The Robert Wood Johnson Foundation® Quarterly Newsletter

ADVANCES®

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RWJF and Grantees Respond To National Tragedy

September 11, 2001. A normal day — or so it started. Employees arrived at the World Trade Center in New York City and at the Pentagon in Washington. They filled coffee mugs, checked their e-mail, exchanged office pleasantries.

In nearby cities, air travelers boarded planes for routine business and leisure travel.

Inexplicably, all became victims.

America and much of the world stood in horror as commercial airliners crashed, buildings collapsed and fiery infernoes altered millions of lives. While many people, too shell-shocked even to speak, stood motionless and in tears, others instinctively sprang to action. Among them were police officers, firefighters, medical personnel, national guardsmen, construction workers and Robert Wood Johnson Foundation grantees.

Physical Transport

"All that I can say is that a more horrific sight I've never seen nor do I ever hope to see," says Benjamin Anagnos, M.B.A., deputy director of Harlem Hospital's Injury Prevention Program (National Program Office for RWJF's *Injury Free Coalition for Kids*). In the minutes and days following the World Trade Center attacks, Harlem Hospital dispatched passenger vans (normally used for their safe-biking program) to the site, transporting rescue workers to and from the restricted area in and around ground zero to where barricades were set up at 14th Street.

"As we saw people with hard hats, gear, we stopped and picked them up," says Anagnos. "We also brought people back [from ground zero]. There were firemen who'd been down there two days straight, covered in

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FEATURES

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dust, exhausted. They'd been digging in rubble and were starting to walk back to 14th Street — with that heavy, heavy gear — to catch the subway."

Emotional First Aid

In Massachusetts, Trauma Intervention Program of Mernmack Valley (an RWJF *Faith in Action* grantee) received a call for help at 9:05 a.m. on the morning of the disaster. Trauma Intervention works closely with police and firefighters to provide on-scene emotional support and comfort.

The call was from a Methuen, Mass., policeman who requested that a volunteer be dispatched to a local woman whose son worked on the 107th floor of One World Trade Center. The son had e-mailed his mother when the first plane hit. He made his way down a few floors and then telephoned his mother. She watched on TV as the second plane hit and then as the buildings collapsed. The woman's son did not make it out of the building.

"That was our first call for service and the phone continued to ring," says Jayan Conlin, R.N., M.S., executive director of Trauma Intervention Program.

Trauma Intervention volunteers have since worked with 30 such families (most of whom lost loved ones on the flights originating from Boston). Volunteers have also dispensed "comfort kits" to local schools and churches containing information to distribute on how to cope with tragedy.

Chinatown Responds

Back in New York, Chinatown — located within walking distance of the financial district — was not damaged physically. But the emotional toll on the neighborhood was immense. As reality set in, mental health teams from Chinatown Health Center (an RWJF *Local Initiative Funding Partners* grantee) went on the radio and spoke to newspaper reporters about how individuals could cope with the disaster — and especially how to help children deal with their fears. Within one week, Chinatown Health Center staffers had developed and distributed bilingual literature to the community on how to begin dealing with the tragedy.

"Many different faiths—one common goal" is the message of RWJF's *Faith in Action* program in the wake of the events of September 11th . To encourage interfaith cooperation, the program ran ads in *USA TODAY*, starting Thanksgiving week through mid-December. *Faith in Action* also will place the ads in religious papers, post them on its Web site and make them available free to *Faith in Action* programs that wish to use them locally. The program encourages interfaith volunteer efforts to help community members with chronic health problems and plays a key role in building ties between Americans of different faiths.

Farther north in New York State, the department of psychiatry at the University of Rochester (whose chair is project director for NY Project Link, an RWJF grantee) immediately mobilized two teams of mental health professionals to send to New York City. These teams assisted grieving families at the Family Center that was established on 55th Street. Department members also participated in Red Cross relief efforts, set up Rochester-based support groups and served as a local media resource on the psychological impact of terrorism and how parents could talk to their children.

"We tried to balance our support of statewide and national relief efforts with our commitment to our local community," says Steven Lamberti, M.D., associate chair for clinical programs in the department of psychiatry.

Tolerance and Understanding

Meanwhile, in Washington, Providence Family Health Centers (another RWJF *Local Initiative* grantee) — within walking distance of the U.S. Capitol building — immediately evacuated its facility in anticipation of receiving many casualities (which did not occur).

Attention has now turned to the special needs of Providence's diverse health care providers. Many of the center's physicians and nurse practitioners are Muslims and come from Middle Eastern countries.

"Our providers from these areas were concerned about how they were going to be treated" in the aftermath of the terrorist attacks, says Cherie Sammis, M.S., clinical administrator of Perry Family Health Centers, one of Providence's clinics. "Patients and other staff weren't mistreating them at all, but these were fears which we needed to allay. They needed to know we are supportive. In all of D.C. and the nation people are looking twice at people who look Middle Eastern."

Sammis, a nurse practitioner, along with a psychiatric clinical nurse specialist, met individually with concerned staff, and provided counseling and confidential resource information. In early November, the entire staff met in Emmitsburg, Md., for a nonreligious, spiritual retreat.

RWJF Initiative

On the day of the attacks, Susan Hassmiller, R.N., Ph.D., senior program officer at RWJF and a member of the Red Cross's National Board of Governors responded personally (see Profile, page 4). And in the initial horrifying days, The Robert Wood Johnson Foundation

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New National Program Seeks Dramatic Improvements in Health Care Processes

Manufacturing cars would seem to have nothing in common with providing health care. But Robert Wood Johnson Foundation officials say the quality of the U.S. health care system could improve dramatically if health professionals applied some lessons from innovative automobile companies and other private industries.

"The early name for this program was actually 'the Toyota project,'" says Michael Rothman, M.P.P., an RWJF senior program officer who heads up a three-year, $20.9-million initiative that came to be called *Pursuing Perfection: Raising the Bar for Health Care Performance.* "Years ago, Toyota showed that if you set high expectations regarding quality and take steps across the board to make major improvements in the system and processes you use, it's possible to make a product better, cheaper and faster," says Rothman.

Systemic changes in the health care system are needed, experts say, because it's become clear in recent years that the quality of health care in the United States is far below what it could — and should — be. One example is the recent Institute of Medicine report that found medical errors are common throughout the system.

There have been few, if any, entities in health care that have systematically focused on dramatically improving quality in ways that private industry has. As RWJF Senior Communications Officer Paul Tarini puts it, "There is no Toyota in health care."

That's not to say health care workers in the United States are not committed, capable and knowledgeable. In fact, health care professionals in this country probably have the greatest depth of medical knowledge in the world, according to Foundation officials. But knowing what the appropriate treatment, diagnostic test or preventive measure is and making sure it reaches the patients who need it at the time they need it are two different things.

"I think for a long time we assumed that quality of care would be there because we've made progress in developing and improving treatments for many different conditions," says Risa Lavizzo-Mourey, M.D., Foundation senior vice president and director of its Health Care Group.

But quality means combining knowledge with an efficient and effective process.

"High quality is the process that leads to the desired outcome for a patient or population of patients, given what we know at that point in time," says Lavizzo-Mourey.

The aim of *Pursuing Perfection* is to help a small number of highly committed hospitals and physician organizations achieve dramatic improvements in quality. Based on the work of the Institute of Medicine, the program has defined ideal quality as always delivering the right care, never providing care that has no potential to help the patient, and never harming patients in the course of providing care.

"At its best, the American health care system exhibits very high quality," says Tom Nolan, Ph.D., co-director with Donald Berwick,

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A Streamlined Grantmaking Process

In planning the *Pursuing Perfection* program, RWJF decided to try tweaking its own process a bit.

"We geared up and had everything ready to go as soon as the project received Board approval," says Michael Rothman, M.P.P., Foundation senior program officer.

The Board gave the go-ahead to the program on January 25, 2001, and by February 1, a National Program Office was in place at the Institute for Healthcare Improvement. RWJF program and NPO staff believed that the program could have the biggest impact if it could begin in the spring of 2001. So, two weeks later, a request for proposals was delivered by e-mail to target organizations such as the American Hospital Association, whose members would be most likely to apply. In what is believed to be a first for the Foundation, the entire grant announcement, application and review process took place electronically, drastically cutting the time typically required. Included in the e-mail announcement was a link to the Web site where interested parties could download a Call for Proposals and application form. Applications were accepted only via e-mail.

"Using this approach allowed us to reach the right people quickly," says Rothman.

By April, more than 226 organizations, including hospitals and large medical groups, applied for *Pursuing Perfection* grants. The review process was then conducted using a custom-built online system. The online review enabled instant access to materials — reducing the need to wait for papers to change hands. It also allowed all the reviewers to see the status of the process at any given time and offered the capacity to make mid-course corrections.

"The whole process went very quickly," says Rothman. "The Board approved the grants in late January and the phase one grants began in early September."

It's not unusual for the traditional application process to take up to two years.

"For some programs, that lead time is appropriate because grantees may need a lot of time," says Rothman. "But other grantees may need to move at a faster pace."

Rothman expects the Foundation will shorten the process for many more programs in the future. "This gives us the flexibility to go after a different type of applicant — innovators who would not apply for a program that delivers grant funds more than one year in the future, but who would try for something that would begin in six months."

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committed $5 million to aid the disaster effort. Originally, the monies were intended to help family members of the victims. But, according to Foundation President Steven A. Schroeder, M.D., that plan has changed.

"We were prepared to come to the aid of families in need," says Schroeder, "but it appears now that the generosity of other sources has taken care of families' immediate needs."

RWJF will instead use the $5 million to help health care organizations in the New York City area — hospitals, health clinics and agencies — that have had their operations disrupted by the attacks or have unusual needs as a result of the attacks.

"The RWJF mission of improving health and health care for people in this country is very consonant with trying to help those organizations that were put under unusual stress due to the September 11 terrorist attack," says Schroeder. "To some extent, we have to take time to figure out who is doing what because there is a tremendous amount of federal government money that's being allocated.

"At the same time, the needs our previous grants went to are still as great. In fact, there is reason to believe that some of our problems have actually gotten worse subsequent to the September 11 event, for example, an increase in the number of people lacking health insurance or people returning to smoking or drinking — those sorts of things. And to that extent we will stay the course."

— Shari Mycek

Check out the special report, *RWJF Responds*, on the Foundation's Web site, <www.rwjf.org> for up-to-date information on how RWJF and its grantees continue to respond to the September 11 tragedies.

Susan Hassmiller, R.N., Ph.D.

Amateur nurse and volunteer Clara Barton, who was known as "The Angel of the Battlefield" during the Civil War, established the Red Cross Society in America in 1881 to serve in peace and war, and in times of disaster. And while the battlefields of relief work have changed throughout the years, there are still many "angels" working on the front lines for the Red Cross. RWJF Senior Program Officer Susan B. Hassmiller, R.N., Ph.D., is one of them. She spoke with *Advances* about her work as a member of the National Board of Governors of the American Red Cross — and a very hands-on volunteer.

How did you get involved with the Red Cross and why?

Hassmiller — While I was a student at Florida State University some 27 years ago, an earthquake hit while my parents were vacationing in Mexico City. I contacted the Red Cross and was relieved to learn that there were no casualties and that the earthquake hadn't affected the area where my parents were staying. Grateful for their help, I promised I would give something back. I became a Red Cross volunteer in college and since then have done everything from CPR, home nursing and disaster work to serving on local, state and national boards and leadership councils.

The Red Cross traditionally responds to natural disasters. Was it prepared for the man-made urban disaster at the World Trade Center on September 11?

Hassmiller — The Red Cross has had nearly 150 years' experience in responding to natural disasters all over the world. Each year, thousands of volunteers receive general disaster training. Others receive more specific training. If there is an airline crash, for example, we have people on call 24 hours a day who are specially trained to handle situations unique to a crash. And we are putting together a special team to respond to bioterrorism. About a year ago, the Red Cross set up the Clara Barton Training Center for Weapons of Mass Destruction, located in Arkansas. While the Red Cross will always give aid to victims of hurricanes and floods, we anticipate more man-made disasters than in the past and that's the purpose of the new training center. The center is currently training volunteers who will serve at the Winter Olympics in Salt Lake City.

You've been on the frontlines for many disasters. What was your role during the World Trade Center crisis?

Hassmiller — On September 11, I served as a volunteer nurse and general coordinator for my chapter, the Central New Jersey Chapter in Princeton. We set up a communications system and fielded hundreds of phone calls from potential volunteers, blood donors and family members alike. We also opened 20 shelters in New Jersey for people stranded due to bridge, tunnel and airport closings. I spent time at the Family Assistance Centers in New York City and New Jersey where people came to give descriptions of their missing family members and receive cash and counseling assistance. And when we learned that there was a backlash against the Muslim community, we reached out to area schools to see if there were children or teachers who might need counseling to cope with what they were feeling. Whatever the need was, I just tried to address it.

What was it like for you being at ground zero?

Hassmiller — It was pretty amazing. The buildings had collapsed and no survivors had been found yet. There was lots of security and checking of badges. Everyone was on high alert. I remember being about a half block away from the scene and looking through a chain link fence and thinking "Oh my God, if they can do this, they can do anything." That's the first time it hit me about how much work America was going to have to do to get back on its feet. I visited shelters inside the disaster zone and talked to some of our volunteers. They knew it was dangerous to be so close, but were compelled to stay because this was where they were needed. At the shelter I saw police and firefighters trying to get an hour nap or quickly grabbing a granola bar so they could get right back out there to help their "brothers."

The Red Cross has been given an unprecedented amount of money for this disaster. Where will it all go?

Hassmiller — The money is being used for a wide range of family assistance needs including rent, medical bills, transportation, funeral expenses, food, child care — really whatever a family needs to see them through. It will take us many years to spend all the money, though. The physical and especially the mental health needs will go on for years to come. It is interesting to note that we only recently closed down our family assistance program for the Loma Prieta [California] earthquake victims, an event that happened 12 years ago. And we are still supporting many families from the Oklahoma City bombing. Emotional wounds take a long time to heal.

What has the Red Cross learned that would help them better cope in the event of another terrorist disaster?

Hassmiller — One of the lessons the Red Cross has learned is that it needs to do a better job of using information technology. In many places throughout the country, including New York and New Jersey, Red Cross offices responding to a disaster are still using too much paper to keep track of each family's needs and how we have addressed those needs. Unfortunately, information technology costs millions of dollars, and for the Red Cross — which depends solely upon donations — it was not, to this point, a top priority. Services to the community have always been the top priority. In the case of disasters, getting financial help to victims has always been our first priority.

Another lesson learned is that relief organizations really need to gear up now to train their volunteers to be prepared to respond to disasters caused by the new threats to our country. It would be nice to think that we will not need to activate so many new disaster workers, but that is not reality. We are indeed holding hundreds of new training sessions as we speak.

Finally, we need to do a better job of informing the American people of how their donations will be spent. Honoring donor intent is important to a long-lasting and trusting relationship.

I'm so very proud to be a part of an organization that has helped so many people. I will be a Red Cross volunteer until the day I die.

— Interview by Hedda Colossi

Using the Internet To Access Health Information: Can It Deliver?

The Internet puts a wealth of health-related information at consumers' fingertips and they appear to be using it to make decisions about their medical care. Last year more than 60 million Americans went online for health information, according to a survey by The Pew Charitable Trusts. More than 70 percent said the information they found there influenced their decision about medical treatment.

The rapid and widespread adoption of the Internet as a medical information source by consumers raises concerns about the quality, accuracy, comprehensiveness and clarity of online health information. To assess the effectiveness of the Internet as a consumer health information resource, this study evaluated the information available on four medical conditions: breast cancer, childhood asthma, depression and obesity. The researchers used several popular search engines and visited a number of well-known health-related Web sites to examine the accessibility of the information, its quality and the reading grade level of the content. Because the U.S. population is increasingly diverse — with Hispanics making up the largest minority group — the investigators looked at health information available in both English and Spanish.

According to the researchers, "search engines are only moderately efficient in locating information on a particular health topic." Overall, only one in five of the links identified by the English-language search engines and one in eight of the links from the Spanish-language search engines led to a Web site with relevant medical content.

Although the Web sites contained thousands of pages of information, they also contained "substantial gaps in . . . key information." Across English-language sites, just half of the topics considered important by the expert panels were more than minimally covered. The topics most often not covered included the symptoms of poorly controlled asthma and the safety and effectiveness of dietary supplements for obesity. Spanish-language sites fared even worse: more than half of the key topics were not addressed. Alternatives to standard medical and surgical treatment for breast cancer and dietary supplements and popular diets for obesity were most often not covered by the Spanish-language Web sites.

Overall, the Web sites did a better job with accuracy of information than they did with completeness. About 95 percent of both English-language and Spanish-language sites contained information that was mostly or completely correct.

Investigators found that most of the health information on the Web sites was written at a high reading level. On all English-language sites, readers needed at least a tenth-grade reading level to understand the material and more than half the sites required a

Selected English-Language Web Sites Containing Medical Information for Consumers

Web Site	Web Address	Conditions Examined
Popular General Health*		
Allhealth.com	www.allhealth.com	Breast cancer, childhood asthma, depression, obesity
CBS Health Watch	www.cbshealthwatch.com	Breast cancer, childhood asthma, depression, obesity
DrKoop.com**	www.drkoop.com	Breast cancer, childhood asthma, depression, obesity
Intelihealth	www.intelihealth.com	Breast cancer, childhood asthma, depression, obesity
Onhealth	www.onhealth.com	Breast cancer, childhood asthma, depression, obesity
WebMD	www.webmd.com	Breast cancer, childhood asthma, depression, obesity
Condition-Specific+		
American Academy of Allergy, Asthma, & Immunology	www.aaaai.org	Childhood asthma
American Cancer Society	www.cancer.org	Breast cancer
American Obesity Association	www.obesity.org	Obesity
Athealth.com	www.athealth.com	Depression
CancerNet	www.cancernet.gov	Breast cancer
Depression.com**	www.depression.com	Depression
MyAsthma	www.myasthma.com	Childhood asthma
National Heart, Lung and Blood Institute	www.nhlbi.nih.gov	Childhood asthma
National Institute of Mental Health	www.nimh.nih.gov	Depression
National Library of Medicine	www.nlm.nih.gov	Obesity
Obesity Online	www.obesity-online.com	Obesity
OncoLink	www.oncolink.com	Breast cancer
Search engine Yahoo	www.yahoo.com	Breast cancer, depression, obesity

* Top six sites ranked by Cyber Dialogue and PC Data Online, September 2000.
** Sites no longer accessible.
+ Selected by project staff.

college reading level. Spanish-language sites required at least a ninth-grade reading level.

The Internet has the potential to be a powerful resource for both patients and health care professionals, but more research is needed in order to assess how this medium can be best used to improve the doctor-patient relationship.

Berland GK, Elliott MN, Morales LS, Algazy JI et. al. Health Information on the Internet: Accessibility, Quality and Readability in English and Spanish. *The Journal of the American Medical Association* 285 (20): 2612–2621, 2001.

Drs. Berland and Algazy were Robert Wood Johnson Clinical Scholars at the time of this research.

Distribution of Neonatal Intensive Care Resources

Over the past 30 years, the field of neonatal intensive care has grown tremendously, spurred on by successes in reducing morbidity and mortality rates for very low-birthweight infants (those weighing less than 1,500 grams or 3.3 pounds).

But has this growth followed a logical pattern? In other words, do the areas of the country that have the greatest number of low-birthweight babies also have the most neonatal intensive care resources?

To answer this question, investigators looked at the number of neonatologists, neonatal intensive care unit (NICU) beds and very low-birthweight infants across 246 neonatal intensive care regions (NICRs). Very low birthweight is an important indicator of medical need because these infants consume the most neonatal intensive care resources and have high mortality rates.

The investigators found significant regional variation in neonatal intensive care capacity — defined as the number of very low-birthweight infants per NICU bed or neonatologist. The variation across NICRs was more than fourfold for both beds and neonatalogists, but very few of the differences in capacity were based on low-birthweight rates. NICRs with the most neonatal intensive care capacity had a very low-birthweight rate of 1.5 percent, while those with the lowest capacity had a similar rate of 1.3 percent for very low-birthweight infants. Even when mid-level NICU providers — such as nurse practitioners and physician assistants — were included in the analysis, there was no evidence of a meaningful relationship between neonatal capacity and need.

The authors suggest that the disparities in neonatal intensive care capacity are best explained by two phenomena: physicians usually practice close to where they train, in urban areas and in more affluent settings; and NICUs are built by hospitals in order to offer the full range of perinatal care, even though similar facilities exist nearby.

Further investigations should be aimed at determining the minimum neonatal capacity needed for effective and efficient care, the authors say. Then underserved and overserved regions could be identified and targeted for improvement by state maternal and child health programs and medical communities.

Goodman DC et al. Are Neonatal Intensive Care Resources Located According to Need? Regional Variation in Neonatologists, Beds and Low Birth Weight Newborns. *Pediatrics* 108 (2): 426–431, 2001.

Adolescents and Smoking: Do They Understand the Risks?

Each year, smoking claims the lives of more than 400,000 adults in this country, 90 percent of whom first experimented with cigarettes as teens. Even today — when much more is known about the health consequences of tobacco use — smoking is on the rise among adolescents. When teenagers first decide to smoke, do they really understand the risks? Past studies provide conflicting evidence: Some studies report that smokers overestimate the health risks of smoking and others indicate that smokers underestimate these risks. This study tried to get a clearer understanding of how young smokers assess the objective health risks of smoking and the personal risks of their behavior — and how the latter affects their desire to quit.

Investigators surveyed 600 youths between the ages of 14 and 22 by telephone; 300 were smokers and 300 were nonsmokers. To understand their perceptions of the objective risks of smoking, they were asked how many young smokers in a group of 100 they thought would get lung cancer, develop heart problems or die because of smoking. The researchers also asked young smokers and nonsmokers how risky smoking is for a person's or their own health and by how many years smoking two packs of cigarettes a day shortens a person's life. Smokers were asked about their plans to quit.

Epidemiologists calculate that 20 percent of smokers will get lung cancer, 50 percent will die from smoking (from a variety of different conditions) and, on average, heavy smokers shorten their lives by seven years. Did the young smokers and nonsmokers in this study correctly assess these risks? The investigators found that respondents overestimated the risk of lung cancer: young smokers said that about 50 percent of smokers would end up with lung cancer, while young nonsmokers believed that nearly 58 percent of smokers would develop this illness. However, these estimates appeared to be inflated by overlap with other conditions, such as heart disease, and by optimism about the survivability of lung cancer.

On average, respondents' estimates of overall mortality from smoking were close to the 50 percent that epidemiologists hold out as the actual mortality risk. However, 41 percent of young smokers and 27 percent of young nonsmokers underestimated the mortality risk of smoking or said they did not know the risk. In addition, about half of the smokers and 44 percent of the nonsmokers underestimated the number of years of life lost because of smoking or did not know how to answer this question. Consistent with their general optimism about smoking risk, many young smokers viewed their own smoking as less than "very risky for their health." About half of the young smokers who correctly estimated the overall mortality risk of smoking at 50 percent evaluated their own smoking as less than very risky. Even the heaviest young smokers felt their own personal health risk was no greater than the risk for individuals who smoked less. Nonetheless, the majority of young smokers — more than 80 percent — said they intended to quit. Young smokers who viewed their smoking as "very risky" to their own health were more than four times as likely to indicate that they planned to quit than were young smokers who saw little or no risk in smoking.

The authors conclude that young "smokers are optimistic about their personal risks of smoking despite their awareness of the objective risks to others." This finding suggests that for young smokers, "perceptions of the likelihood of smoking-related death are not powerful considerations in determining the risks they embrace by smoking." These findings underscore a significant challenge for antismoking campaigns: how to overcome the "tendency of young people to underestimate the risk of their own smoking while overestimating the ease of quitting."

Romer D and Jamieson P. Do Adolescents Appreciate the Risks of Smoking? Evidence from a National Survey. *Journal of Adolescent Health* 29 (1): 12–21, 2001.

Communicating Prognoses to Cancer Patients at the End of Life

Just 40 years ago, physicians were much less frank with their patients. Patients dying of cancer were unlikely to learn about their diagnoses from their doctors. Today, the medical community considers this nondisclosure approach to patient care both old-fashioned and paternalistic. Patients and families are routinely informed of their diagnoses. Does the same hold true for prognoses? Do physicians provide patients with frank estimates of the amount of time they have left at the end of life so patients can make appropriate treatment decisions? Research has shown that patients often have more optimistic perceptions of their prognoses than their physicians and that this misinformation may guide their decisions to try medical therapies considered futile by most doctors. This study looked at the kinds of prognoses physicians communicate to cancer patients at the end of life — whether they were frank, optimistic or pessimistic — and how particular patient and physician characteristics affect the tenor of the prognoses communicated.

Investigators surveyed by telephone 258 physicians who referred more than 300 cancer patients to five outpatient hospice programs in the Chicago area in 1996. The researchers collected information on physicians' specialty, years of practice and board certification from public records. The hospices provided demographic information on the patients, including their age, sex, ethnicity, religion, marital status, cancer diagnosis and other health conditions. The investigators asked physicians to estimate how long their patient had to live and what the physician would tell the patient if the patient asked for an estimate of survival time. The study refers to these prognoses as the formulated and communicated prognoses, respectively. Physicians also were asked how confident they were in their formulated prognoses.

For 300 patients, physicians had formulated prognoses and shared them with the researchers. The physicians reported that they would communicate a frank prognosis for only 37 percent of patients. They would not provide a specific prognosis even if asked for 23 percent of patients and they would intentionally offer what they believed to be an inaccurate prognosis for 40 percent. Among the physicians who would provide such non-frank prognoses, 70 percent said their survival estimate would be overly optimistic, while 30 percent would provide an overly pessimistic prognosis. "Overall, the median formulated prognosis was 75 days and the median communicated prognosis (in the 232 patients who would have received one) was 90 days," the authors write. The actual median survival time for these patients was 26 days — far shorter than either prognosis. In fact, the physicians' communicated prognosis would have been more than three times longer than their patients' actual survival time. Interestingly, patients who would have had an optimistic prognosis or no prognosis communicated to them had the shortest anticipated survival times, while those who would have received pessimistic prognoses had the longest anticipated survival times.

Physicians were more likely to provide frank prognoses to older patients and sicker patients. Physicians with more years of practice experience were more likely to provide no prognosis at all; in contrast, physicians with more experience caring for terminally ill patients were more likely to communicate a pessimistic prognosis. Female physicians also tended to share pessimistic prognoses. When physicians lacked confidence in their prognoses, they were less likely to communicate them in any form to patients.

According to the authors, "most types of physicians tend to avoid frank disclosure for most types of patients with cancer." Improvements are needed both in physician training in breaking bad news and the medical science of prognostication. They conclude: If patients have clear information on the expected course of their illness, they might be "better able to plan for, and achieve, the kind of 'good death' most Americans say they want."

Lamont EB and Christakis NA. Prognostic Disclosure to Patients with Cancer Near the End of Life. *Annals of Internal Medicine* 134 (12): 1096–1105, 2001.

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

Use of Preventive Services by Medicare Beneficiaries

By the early 1990s, Medicare — under its Part B coverage — began covering a range of preventive medical services for individuals age 65 and older, including annual Pap smears, flu vaccines and mammograms every other year. However, many Medicare beneficiaries did not immediately take advantage of their new access to preventive services. In fact, studies conducted shortly after Medicare initiated this coverage extension found that preventive services were more often used by individuals who had some type of supplemental coverage that augments Medicare by covering the cost of deductibles and co-payments.

Did use of preventive health care services increase across the spectrum of Medicare beneficiaries in the several years after the coverage expansion?

The investigators analyzed data on more than 2,000 Medicare beneficiaries from a 1996 national survey of 10,500 households conducted by the Agency for Health Care Policy and Research. In a series of face-to-face interviews, beneficiaries reported demographic information, health insurance status, health status, functional status, sources of care and use of health care services, including preventive services. The survey focused on seven preventive services in particular — blood pressure measurement, cholesterol screening, flu vaccines, Pap smears, clinical breast exams, mammograms and prostate/rectal exams.

Most beneficiaries had some type of insurance in addition to standard Medicare coverage: approximately 16 percent belonged to an HMO (which limited co-payments and deductibles), 55 percent had private supplemental coverage and nearly 7 percent also had Medicaid coverage. Just 22 percent of respondents had no type of supplemental coverage.

Although use of preventive services varied by type of insurance, the differences were significantly smaller than those reported when Medicare was just beginning to provide coverage for preventive services. Then, use of preventive services was 20 to 30 percent greater among individuals with supplemental coverage. By 1996, the overall proportion of beneficiaries using preventive services was much higher and the difference among beneficiaries was about only about 10 percent, with older beneficiaries without supplemental coverage less likely to access preventive services.

According to the authors, "differences in the use of preventive services among elders with and without supplemental insurance coverage have narrowed substantially over time. These findings suggest that policies and programs initiated in the early 1990s, including extension of Medicare coverage to include preventive services, have largely had their intended effect."

In this study, the biggest single predictor of appropriate use of preventive services was the

number of visits an individual made to a health care provider during the previous year. Beneficiaries without a usual source of care and those who had made no visits to a health care provider during the preceding 12 months were about one-third less likely to have received any of the seven preventive services than those individuals who saw a health care provider one to four times that year. Respondent age and education level were also strong predictors of service utilization: beneficiaries over the age of 84 and those with less education used fewer preventive services.

Interestingly, Medicare beneficiaries in HMOs were more likely to receive Pap smears, mammograms and breast exams than were individuals with private supplemental coverage, which "may reflect the emphasis that HMOs place on preventive services."

On a cautionary note, the investigators point out that nearly a third of Medicare beneficiaries did not get their yearly flu vaccine and 27 percent of female beneficiaries had not had a mammogram within the past two years. "These findings," they conclude, "emphasize a need for ongoing surveillance and interventions . . . targeted at elders without a usual source of care and those of lower educational attainment."

Carrasquillo O, Lantigua RA and Shea S. Preventive Services Among Medicare Beneficiaries with Supplemental Coverage Versus HMO Enrollees, Medicaid Recipients and Elders with No Additional Coverage. *Medical Care* 39 (6): 616–626, 2001.

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

Law Enforcement Officers and Firearms: Do They Practice Safe Storage?

More than one-third of families with young children in this country have firearms in their homes. These guns are accidents waiting to happen unless they are stored safely — locked and unloaded with ammunition locked separately from the firearm. Publicly, law enforcement officers are staunch advocates of firearm-related injury prevention: they sponsor gun buy-back programs, enforce laws restricting access to firearms and, as spokespersons, urge the public to store guns safely. In the privacy of their own homes, do law enforcement agents practice the gun safety techniques they espouse? In this study, researchers surveyed officers from a law enforcement agency in the urban South about their firearm storage habits — and found a wide gap between what law enforcement officers say and what they do.

The responses of 207 officers to an anonymous, self-administered questionnaire revealed that 80 percent have guns, in addition to their service weapons, at home. Some 44 percent of the officers stored their firearms unlocked and loaded. Officers with young children at home were more likely to store their guns safely: 69 percent locked up their guns compared to only 31 percent of those without children.

Despite law enforcement officers' apparent laxity in safe firearm storage practices, the majority privately supported the other gun-related injury prevention efforts they publicly advocate. Most officers favored registration and storage laws, waiting periods for background checks and mandatory training for firearm owners.

The authors expressed concern about the incongruity between officers' public role in firearm safety promotion and their own personal gun storage practices. However, they counterbalance this with an understanding that "keeping firearms readily accessible for the purpose of self-protection relates to officers' line of work." A majority (85 percent) of officers said they feel an added need to protect themselves and their families because of their job. However, the authors note that the high prevalence of firearm ownership among officers coupled with their unsafe storage practices may actually increase their children's and families' risk of firearm injury.

Until law enforcement officers feel safe in their homes and communities, the investigators contend, it is unlikely that they will change their personal gun storage practices. They suggest that "personalized guns" may offer a promising firearm safety option. A magnetic or electric lock built into the gun's grip allows only the owner to fire the weapon.

Coyne-Beasley T et al. Firearm Storage Practices of Officers in a Law Enforcement Agency in the South. *American Journal of Preventive Medicine* 21 (2): 118–123, 2001.

Dr. Coyne-Beasley is a fellow in The Robert Wood Johnson Foundation Minority Medical Faculty Development Program.

Use of Flexible Spending Accounts Among Employees

Medical flexible spending accounts (FSAs) allow employees to set aside a certain portion of their pre-tax pay to cover medical and dental expenses not covered by health insurance. By the end of a calendar year, employees must use all of the money in their FSA or forfeit it.

FSAs are a particularly popular employee benefit option among larger employers. According to the Bureau of Labor Statistics, in 1993 and 1994, FSAs were available to more than 50 percent of employees in medium and large companies and more than 60 percent of employees of state and local governments. Are employees taking advantage of this tax shelter for their out-of-pocket medical care spending? In this 1998 study of employees in 15 Minnesota firms, the investigators found that FSAs were unevenly favored by more highly educated workers and higher income workers.

Using a telephone survey, the researchers asked employees about their FSA contributions, medical care received over the previous year, self-reported health, income and education. They also obtained information on strategies employers use to inform employees about the availability and benefits of FSAs through a telephone survey of employee benefits administrators at the 15 firms.

Almost 20 percent of single employees and 33 percent of employees with families reported that they participate in FSAs. The average yearly contribution was $415 and $773, respectively.

Education was the strongest determinant of FSA participation. Highly educated employees — whether single or with dependents — were more likely to have an FSA. The impact of education was greatest on employees with families — those with some college were 16 percent more likely to participate in an FSA than those with a high school diploma or less. The figure rises to 31 percent for those with college degrees and to 48 percent for postgraduate education. Families in higher tax brackets were more likely to make larger contributions to their FSAs.

Employers used a number of techniques to tell employees about FSAs — from informational booklets and internal newsletters to special classes and seminars. Only one strategy — holding special meetings to encourage employees to participate in FSAs — had a significant impact, increasing FSA participation rates by 7 percent.

The authors believe that their findings can inform the policy debate around FSAs. They conclude: "A tax exemption that only highly educated employees can use effectively may be perceived as inequitable."

Feldman R and Schultz J. Who Uses Flexible Spending Accounts: Effects of Employee Characteristics and Employer Strategies. *Medical Care* 39 (7): 661–669, 2001.

RWJF Boosts Support for Childhood Injury Prevention

The broken bones, scrapes, burns and bruises of childhood can easily be dismissed as kids being kids — and kids having accidents. But hospitals that have tracked unintentional injuries have come to a different conclusion — when kids have safe places to play, are given alternatives to gang violence, follow street safety when walking and wear helmets when biking, they have many fewer injuries and fewer visits to the hospital emergency department. To help hospitals prevent childhood injuries — which kill more children than AIDS, cancer and all other diseases combined — The Robert Wood Johnson Foundation is expanding funding for an injury-prevention program that has an outstanding track record.

The program is based on a model that started in Harlem 13 years ago with RWJF funding and was then replicated in eight cities. Called the *Injury Free Coalition for Kids*, it helps hospitals begin injury-prevention programs. With its new $15-million commitment from RWJF, and working with the National Association of Children's Hospitals and Related Institutions, the *Injury Free Coalition for Kids* seeks to expand to at least 40 children's hospitals over the next five years.

"The Foundation spent less than $5 million over 13 years on a program that epitomizes success," says Judith Stavisky, M.P.H., M.Ed., senior program officer at RWJF. "We felt that the coalition should be a formal national program of the Foundation and bring the (Harlem) model into full-scale adoption."

In 1988, RWJF funded what turned out to be a highly successful model for injury prevention, the Harlem Hospital Injury Prevention Program at Columbia University. The brain-child of Barbara Barlow, M.D., director of pediatric surgical services at Harlem Hospital and professor of clinical surgery at Columbia University College of Physicians and Surgeons, the program achieved remarkable reductions in childhood injury rates resulting from falls (down 96 percent from 1979 to 1981) and other traumas (a 55 percent decrease in all injuries requiring hospitalization since the program began).

Key to the program's success is its recognition that most unintentional injuries are closely tied to poverty. Poor children, like those in Harlem, typically live in households that lack safety devices, such as window guards and smoke alarms; they also typically have nowhere to play but dilapidated playgrounds or busy streets. Injury rates in Harlem started to drop after Barlow pioneered a community effort to install window guards in high-rise buildings, build and repair playgrounds, run sports and arts programs, and provide safety education in the schools.

In 1994, with additional funding from RWJF, Barlow brought the Harlem program — renamed the *Injury Free Coalition for Kids* — to Atlanta, Chicago, Dallas, Kansas City, Los Angeles, Philadelphia, Pittsburgh and St. Louis. Again there were successes, including a 28 percent decline in trauma-related hospital admissions in Chicago and a 66 percent decline in pediatric burns in St. Louis.

"For each area, the types of injuries are different," Barlow says. Drowning doesn't occur in Harlem, for instance, but it is a major cause of childhood injury and death in Dallas. More gunshots and car crashes injure children in St. Louis and Kansas City than in Harlem, where most kids play in the streets, she says. "You can track injury rates and see if you're making a difference."

Hospitals interested in applying for the grant must have an established pediatric trauma center, a surveillance system that tracks injuries in its community and be willing to work with community coalitions. They also are required to match RWJF funding with money from their own hospitals and local funders. "We don't fund until everything's in place," Barlow says.

Hospitals need not be concerned about childhood injury prevention reducing admissions and reimbursement rates. As Stavisky points out, "Many trauma victims don't have insurance and hospitals end up absorbing the unreimbursed costs. Hospitals can look at injury prevention as an investment in avoiding costly medical care."

More importantly, it is a life-affirming investment. "Injury is the major health care problem of children. It is preventable and predictable," Barlow says. "As health care providers our goal is to make children healthy and free of injury."

For more information about the *Injury Free Coalition for Kids*, see <www.injuryfree.org>.

— ANDREA KOTT

Each year since 1989, The Robert Wood Johnson Foundation has provided every first-year medical student in the United States with a copy of *On Doctoring*, a collection of poems, stories, essays and memoirs celebrating the humanity of medicine. This August, the third edition of the anthology, edited by Richard Reynolds, M.D., and John Stone, M.D., and published by Simon & Schuster, was released. The updated text includes a poem by Gregory Edwards (pictured below), a sixth grader in Avondale, Ga. "The Shot" — Edwards' first published piece — is one of more than 80 selections that include works by W.H. Auden, Eudora Welty, Anton Chekhov, Zora Neale Hurston and Ernest Hemingway.

The Shot

Going to the doctor
With my father.

The scary, scary doctor!

Dad's gonna get a shot.
He's as stiff as a robot!

The scary, scary doctor!

We are getting closer.
We are in.

The scary, scary doctor!

He got his shot.

All that was left was a dot.

By Gregory Edwards

Editor John Stone, M.D. (left), congratulates poet Gregory Edwards on his publishing debut. Edwards' poem "The Shot" is included in the newest edition of the anthology *On Doctoring*.

Grantee Snapshot

Arneatha Martin, M.S.N

Providing Health Care That Doesn't Cost a Person Their Dignity

When you're poor, black and uninsured, the search for decent medical care can be downright humiliating. **Arneatha Martin, M.S.N.,** learned that painful lesson firsthand when she was a pregnant 16-year-old in Wichita, Kan. Ever since, she's devoted herself to creating a different model of health care — a model that doesn't ask poor patients to barter their self-respect to pay for basic medical treatment. Now, she heads a clinic that serves Wichita's poorest neighborhoods, providing care to some 15,000 patients — one-third of them uninsured — in the first two years of operation.

I graduated from high school at 16, and got married that same summer. It was 1961, and I started to work as a lab assistant at minimum wage. I don't know if I even knew what health insurance was, but I knew I didn't have any.

I had never in my life even seen a doctor. But when I found out I was pregnant, I started trying to find someone to help me have a healthy baby. It was a very painful experience. When you're uninsured, or underinsured, you suffer a lot of indignities just finding someone who will take you as a patient. You keep getting turned down. It's like searching for a needle in a haystack. You have to keep trying to find somebody willing to let you pay a little bit at a time. It's lucky for me that I was a healthy young woman, because I didn't find a doctor who would take me until I was in my second trimester.

When I got to the hospital [to have my baby], that was where the trauma really started. It was the first time I had ever set foot in a hospital. When you're black and you're young and you don't have any insurance, this is what happens: They act like you're invisible. You walk in, you're in labor and you get no recognition. You have to stand there until some person at the desk decides to pay attention to you. When they do finally look up, you say, "My water just broke and my doctor told me to come to the hospital." And they say, "Go sit down." So you sit down and wait. Then pretty soon, your husband goes up and says, "My wife is in labor, can you help her?" And they say, "How are you going to pay this bill?" There's no good feeling. It's like, "You're poor, you're black — what are you doing in here having a baby anyway?"

Finally, they took me up to the room and started talking words I did not know. Then they looked at me like, "Why don't you understand?" I felt they were totally trying to rob me of every little ounce of respect.

That's another thing they do to poor people. Everybody is looking under your dress. They bring in residents and say, "Let me show you what this looks like," without getting your permission. You have to endure it, because you don't have any insurance.

My physician delivered the baby, and then left. Right after he was gone, somebody asked me if I needed to urinate. I didn't know what that word meant. I thought it must be something I was supposed to know, so I just said no. Then she went and got this catheter, and I immediately learned what that word means. It means, "Do you have to pee?" I got a urinary infection from the catheter, and I had to stay in the hospital another couple of days, because I didn't understand what a word meant, and I was too proud to let them know that I didn't know.

In watching the nurses at the hospital, I thought, "I could do this. I could do this nicer, I could be better. I wouldn't scare people half to death." I don't know how I knew it, but I knew it surely could be better than this.

I have spent my whole life trying to figure out how to do this better. Can't we treat people right? Shouldn't we be able to do this in a more humane way? In our mission statement, I just put it right in there: Our goal is to deliver "good-enough-for-me" health care. That means providing a center where people feel comfortable bringing in their mothers, their children, the people they love and knowing that they'll be getting the best health care. It means letting people know that we're going to protect their dignity. If you don't have insurance, we're going to take you anyway. We're going to give you a little power. I don't want your dignity; I just want you to come on in.

Arneatha Martin is one of 10 outstanding individuals chosen to receive a Robert Wood Johnson Community Health Leadership Program award for 2001. She is the co-president and CEO of the Center for Health and Wellness in Wichita, Kan., which opened in 1998. The center has instituted a policy requiring that all patients are seen by a physician and nurse before any questions are asked about insurance.

See <www.rwjf.org> for this and other Grantee Snapshots, a regularly changing feature of Advances Online.

From **New Program** — page 3

M.D., M.P.P., of the Boston-based Institute for Healthcare Improvement (IHI), which serves as the National Program Office for *Pursuing Perfection*. "However, for many patients, even those treated in well-known, highly regarded institutions, the quality of care does not approach this standard reliably."

For example, Nolan says, some patients may receive state-of-the-art radiation therapy executed to perfection, but others treated in the same hospital may have less than optimal care because of delays and other breakdowns in the delivery system.

Actions taken by hospitals or physician practices to improve quality are not necessarily expensive, says Lavizzo-Mourey. After the initial investment, many quality improvement changes save money in the long run.

In the first phase of the *Pursuing Perfection* program, 12 grantees were chosen from among 226 applicants to develop comprehensive plans to systematically pursue perfect health care in specific areas — such as pediatric asthma, depression, heart disease or diabetes — while encouraging a working culture that fosters improvements throughout the organization. Six of the 12 organizations later will receive grants of $1.5 to $3.5 million to help implement their plans.

As part of the program, IHI is developing a Web-based network for those interested in pursuing perfection to share their experience widely.

According to IHI's Nolan: "This project provides a pragmatic research and development effort to determine how to raise the bar in health care performance and to demonstrate that, at least in a few organizations, perfect care can be pursued and near perfect care can be realized."

For more information, see <www.ihi.org/pursuingperfection>.

— Laurie Jones

SELECTED GRANTS

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

- For development of an integrated system of health care for impoverished persons in the Texas border region, $3.8 million to the Texas A&M University System Health Science Center Research Foundation, College Station.
- For creating and nurturing a support center for health care ombudsman programs, $5.4 million to Families USA Foundation, Washington.
- For the Fragile Families and Child Well-Being Study, $2.2 million to Princeton University, Bendheim Thoman Center for Research on Child Wellbeing, Princeton, N.J.
- For a national campaign to prevent teen pregnancy, $1.6 million to the National Campaign to Prevent Teen Pregnancy, Washington.
- *State Coverage Initiatives.* Awards to three sites, totaling $1.8 million.
- *Medicare/Medicaid Integration Program.* An award of $382,807 to State of Wisconsin Department of Health and Family Services, Madison, for the Wisconsin Partnership Project.

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

- *Rallying Points: Support for Community Coalitions in End-of-Life Care*, $12 million to Partnership for Caring, Washington.
- For examining decisions, choices and care management among an admission cohort of privately insured disabled elders, $586,352 to Center for Health and Long-Term Care Research, Waltham, Mass.
- For educating health care leaders on developing a patient-oriented system of care, $398,488 to FACCT, Portland, Ore.
- *Promoting Excellence in End-of-Life Care.* Award of two grants from the Special Opportunities Fund, totaling $344,450.
- For building a collaborative to improve care for children with attention deficit hyperactivity disorder, $367,985 to Institute for Healthcare Improvement, Boston.
- For developing an evidence-based model of clinical management of patients with chronic conditions, $392,619 to Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin.
- For collecting and reporting consumer views of health care quality at the physician level, $327,420 to Massachusetts Health Quality Partners, Watertown.
- For developing a new set of actionable measures for prevention and chronic illness care, $399,327 to National Committee for Quality Assurance, Washington.
- For evaluation of the Internet-Based Chronic Disease Self-Management Program, $528,730 to Stanford University School of Medicine, Stanford, Calif.
- To conduct a physician-level quality assessment of chronic illness care, $397,604 to Tufts University School of Medicine, Boston.
- For evaluation of the *Cash and Counseling Demonstration and Evaluation* program, a supplemental award of $399,727 to University of Maryland Center on Aging, College Park.
- *Faith in Action II.* Awards to 66 sites, totaling $2.3 million.
- *Managing Pediatric Asthma: Emergency Department Demonstration Program.* Awards to four sites, totaling $2.9 million.
- *Managing Pediatric Asthma: Improving Asthma Care for Children*. Awards to four sites, totaling $2 million.

Projects to Promote Healthy Communities and Lifestyles

- For promoting activity through community design — a planning and education initiative, $532,000 to The American Planning Association, Chicago.
- For using policy briefs to improve population health, $722,925 to California Center for Public Health Advocacy, Santa Monica.
- For facilitating communication among organizations using the *National Blueprint: Increasing Physical Activity Among Older Adults Age 50 and Over,* $568,767 to University of Illinois at Urbana-Champaign.
- For studying the longitudinal effects of housing policies on health indicators and outcomes, $748,572 to Princeton University, Woodrow Wilson School of Public and International Affairs.
- For an evaluation of the implementation phase of *Turning Point: Collaborating for a New Century in Public Health*, $746,548 to Public Health Institute, Berkeley, Calif.
- For fostering partnerships between the public health community and The National Health Museum, $397,864 to The National Health Museum, Washington.
- For dissemination of consensus guidelines on media coverage of suicide, $275,000 to University of Pennsylvania, The Annenberg School for Communication, Philadelphia.
- *State Health Leadership Initiative.* Renewal award of $919,725 to National Governors' Association Center for Best Practices, Washington.
- *Studying the Relationship Between Social Connectedness and Health.* Award of $699,311 to Mind Brain Body and Health Initiative, Galveston, Texas.
- *Translating Research to Practice: Improving Physical Activity Levels of Mid-Life and Older Adults*. Award of $4.3 million to American Association of Retired Persons, Washington, for marketing communications and policy activities.

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

- For educating the U.S. public about the framework convention on tobacco control, $2.5 million to National Center for Tobacco-Free Kids, Washington.
- For tracking the media and policy impacts of state-level tobacco control: *SmokeLess States* evaluation, $2.3 million to University of Illinois at Chicago School of Public Health.
- For encouraging accurate depictions of substance abuse and addiction in entertainment industry products, $3.5 million to Entertainment Industries Council, Reston, Va.
- For analysis of the substance abuse treatment delivery system, $289,264 to Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, Mass.
- *A Matter of Degree: Reducing High-Risk Drinking Among College Students*. Renewal awards to four sites, totaling $1.5 million.
- *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol.* Renewal awards to two sites, totaling $514,517.
- *Innovators Combating Substance Abuse*. Awards to three sites, totaling $899,506.
- *Partners With Tobacco Use Research Centers: Advancing Transdisciplinary Science and Policy Studies.* Renewal awards to two sites, totaling $1.5 million.
- *Research Network on the Etiology of Tobacco Dependence.* Renewal award of $4.6 million to University of Kentucky Research Foundation, Lexington.
- *Voices in the Debate: Minority Action for Tobacco Policy Change*. Award of $2.5 million to Association of Asian Pacific Community Health Organizations, Oakland, Calif.

Other Programs and Those That Cut Across Foundation Goals

- For the Council on Health Care Economics and Policy, $1.7 million to Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare.
- Continued support for *Health Affairs,* $1.8 million to Project Hope — The People-to-People Health Foundation, Millwood, Va.
- For expanding the Experience Corps senior volunteer program, $6.8 million to Civic Ventures, San Francisco.
- For attracting the attention of young scholars to the health of the public, $8.5 million to College Entrance Examination Board, New York.
- *Pursuing Perfection: Raising the Bar for Health Care Performance.* Awards to 12 sites, totaling $599,830.
- *Investigator Awards in Health Policy Research Program.* Awards to three sites, totaling $646,516.
- *Changes in Health Care Financing and Organization.* Awards to seven sites, totaling $2.1 million.
- *Local Initiative Funding Partners Program.* Awards to 17 sites, totaling $6.3 million.
- For evaluation of a program to increase the number of women leaders in academic medicine, $354,368 to MCP Hahnemann University, Philadelphia.

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

People

David J. Morse, M.A., has been named RWJF vice president for Communications. Formerly, Morse served as director of public affairs at The Pew Charitable Trusts in Philadelphia.

Prior to his work at Pew, Morse was at the University of Pennsylvania in a variety of positions, including director of federal relations for the University, associate executive vice president for government relations for Penn's Medical Center and associate vice president for policy planning. He also served as a professional staff member in the U.S. Senate and as staff director of the Presidential Task Force on the Arts and Humanities. Morse earned his master's degree in International Relations from The Johns Hopkins University, School of Advanced International Studies.

Albert O. Shar, Ph.D., joined the Foundation in September as vice president, Information Technology. Formerly, Shar was with the R.W. Johnson Pharmaceutical Research Institute, a Johnson & Johnson Company, where he served as a technical director for Global Information Solutions. He earned his doctorate from the University of Pennsylvania.

Kathryn Thomas, M.A., came to RWJF in November as a senior communications officer with the Health Group/ Population Health Sciences and Policy Program Management Team. Previously, Thomas was a co-founder at Digital Ingenuity in Philadelphia. She received her master's degree in journalism from Temple University.

Lori K. Grubstein, M.P.H., M.S.W., began working at the Foundation in August as a program associate for the Community Health Program Management Team. Grubstein was formerly with the Crime & Justice Research Institute in Philadelphia. Her training includes a B.A. in psychology from Clark University, a Certificate from the London School of Economics and Political Science, and an M.P.H./ M.S.W. from the University of Michigan.

Farewell

Frank Karel, M.P.A., retired from the Foundation in December as vice president for Communications, a position he held from 1974 until early 1987 and then resumed again in 1993. During the interim years, he served in the same capacity at the Rockefeller Foundation. Before coming to RWJF, Karel served as a program officer at the Commonwealth Fund, headed the public relations office at The Johns Hopkins Medical Institutions, and was an associate director of the federal government's National Cancer Institute and National Cancer Program. In addition, he was director of planning for National Jewish Hospital and Research Center in Denver, and was the Miami Herald's first science writer.

Greg Hall, program officer with the Community Health and Population Health Science and Policy Teams, left the Foundation in August to become a program officer for the California Endowment in San Diego.

Joan K. Hollendonner, senior communications officer and member of the Alcohol and Illegal Drugs Team, left the Foundation in September to become the principal caregiver for her mother. She had been with RWJF for 15 years.

New Grant Results Reports Posted on RWJF Web Site

As of October 2001, 516 Grant Results Reports and 23 National Program Reports were available at <www.rwjf.org>. These reports, which detail the results of grants that are now closed, are organized by topic area. The search engine allows a full-text search. Among the added reports:

- **Case studies describing urban hospitals' cross-cultural issues.** The National Public Health and Hospital Institute (NPHHI) conducted six case studies of U.S. public and private urban hospitals' ability to meet the needs of a culturally diverse workforce and society. NPHHI transformed the questionnaire into a self-administered tool, *The Cultural Competence Self-Assessment Protocol*, which allows hospitals and other health organizations to assess their own cultural competence. The protocol is available free from Dennis P. Andrulis, Ph.D., *dandrulis@netmail.hscbklyn.edu.*
- **A book on medical marijuana based on a National Academy of Sciences — Institute of Medicine (IOM) report.** The IOM prepared a 216-page book, *Marijuana as Medicine? The Science Beyond the Controversy*, based on an IOM study sponsored by the White House Office of National Drug Control Policy. The book includes information on marijuana's medical benefits, physical and psychological side effects, potential harm, disease-by-disease efficacy, derivative pharmaceuticals and legal complexities. The book can be read online from the National Academy Press at <www.nap.edu> or purchased at a discount for $14.36 through the Web site.
- **Report on public health and medicine partnering to improve community health.** The New York Academy of Medicine (NYAM) facilitated a partnership between the American Medical Association and the American Public Health Association to study the changing roles and responsibilities of medicine and public health in the 21st century. A monograph, *Medicine and Public Health: The Power of Collaboration,* documents the emergence of collaborative relationships between medicine and public health, categorizes those relationships and offers strategies for success and recommendations for future actions. NYAM also assembled *The Pocket Guide to Cases of Medicine and Public Health Collaboration,* which lists 380 cases of collaboration. The monograph is to be found at <www.cacsh.org/mph.html>; the guide is available at <www.cacsh.org/mphguide.html>. Both are free.

— Molly McKaughan