as death approaches," they write.

McCarthy EP et al. Dying with Cancer: Patients' Function, Symptoms, and Care Preferences as Death Approaches. *Journal of the American Geriatric Society* 48 (May):S110-S121, 2000.

Health Insurance Declines for People with Mental Illness

People with mental illness often are in danger of becoming uninsured, not only because they may be unemployed or unable to afford employer-sponsored health insurance, but because insurance coverage for mental health care itself has declined over the past decade. Health plans continue to impose more limitations and higher payment rates for mental health than for physical illness coverage. Legislation in some 30 states has attempted to equalize physical and mental health

coverage, but it has had little effect on patients' benefits or their access to care. There also is concern that the additional cost of such policies could cause some employers to drop medical or mental health coverage altogether.

For a better understanding of how these developments in insurance coverage have affected persons with mental illness, the investigators examined data from Healthcare for Communities, a 1998 national household survey sponsored by RWJF that tracks changes in the health care system for mental health and substance abuse treatment. Clinical screening questions identified individuals likely to have major depression and dysthymic disorder, generalized anxiety disorder, bipolar disorder, and psychotic disorder.

The researchers compared individuals who did not screen positively for a mental disorder with those in 3 other categories: individuals with probable depression, those with any one of the other mental disorders, and those with a high level of psychological stress.

In these different comparisons, the researchers examined whether insurance status changed (insured to uninsured, no change, or uninsured to insured); if the individuals felt their insurance coverage was better, worse, or the same as 2 years ago; and whether they felt it was easier, harder, or about the same to get good health care as compared to 2 years ago.

The results showed that, compared to people without a mental disorder, individuals with mental illness were more likely to have lost health insurance in the previous year, to report that their health insurance had deteriorated, and to feel that access to care had become more difficult. In contrast, in the general

population, the percentage of uninsured persons did not change appreciably over the same time period, and most people felt that their insurance coverage had improved.

The investigators contend that while more aggressive case management for mental health care may contribute to the feeling that the quality of insurance coverage and the availability of care for mental health has declined, people with mental illness have, in fact, experienced greater declines in their insurance status than the general public.

Sturm R and Wells K. Health Insurance May Be Improving — But Not for Individuals with Mental Illness. *Health Services Research* 35 (April):253–262, 2000.

See related article by the authors in the same issue: Mental Health Parity Legislation: Much Ado About Nothing, 263–275.

Underage College Students Find Alcohol Cheap and Easy to Get

College campuses in the United States are often settings for heavy drinking among students, about half of whom are under the legal drinking age of 21. Studies have shown that underage drinking on college campuses is widespread, even though the minimum legal drinking age was established in 1984. Legislation enacted in 1989 required colleges to publish information on the legal drinking age and establish penalties for violators.

Researchers know that heavy drinkers on campus are most likely to be white, male, under age 23, and a fraternity or sorority house resident. But they know less about “environmental” factors linked with student drinking — alcohol prices, proximity of bars to campus, and

promotions that lower drink prices. If the ways in which these factors influence underage versus of-age students to drink were better understood, more effective prevention strategies could be developed.

Researchers reviewed data from their 1997 Harvard School of Public Health College Alcohol Study, which surveyed students at 116 colleges about their drinking habits, to try to identify some of these environmental factors. They compared drinking patterns among 7,061 underage students with those of 4,989 students ages 21 to 23 and found important differences between the two groups. Compared to the students who could legally drink, fewer underage students drank alcohol, and those who did so drank less frequently. While they drank less often, underage students drank more at each setting than the of-age students — nearly half of those under the legal age had five or more drinks on a single occasion. The underage students experienced more alcohol-related health and behavioral problems than their older peers, with one notable exception — they were less likely to drive after drinking.

Almost all of the underage students said it was easy or very easy to obtain alcohol. Beer was the drink of choice. Most of the underage students (80%) got their alcohol from older students, but half got it from other underage students. About one quarter got it without proof of age, and about one fifth obtained it by using a fake identification card. Underage students got free drinks more often than legal-age students (25% vs. 5%), and they also paid much less, through set prices for unlimited drinks.

Among the underage students, binge drinking (defined as five

or more drinks in a row for men, four for women) was most strongly related to several factors: living in a fraternity or sorority house; having easy access to alcohol; drinking beer; and getting unlimited drinks for a set price or paying under \$1 for a drink.

The authors feel that the environmental factors identified in this study are important areas for interventions. Among their recommendations: closer monitoring of fraternity parties and stricter enforcement of the laws requiring proof of age at off-campus bars; eliminating low-price incentives such as happy hours and the sale of beer in large volume; and stopping the common custom at private parties of charging an admission fee and providing guests with unlimited drinks, which is tantamount to selling alcohol without a license.

Wechsler H et al. Environmental Correlates of Underage Alcohol Use and Related Problems of College Students. *American Journal of Preventive Medicine* 19 (1):24–29, 2000.

Men and Women Physicians: How Are They Different?

During the next decade, many of today's seasoned, mostly male physicians will retire. In their place will come a greater proportion of women physicians.

Although men and women go through the same professional socialization — “a long and intensive process of learning how to become a physician by instilling knowledge, values, and a set of occupational norms” — research suggests that their practice styles differ. As women physicians increase in number, their unique practice style will

likely affect both the makeup of medical specialties and health care delivery. To identify these gender differences, this study surveyed practicing physicians in family practice, general internal medicine, pediatrics, and internal medicine and pediatric sub-specialties.

The investigators mailed an 8-page questionnaire to a sample of physicians that proportionately represented the overall physician population by gender, ethnicity, work setting, and level of participation in managed care. Some 2,326 physicians completed the survey; 735 (32%) of whom were women.

Women physicians were more satisfied than the men with their relationships with patients and colleagues but less satisfied with their autonomy at work, the resources available to them (e.g., supplies, exam rooms, staff), and their pay. On average, female physicians in the same specialty, practice type, age group, and ethnic group reported earning about \$22,000 less annually than their male peers. Women perceived that they had significantly less control than male physicians in selecting physicians for referrals, the length of their patients' hospital stay, their patient load, and clinic or office schedules. Female and male physicians practicing in HMOs reported the lowest levels of control over these aspects of their practice.

Women physicians cared for more female patients and greater numbers of “frustrating” and psychosocially complex patients, and they reported feeling greater time pressure than did men physicians. Female physicians felt that they needed 36% more time than allotted for new patient evaluations in order to provide quality care. Women physicians were 60% more likely than men

to report feeling “burned out.” For each additional 5 hours female physicians worked a week, over and above the normal 40 hours, their likelihood of experiencing burnout increased by 12% to 15%. For younger female physicians — who are often balancing career and children — support from colleagues and spouse provided protection from burnout.

The authors say their study demonstrates that gender differences exist in how physicians practice medicine, and in how satisfied they are with their practices. They conclude: “Appreciating and addressing these differences will allow physician practices and policy makers to create a medical workplace that is equitable, rewarding, and effective.”

McMurray JE et al. The Work Lives of Women Physicians: Results from the Physician Work Life Study. *Journal of General Internal Medicine* 15 (June): 372–380, 2000.

Nicotine Gums and Patches Reduce Sales of Cigarettes

Cigarette smoking has been declining since the 1980s under a variety of influences, including widespread publicity about the dangers of smoking. The contribution to this trend of nicotine gums (introduced in 1984) and patches (introduced in 1992) has not been examined. Sales of these products have doubled since 1996, when they changed from prescription drugs to over-the-counter products. If nicotine replacement products play any significant role in smoking cessation, their promotion could be strategically incorporated into future tobacco control policies.

These researchers evaluated the relationship between nicotine replacement product sales and cigarette consumption. They used data provided by the US Bureau of Alcohol, Tobacco, and Firearms on overall cigarette consumption from 1976 to 1998, and sales figures for the gums and patches (Nicorette Gum, Nicoderm Patch, and Nicotrol Patch). They also devised a method to measure the effect of the change from prescription to over-the-counter status, and they factored in the price of cigarettes during this time period.

They found that increased sales of nicotine gums and patches reduced the sale of cigarettes. A 10% increase in the sales of gums and patches will reduce cigarette sales by .04%. When the impact of nicotine replacement products is measured over 15 years, however, researchers estimated that the products reduced cigarette use by about 8%, which is substantial.

This report concluded that “additional efforts for promoting sales of nicotine gums and patches will be another effective alternative to discouraging cigarette consumption.” These efforts could supplement existing strategies, namely, higher cigarette taxes, antismoking campaigns, and bans on smoking in public places. The extent to which consumers will adopt the gums and patches may depend on their price, effectiveness, and relative cost versus the cost of cigarettes. From the public health point of view, however, it would make sense for insurance programs to cover these products.

Hu T-w et al. Cigarette Consumption and Sales of Nicotine Replacement Products. *Tobacco Control* 9 (Suppl II):ii60–ii63, 2000.

Medical Schools Are Weak in Teaching Cultural Issues

As ethnic and racial diversity increase in the United States and Canada, research shows that culture has a profound effect on health care, influencing access, health status, rates of screening and immunization, and doctor-patient communication. Yet little is known about the extent to which medical schools have kept pace with these changes in their teaching of cultural aspects of medicine. To gain some insights, researchers surveyed all 126 US and all 16 Canadian medical schools about this subject.

They telephoned each school, reaching a dean of students or the director of courses on cultural issues in all but nine. They asked the school whether it offered a separate course on cultural sensitivity or multicultural issues, and if it did, they asked about its format, content, timing, and ethnic groups covered. The researchers defined a course of this type as one that discussed culture, cultural differences, ethnicity, race, or language in relation to health care.

Only 8% of US medical schools and none in Canada teach a separate course on cultural issues. Most provide just a couple of lectures. Schools usually offer the course in the first 2 years of medical school, before students begin to see patients.

In both countries, most of the course content doesn't discuss the dominant nonwhite ethnic populations. In the United States, two-thirds of the schools omit reference to African Americans, three-quarters don't mention the Latino population, and 80% leave out Asians/Pacific Islanders and Native Americans. In Canada, two-thirds of the schools fail to consider the country's two largest nonwhite groups, Native Canadians and Asians/Pacific Islanders.

This is inadequate and disturbing, the researchers assert. They say the state of cultural sensitivity training in US medical schools has deteriorated from a decade ago, when 13% of schools offered such courses.

To correct this situation, the authors recommend that medical schools require students to take a separate semester-long or longer course devoted to cultural issues, preferably during the clinical years. They believe that “greater cultural understanding might help to eliminate the often dramatic ethnic disparities in health and use of health services that exist in both countries.”

Flores G, Gee D, and Kastner B. The Teaching of Cultural Issues in US and Canadian Medical Schools. *Academic Medicine* 75 (May):451–455, 2000.

Dr. Flores is a fellow in the Robert Wood Johnson Foundation Minority Medical Development Program and a former Robert Wood Johnson Clinical Scholar.

CORRECTION: The summary “Can the Chronically Ill Get Adequate Insurance Coverage?” in *ABridge*, Issue 3, 2000, stated that: “HIPAA prevents insurers from charging higher premiums to sicker individuals and limits insurers' ability to permanently exclude preexisting conditions from coverage.” That summarization over-simplified the provisions of HIPAA, the Health Insurance Portability and Accountability Act. According to the original article, “HIPAA limits an insurer's ability to impose permanent preexisting condition exclusions on individuals who already have health insurance and move into a new group. In addition, HIPAA prohibits insurers from charging higher premiums to individuals within a group due to their illness.” We apologize for any confusion this may have caused.

JAMA Series Focuses on Options for the Chronically III

Consider a 64-year-old man with adult onset diabetes; a 55-year old woman with rheumatoid arthritis; and a 36-year-old woman with endometriosis, pelvic pain, and infertility.

What could they have in common?

They're all struggling to deal with the physical, psychological, and financial aspects of living with chronic illness, says Tom Delbanco, MD, Koplow-Tullis Professor of General Medicine at Harvard Medical School and Beth Israel Deaconess Medical Center. And each of these patients has been among the more than 50 cases featured in the monthly "Clinical Crossroads" series in *The Journal of the American Medical Association (JAMA)*, directed by Delbanco and supported by The Robert Wood Johnson Foundation since its beginning in 1994.

Each "Clinical Crossroads" report focuses on a specific case and has its origin as a live discussion that includes physicians and patients in a grand rounds style at Beth Israel Deaconess. A leading expert in that month's topic takes part, offering a critical review of the evidence-based treatment options for the patient and engaging in a discussion with the audience.

What distinguishes "Clinical Crossroads" from other grand rounds style discussions in medical journals is its focus on typical chronic illnesses and its inclusion of patients — and sometimes family members — in the discussion, says Rosemary Gibson, RWJF senior program officer.

"In creating this series, we wanted to look through the patients' eyes," Delbanco says. "And patients, no matter what their circumstances, rich or poor, old, young, or middle-aged, never fail to offer us gold in terms of what they have to say and what we learn from them."

"Their experiences with illness help move us away from the narrow 'what test do we do now,' and move us toward looking at the broad picture," says Delbanco. "The patients' participation reminds us that factors such as the patient's emotions, lifestyle, family relationships, and work life all affect how chronic illness can be managed." The patients' involvement also highlights the inescapable connection between the treatment approach and what the patient's insurance will cover. Based on reader surveys, "Clinical Crossroads" ranks in the top half of all articles in terms of readership, usefulness, and importance, according to *JAMA*.

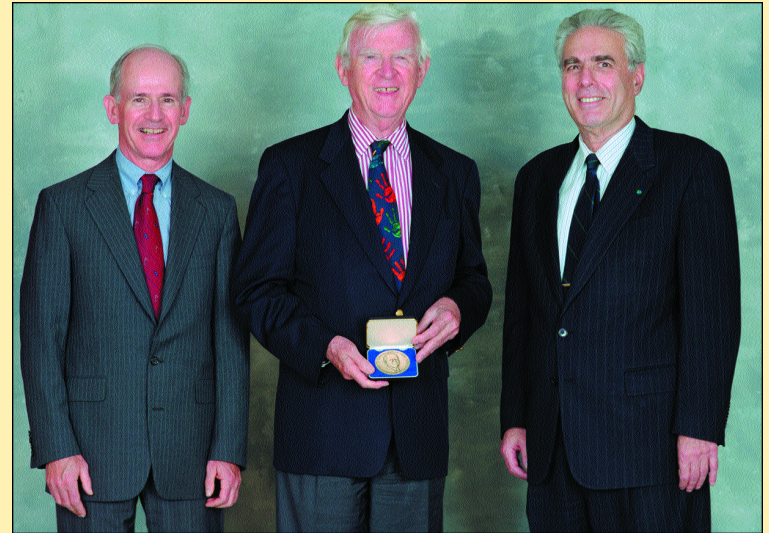
"These cases are the kinds of real-life dilemmas that occur in primary care physicians' offices every single day," Delbanco notes. "There are unexpected twists and turns, and, unfortunately, the outcomes are not always happy. We print follow-ups about each patient a year after the original report, and the *JAMA* audience finds them fascinating."

"The more we discuss these scenarios and the more we include the patients' perspective, the more we, as physicians, can improve the way we provide care," says Delbanco.

— LAURIE JONES

Phillip R. Lee, MD, emeritus professor at the Institute

for Health Policy Studies, University of California at San Francisco, received the fifteenth annual Gustav O. Lienhard Award from the Institute of Medicine (IOM) in Washington, D.C. Mr. Lienhard was the first chairman of RWJF's Board of Trustees, serving from 1971 to 1986. Lee is pictured below with RWJF President Steven A. Schroeder, MD, (left) and IOM President Kenneth I. Shine, MD (right).



The Lienhard Award — a medal and \$25,000 — recognizes individuals for outstanding achievement in improving health care services in the United States.

Lienhard Award recipients have typically "devoted much of their life to improving the quality, accessibility, and humaneness of health care delivery," says IOM's Shine.

Lee, who established the National Center for Health Services Research, created the health policy program at the University of San Francisco, and twice served as the nation's assistant secretary of health, was honored for his work as a practitioner, advocate, researcher, policy-maker, administrator, and public leader. Eighteen people — among them leaders in medicine, nursing, health policy, elder services, women's health, and community health — have received the Lienhard Award since 1986.

For more information about the RWJF-funded Lienhard Award and the nomination process, contact the Office of Health Policy Programs and Fellowships at the Institute of Medicine (202-334-1506;hppf@nas.edu) or visit their Web site, <www.iom.edu/lienhard>.

From Lessons — page 2

break up strenuous activities, and ergonomic changes, such as raising or lowering chairs or getting special equipment, to improve the work environment. Feuerstein says these kinds of changes not only reduce workplace stress, they directly address one of the biggest concerns injured workers have, which is returning to a work environment they perceive as unsafe.

Some corporations are already picking up on this approach to health care. This year Marriott International, which employs 150,000 workers in the United States, extended the use of its occupational nurse managers to

workers on short-term disability with the goal of improving their function and returning them to work, says Robert Stegert, Marriott's vice president of casualty claims. "Our nurses have delivered results in occupational medicine that we couldn't match by just hiring a network of providers."

The efforts of the *Workers' Compensation Health Initiative* are beginning to shed new light on the need to consider people's occupational experiences and workplace health programs as a critical part of improving the health and health care of all Americans.

— HOWARD LARKIN

Creative Solutions to Combating Substance Abuse

- An academic takes on Hollywood for glamorizing cigarettes in movies.
- A researcher helps to understand the cultural aspects of smoking.
- A scientist breaks new ground in the pharmacology of nicotine addiction.
- An anthropologist explores the relationship between rap music and drinking.
- An advocate scrutinizes the effectiveness of anti-drug campaigns.

These are today's trailblazers — and the recently named Innovators Combating Substance Abuse. The new award program is part of The Robert Wood Johnson Foundation's *Developing Leadership in Reducing Substance Abuse* program, headed by John Slade, MD, professor of medicine at Robert Wood Johnson Medical School, New Brunswick, N.J., and a prominent researcher and advocate in the tobacco-control field. Each of the Innovators receives a \$300,000 award over three years to advance their work.

"Historically, many innovators have worked on tobacco and alcohol-related issues as a sideline to their regular work, due to lack of funding and lack of strong public or professional recognition," says Slade. "We want to recognize individuals who have made outstanding contributions to the substance abuse field — and to reward them with the resources necessary to take their efforts a step further."

This year's Innovators are: Stanton Glantz, PhD, professor of medicine, University of California, San Francisco. Over the past 20 years, Glantz has made numerous contributions to tobacco control. He founded Americans for Nonsmokers' Rights (1980), co-authored the first comprehensive guide to passing local clean indoor air ordinances, and led the first scholarly analysis of a major cache of internal documents from the tobacco companies. Glantz will use the Innovators award to oppose the widespread use of tobacco in Hollywood films.

Sandra Headen, PhD, executive director, National African American Tobacco Prevention Network, Raleigh, N.C. Headen is widely known for her work on

how race and gender influence teens' motivations to smoke or not smoke. Her culturally focused preventive program targeted at African-American youth has helped to put tobacco on the political agenda in black communities throughout North Carolina. She plans to use the Innovators award to expand the program beyond that state.

Jack Henningfield, PhD, vice president for research and health policy, Pinney Associates, Bethesda, Md. Henningfield's work on the pharmacology of nicotine helped lay the foundation for the modern understanding of nicotine as an addictive drug and nicotine replacement as a treatment strategy for tobacco dependence. He was one of the scientific editors for the 1988 Surgeon General's Report on Nicotine Addiction and is expert at distilling scientific information into more easily understood language. Henningfield will use the Innovators award to continue fostering the use of science to inform public policy on tobacco-related issues.

Denise Herd, PhD, associate professor, School of Public Health, University of California,

Berkeley. Herd's research has led to a greater awareness and understanding of the drinking patterns and problems in African-American populations. Her most recent efforts are directed at popular music — specifically rap — and whether rap music leads to increased drinking, violence, and use of illicit drugs among youth. She will use the Innovators award to conduct interactive workshops and forums and to explore the relationship further.

Lawrence Wallack, PhD, professor and director, School of Community Health, Portland State University, and founder, Berkeley Media Studies Group. Over the years, Wallack has helped to broaden society's understanding of the causes of alcohol-related problems and how they can be prevented. Through community organizing, constituency building, and strategic planning, he has used media advocacy to create change. He will use the Innovators award to examine the federal government's anti-drug advertising campaign, and will explore factors that have enhanced the effectiveness of prevention agencies.

— SHARI MYCEK

From *SmokeLess States* — page 3

message. "This money came to the state because of the damage caused by the tobacco industry in the past," she says. "We need to ensure this doesn't happen again in the future. To do that, we need a good tobacco prevention program."

The *SmokeLess States* National Program started in 1993 with an initial allocation of \$10 million for 19 states. In the early years, the grants were given to projects such as Tucson's Full Court Press, which involved Tucson teens in peer-leadership programs and publicized events to spread the word that smoking is not cool. As more

state health departments developed their own prevention programs, however, *SmokeLess States* shifted its focus to policy.

For example, when tobacco-control groups set out to advocate an increase in the excise tax on cigarettes in New York, the *SmokeLess States* program helped them launch an intensive, 18-month public education campaign about the benefits of tobacco prevention. New York approved an increase in the excise tax to \$1.11 per pack (the highest in the nation) in December 1999, with the extra tax revenue earmarked to reduce youth smoking rates and offer

subsidized health coverage to uninsured families. One of the challenges *SmokeLess States* successfully faced in supporting this campaign was to provide the valuable contacts, research, and support to tobacco-control efforts while avoiding prohibited lobbying and grassroots lobbying.

"We were able to access all kinds of expertise and learn from the experience of other people in other states," says Russell Sciandra, director of the Albany-based Center for a Tobacco Free New York. "This would not have happened without the *SmokeLess States* program."

Even after states successfully enact policy changes or negotiate a significant settlement, there's no time to rest, says Donna Grande, co-director of the *SmokeLess States* National Program, which is headquartered at the American Medical Association in Chicago. Policy decisions can always be reversed if public opinion changes. "The tobacco industry has gotten a lot more sophisticated," Grande says. "We have to be stronger, louder, and more vocal."

— MELISSA KNOPPER

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

- For researching the service and treatment needs of injection drug users, \$339,261 to Boston University School of Social Work.
- For improving alcohol and drug treatment services for people with disabilities, \$622,865 to National Association on Alcohol, Drugs, and Disability, San Mateo, Calif.
- For efforts to revise and evaluate DARE, a renewal award of \$704,204 to The University of Akron, Ohio.
- For an evaluation of office-based treatment of addiction, \$398,292 to Treatment Research Institute, Philadelphia.
- For an employer leadership initiative on alcohol and drug abuse, a renewal award of \$500,000 to Washington Business Group on Health, Washington, D.C.
- *A Matter of Degree: Reducing High-Risk Drinking Among College Students.* One award of \$2.3 million for A Matter of Degree Communications Program to American Medical Association, Chicago.
- *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol.* Renewal awards to Kansas City, Mo., and Santa Barbara, Calif., totaling \$2 million.
- *Innovators Combating Substance Abuse.* Awards to two sites, totaling \$600,000.
- *Research Network on the Etiology of Tobacco Dependence.* A renewal award of \$1.6 million to University of Kentucky Research Foundation, Lexington.
- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy.* Awards to 14 sites, totaling \$5.5 million.
- *SmokeLess States: Statewide Tobacco Prevention and Control Initiatives.* Renewal awards to eight sites, totaling \$925,458.
- *Substance Abuse Policy Research Program.* Awards to four sites, totaling \$399,683.
- For strategic planning and infrastructure development, \$400,000 to the California Mentor Foundation, Tiburon, Calif.

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

- For promoting health and physical activity in a rural community, \$139,998 to The Wray Rehabilitation and Activities Center, Wray, Colo.

- For promoting early childhood literacy as a health intervention, a renewal award of \$300,000 to Boston University School of Medicine.
- *State Health Leadership Initiative.* One renewal award of \$919,485 to the National Governors' Association Center for Best Practices, Washington, D.C.
- *Turning Point: Collaborating for a New Century in Public Health.* A renewal award of \$410,437 to State of West Virginia Department of Health and Human Resources, Charleston.
- For researching models to expand health insurance, \$162,046, to Columbia University, New York, N.Y.
- For an evaluation of *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP, and Food Stamps*, \$398,400 to Bryn Mawr College, Bryn Mawr, Pa.
- *Southern Rural Access Program.* Renewal awards to three sites, totaling \$2.4 million.

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

- For the Pittsburgh Regional Healthcare Initiative, \$1 million to The Jewish Healthcare Foundation of Pittsburgh.
- For implementation and evaluation of the Chronic Care Networks for Alzheimer's disease project, \$1.3 million to Alzheimer's Disease and Related Disorders Association, Washington, D.C.
- *Targeted End-of-Life Projects Initiative.* For research on intensive care units and end-of-life care, \$660,217 to Rhode Island Hospital, Providence.
- For disseminating research findings in chronic disease management, \$174,678 to Henry Ford Health System, Detroit, Mich.
- For improving the quality and capacity of safety-net organizations to deliver chronic care, \$150,000 to Institute for Healthcare Improvement, Boston.
- For expanding family-centered care principles in medical education, \$154,860 to Parent to Parent of Vermont, Winooski, Vt.
- For state policy fellowships in long-term care, \$586,681 to University of Minnesota School of Public Health, Minneapolis.
- For evaluating the impact of medication algorithms on people with chronic mental illnesses, a renewal award of \$634,628 to The University of Texas Southwestern Medical Center at Dallas.
- *Clinical Care Management of Depression in Primary Care: Linking Clinical and Systems Strategies.* Award of two grants, totaling \$115,531.
- *Managing Pediatric Asthma: Improving Clinical Care in Vulnerable Populations.* For tools and training to improve pediatric asthma management by clinicians, \$2.4 million to University of Michigan School of Public Health, Ann Arbor.

- *Medicare/Medicaid Integration Program.* For the Medicare/Medicaid Integration Project — New England States Consortium — Phase II, a renewal award of \$834,918 to State of Maine Department of Human Services, Augusta.

Other Programs and Those That Cut Across Foundation Goals

- To help construct a children's hospital at the Robert Wood Johnson University Hospital, \$8 million to Robert Wood Johnson University Hospital Foundation, New Brunswick, N.J.
- For raising public awareness of global infectious diseases, \$714,135 to Global Health Council, White River Junction, Vt.
- For identifying and communicating public health implications of new and emerging infections, \$300,000 to The Johns Hopkins University School of Medicine, Baltimore.
- For using the *Dartmouth Atlas* to address practice variations in health care, \$325,074 to Healthcare Education Foundation of West Virginia, Charleston.
- For examining the impact of molecular medicine on health care and society between 2000 and 2050, \$359,999 to Brookings Institution, Washington, D.C.
- For developing a multidisciplinary health care workforce collaborative, a renewal award of \$509,000 to Medical College of Wisconsin, Wauwatosa.
- *Health Tracking.* For tracking changes in alcohol, drug abuse, and mental health care, a renewal award of \$200,000 to Rutgers, The State University; Institute for Health, Health Care Policy, and Aging Research; New Brunswick, N.J.
- *Investigator Awards in Health Policy Research.* For an analysis of the history of race, racism, and American medicine, \$246,704 to Association of American Medical Colleges, Washington, D.C.
- *State Forums Partnership Program.* For the State Forums Partnership Project, \$125,000 to Kansas Health Institute, Topeka.
- For a survey of the market for *The Robert Wood Johnson Clinical Scholars Program*, \$273,574 to University of California, San Francisco.
- *Changes in Health Care Financing and Organization.* Awards to two sites, totaling \$351,262.
- *Local Initiative Funding Partners Program.* Awards to 20 sites, totaling \$7 million.
- For improving New Jersey's community health centers, \$500,000 to Community Foundation of New Jersey, Morristown.

New Grant Results Reports Posted on RWJF Web Site

Thirty-five Grant Results Reports and one National Program Report have been posted on The Robert Wood Johnson Web site <www.rwjf.org> under *Grant Outcomes & Related Publications*. These include:

- **Development of Technical Assistance Materials for Free Clinics.** The Volunteers in Medicine Institute, Hilton Head Island, S.C., has developed technical assistance materials for volunteers interested in creating free health clinics. The institute is the originator of a free-clinic model that uses retirees, many of them medical providers, to deliver health care to the medically underserved. RWJF provided \$99,480 from December 1996 through May 1998. Project personnel produced a guide on how to start a clinic and a manual on how to run a clinic, both of which are available in hard

copy and on disk; as well as a 10-minute videotape, "Culture of Caring," featuring interviews with patients and clinic volunteers; a book, *A Circle of Caring*, which chronicles the creation of the first clinic on Hilton Head; and a brochure about the institute. Project personnel also provided paid consulting services to 22 communities that either opened a free health clinic or are in the process of developing one. *Contact: Jack B. McConnell, MD, 843-681-6612.*

- **Survey of Undocumented Hispanic Immigrants' Access to Health Care Services.** Researchers at The People-to-People Health Foundation (also known as the Project HOPE Center for Health Affairs) conducted in-depth interviews of 440 households in Houston and El Paso, Texas, to find the barriers undocumented

immigrants faced in getting care, and the likely effects of denying services to these people. The RWJF grant of \$451,207 ran from February 1996 through May 1999. The survey found that the population of undocumented Latino immigrants, most of whom emigrated from Mexico, was relatively young. No respondent reported coming to the United States for health or social services. Their use of ambulatory health care services was very low compared to the overall US population, and their rates of hospitalization (except for pregnancy) were similar to overall Latino and US populations. The researchers concluded that excluding undocumented Latinos from receiving government-funded health care services is unlikely to reduce the level of immigration and may affect the well-being of children who were born here and are US citizens living with their immigrant parents. The findings were published in the July/August 2000 issue of *Health Affairs*.

Contact: Mark L. Berk, PhD, or Claudia L. Schur, PhD, 301-656-7401, cschur@projhope.org. Web site: <www.healthaffairs.org>.

- **Tobacco Policy Research and Evaluation Program.** This National Program, authorized by RWJF's Board of Trustees for up to \$5 million in January 1992, has allowed investigators from diverse disciplines, such as medicine, health economics, political science, public health, sociology, psychology, criminal justice, and law, to conduct policy research aimed at helping public and private policymakers adopt policies to reduce tobacco use, especially among children and youth. Some 22 research projects received grants under the program.

Contact: Robert L. Rabin, JD, PhD, 415-723-3073, rrabin@leland.stanford.edu or David G. Altman, PhD, 910-716-9556, daltman@wfubmc.edu.

A total of nearly 700 grants are covered by the reports available at RWJF's Web site <www.rwjf.org>.

PEOPLE

WELCOME

GREGORY HALL, MCP, joined the Foundation in August as a program officer in the Program Office. Previously, he worked with the Foundation's Grant Results Reporting Unit and served as a consultant in Philadelphia on special projects for the Pew Charitable Trusts, the Alzheimer's Association, and SmithKline Beecham's Community Partnership initiative. Hall earned his Master of City Planning degree from the University of Pennsylvania.



KELLY HUNT, MPP, joined the Foundation in August as a research associate in the Research and Evaluation Unit. Prior to joining RWJF, Hunt held the position of Health and Welfare Consultant for Towers Perrin in New York City. She earned a Master of Public Policy degree from Georgetown University.



PROMOTIONS

CALVIN BLAND, MS, was appointed interim director, Health Care Group, in August, succeeding Jack Ebeler. Bland had served as senior program adviser to the Foundation since February. Prior to that, he was president and chief executive officer at St. Christopher's Hospital for Children in Philadelphia.

MARCO NAVARRO, MCRP, was promoted to program officer in the Program Office in September. Navarro, who joined the Foundation as a financial officer in 1995, holds a Master of City and Regional Planning degree from Rutgers University.

FAREWELL

JACK EBELER, MPA, left the Foundation in September to pursue other opportunities closer to his Washington, D.C., area home. Ebeler served as senior vice president and director of the Health Care Group from early 1999.