

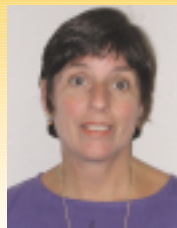
The  
Robert  
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Quarterly  
Newsletter

## Schroeder's "Extraordinary Contribution"



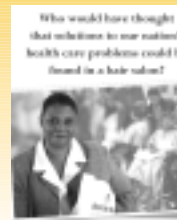
PAGE 3

## Breaking Through Death-Denying Culture



PAGE 4

## Roll Call Ads Highlight Grantees' Work



PAGE 10

# No "Best" Place to Die in the United States

For an in-depth look at the report, see [www.rwjf.org/special/betterend](http://www.rwjf.org/special/betterend)

People want to die at home, but most don't. They want to die free from pain, but too many don't. At the same time, most people don't want to talk about their wishes—or about dying at all—and they either don't know about options for end-of-life care or they don't ask for them.

A report released in November is aimed at helping inform people about those choices. The report reviews end-of-life care in each state and the District of Columbia. Such care includes palliative care, which aims not to cure people of disease, but to promote quality of life by relieving physical symptoms and providing emotional and spiritual support.

The report, "Means to a Better End: A Report on Dying in America Today," was generated by *Last Acts*, a national program funded by The Robert Wood Johnson Foundation (RWJF) to promote improvements in care and caring near the end of life. It details eight measures that represent key elements involved in end-of-life care, and grades the care in each state on those measures.

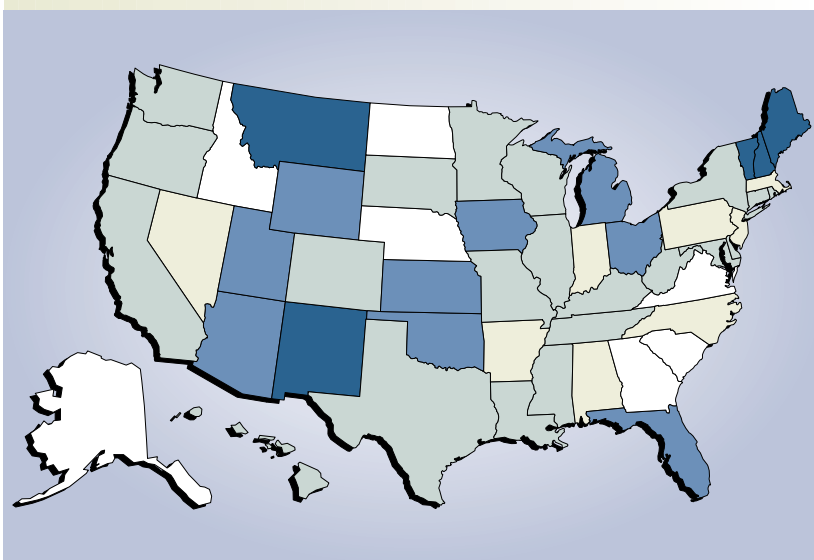
"We realized we needed to develop a report that would give people something to chew on," says Judith Peres, L.C.S.W., *Last Acts* deputy director (see related Q&A, page 4). "We wanted a report that would gain visibility and provoke action."

The report's key finding? "At best, Americans have only a fair chance of receiving good end-of-life care," says Peres. "One of the things that was most surprising was that no state really rose above all the others as a shining example. They were

See No "Best" Place—page 2

U.S. Primary Care Physicians Certified in Palliative Care, 2000

Range 0.00–0.97% Mean 0.33%



**A** 0.50–0.97%

Maine  
Montana  
New Hampshire  
New Mexico  
Vermont

**B** 0.37–0.49%

Arizona  
Florida  
Iowa  
Kansas  
Michigan  
Ohio  
Oklahoma  
Utah  
Wyoming

**C** 0.22–0.36%

California  
Colorado  
Connecticut  
Delaware  
District of Columbia  
Hawaii  
Illinois  
Kentucky  
Louisiana  
Maryland  
Minnesota  
Mississippi  
Missouri  
New York  
Oregon  
Rhode Island  
South Dakota  
Tennessee  
Texas  
Washington  
West Virginia  
Wisconsin

**D** 0.18–0.21%

Alabama  
Arkansas  
Indiana  
Massachusetts  
Nevada  
New Jersey  
North Carolina  
Pennsylvania

**E** 0.00–0.17%

Alaska  
Georgia  
Idaho  
Nebraska  
North Dakota  
South Carolina  
Virginia

Source: American Board of Hospice and Palliative Medicine; [www.abhpm.org](http://www.abhpm.org). American Medical Association. *Physician Characteristics and Distribution in the U.S., 2002–2003 Edition*. Chicago: American Medical Association Press, 2002.

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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, NJ 08543-2316

[advances@rwjf.org](mailto:advances@rwjf.org)

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uniformly not doing well."

However, notes Victoria Weisfeld, M.P.H., RWJF senior communications officer for *Last Acts*, state-level data mask local differences: A state's large cities might have many end-of-life services, while its small towns might have few or none.

"There's variation all over the map," Peres agrees. "There may be some excellent programs [in a state], but there's no guarantee you will wind up in them, and the public doesn't necessarily know to ask for them."

States were given grades from A to E. "It was quite surprising that for some measures, no state got an A or a B," Weisfeld says. "For example, states fell short on the number of hospitals with a palliative care service. I think that's disturbing. Really sick people shouldn't have to work hard to find their way to services they need; they ought to just *be* there."

States also fell short on treating pain in nursing home residents. "These are people who have been assessed for whether or not they're in pain," Weisfeld explains. "The answer is 'yes,' and months later the answer is still 'yes.' It's unconscionable. Some of these measures really pass the blood pressure test—they make you mad."

Just collecting the information was a major challenge. The report's authors found that some of the data they wanted to include—such as information on spirituality and on the accessibility of end-of-life care to historically underserved populations—were simply unavailable, and other data were difficult to obtain.

"I was surprised at how difficult it was to find data that captured the measures we were looking for," says Tricia Nitsche, *Last Acts* research associate. "We thought we would have an easier time with that."

## Key findings from *Means to a Better End*:

- Nationally, only 25 percent of deaths occur at home, although more than 70 percent of Americans say that this is where they would prefer to die.
- About half of all deaths occur in hospitals, but less than 60 percent of the hospitals in any given state offer hospice care or palliative care services.
- In any given state, at least one in four nursing home residents experiences pain for at least two months without appropriate management.
- Although care in an intensive care unit (ICU) is often unwanted and uncomfortable at the end of life, between 16 and 37 percent of Medicare decedents in any given state had an ICU stay in their last six months of life.
- Experts agree that up to 95 percent of serious pain can be effectively treated, but half of all dying people still experience pain.
- The state average percentage of U.S. primary care physicians certified in palliative care is 0.33 percent (see map, page 1); the average percentage of nurses certified in hospice and palliative care is 0.41 percent.
- Twenty states recommend that people draw up a single, comprehensive advance directive (living will and/or medical power of attorney), which reduces confusion. Thirty-five states do not require mandatory forms or that certain language be used for advance directives; this means people can state their wishes in their own way.
- The percentage of deaths that include a hospice stay varies from about 5 percent to 42 percent. In most states, only about 12 to 25 percent of deaths include a hospice stay.
- Experts agree that patients need at least 60 days of hospice care to maximize its benefits, but hospice stays ranged from 14 to 43 days per state—well below this figure.

The researchers also struggled with benchmarks: What constitutes "enough" physicians certified in end-of-life care? Is there an acceptable level of untreated or undertreated pain in nursing home residents?

"For most of our measures, we were able to find a published benchmark or establish a commonsense one," Weisfeld says. "But for some of the measures, we had to grade on a curve. In those areas, maybe a state gets an A, but is that really good enough? We can't say yet."

The bad marks do, however, call attention to the problem. "We hope that researchers and policy-makers will see that we've identified the issue and take it on as a challenge," Peres says.

For consumers, Weisfeld believes that the report "can help build awareness of how bad things are and how much improvement

needs to be made in areas that are unequivocally important."

As a companion to the report, *Last Acts* has published a guide called "Seize the Opportunity," which provides ideas about what advocacy groups and individuals can do with the report's messages.

"While the findings are grim, there is much being done on the local level through coalitions already working in communities across the nation to make improvements in end-of-life care," Weisfeld says. "We can't put the burden of improving end-of-life care on the patients and families—that's not fair. The system has to be their advocate."

— NANCY VOLKERS

For information on forming or joining a community coalition to improve end-of-life care, see [www.rallyingpoints.org](http://www.rallyingpoints.org). For the complete report, see [www.rwjf.org/special/betterend](http://www.rwjf.org/special/betterend).

# President Schroeder Leaves Strong Legacy

The process that led to the selection of Steven A. Schroeder, M.D., as The Robert Wood Johnson Foundation's third president began at a dinner in San Francisco with then-RWJF Chairman Sidney Wentz. Schroeder's "spontaneity, energy and creativity" impressed Wentz. He and the other Trustees also responded to the characteristic that most often surfaces in descriptions of Schroeder: "He was very much a 'people guy.'" But there was something more that grabbed Wentz.

"Steve Schroeder said something to the nominating committee that was very persuasive," says Wentz. "He said that what the Foundation should be doing is looking for leverage



and for what others are *not* doing."

Schroeder left his position as head of the University of California, San Francisco, Medical School's Department of General Internal Medicine to become president of RWJF in July 1990. At the end of 2002, he plans to return to UCSF. During the past 12 years, Schroeder has overseen growth of the Foundation's assets from \$2.9 billion to more than \$8 billion, a corresponding rise in its annual grantmaking from \$132 million to more than \$400 million, and a substantial increase in staff.

Interviews with people close to Schroeder, however, reveal a contribution deeper than these statistics.

## Best Programs

Schroeder arrived at the Foundation with a two-item agenda, which he explained to staff at their first meeting: "Best place to work; best possible programs."

On the program side, he dug in immediately, meeting with staff to develop priorities that included a focus on access to basic health care, reducing substance abuse, improving chronic care and addressing health care costs. (In the intervening years, the "costs"

goal was dropped and a new goal to promote healthy communities and lifestyles was added.)

"Steve has two qualities rare in Foundation presidents," says Joseph Califano, former U.S. Secretary of Health, Education and Welfare and head of the RWJF-funded National Center on Addiction and Substance Abuse, a centerpiece program in the Foundation's substance abuse portfolio. "They are vision and tenacity. He immediately saw that substance abuse and addiction are among our leading health problems. Because he's stayed the course, he's made an extraordinary contribution, as significant as anybody in this field."

But helping young people avoid or stop

tobacco use is the program area most clearly associated with Schroeder's presidency. During his tenure, RWJF has invested approximately \$408.6 million in programs in this area.

The grants and programs he fostered have "changed the way the country has thought about tobacco use and the role philanthropy can play in making such a change," says Risa Lavizzo-Mourey, president and CEO-designate at the Foundation. "Fifteen years ago, this large an improvement would have seemed impossible."

With RWJF's work in substance abuse as a base, Schroeder, over a period of years, moved the Foundation Board to a broader programmatic consideration of "health," rather than just "health care." This significant expansion "meant knocking down a lot of barriers," says current Board Chairman Robert E. Campbell. RWJF's health programming, in dollar terms, now equals health care programming and carries a commitment to community work. According to former Surgeon General David Satcher, M.D., Schroeder's role was "invaluable" as RWJF began "investing in commu-

nities to develop the partnerships and leadership to tackle the health problems most relevant to them."

While Schroeder emphasizes sound strategy development and measurable objectives for Foundation programs, he recognizes the difficulties inherent in translating idea into action. "Execution trumps strategy," he likes to say. And, as RWJF Vice President of Human Resources David Waldman puts it, "Execution depends on people."

## Best Place to Work

As quickly as Schroeder put in place a vision for the Foundation's programs, he also jumped in to improve the Foundation's culture.

When Schroeder arrived, "staff weren't allowed to approach or engage Trustees, and they didn't attend Board meetings," says Schroeder's assistant, Sara Wilkinson. Today, program officers participate, the meetings are televised closed-circuit for all employees to view, and the relationship between Trustees and staff has grown into one of mutual respect.

Over his tenure, Schroeder has worked with his chairs to diversify the Board—more women, more people of color and younger Trustees. According to Campbell: "Today's Board simply has broader perspectives. We needed to do this to support the evolution in our programming, specifically our move into the health arena."

The Foundation started regularly polling key constituencies—grantees, policy-makers, media, applicants and staff—to flag areas for improvement. The anonymous staff survey, particularly, is unusual in philanthropy. All of these efforts fit Schroeder's broader commitment to the discipline of measurement.

He has worked closely with staff, consultants and Trustees to develop meaningful measures of RWJF's activity, impact and program effectiveness.

Schroeder also produced a statement of principles for the Foundation, much like Robert Wood Johnson's famous credo for Johnson & Johnson.

## Let the Ideas Flow

Schroeder is as proud of his contribution to the culture at RWJF as he is of his programmatic contributions. Regularly walking around the building and stopping by people's offices, he took the pulse of the organization like any conscientious internist.

If you had an important project coming before the Board, Schroeder would reassure you, show his confidence in you—and make you rehearse your presentation yet again. If you were facing a serious personal situation, Schroeder was there—"no walls, no pretenses,"

Wilkinson says. If you needed to talk candidly about RWJF, "nothing was off-limits," says Waldman.

"Steve is not afraid to let the ideas flow," says Executive Vice President Lew Sandy, M.D. Using this approach, "Steve created a climate for staff achievement."

Vice President for Communications

David Morse agrees. "Maybe it's reinforced because he continues to see patients, but Steve has that gift that the best clinicians have, of being able to connect."

A legacy, of course, is for the benefit of those who carry on. Lavizzo-Mourey says that Schroeder has guided staff to "think about our work in social change, our patience and impatience in making those changes, and the rigor with which we approach our work. I hope I am wise enough to continue that."







**How do you want to die? Most of us shrink from answering that question. But if we don't face the tough realities awaiting us**

**at the end of life, we can't create a system of care that will offer humane choices for the aging and terminally ill, insists Judith R. Peres, L.C.S.W., deputy director of the Last Acts® National Program Office in Washington. In this interview with ADVANCES, she talks about what it takes to create a good death, both for individuals and society.**

### What makes a good death?

**PERES**—The vast majority of people say they would prefer to die at home surrounded by loved ones, free of pain, with their spiritual needs met. But in reality, about half of all people die in the hospital, and more and more people are dying in nursing homes. While you can have a very good death in a hospital or a nursing home, that's not what most people say they want.

**But if you ask not how, but if they want to die, you get a very different answer. Isn't that the biggest hurdle to improving end-of-life care?**

**PERES**—No one wants to die, but it's inevitable for everyone. Often, because of people's reluctance to confront that reality, they don't know how to ask for better care at the end of life. *Last Acts* was formed to help break through this death-denying culture.

**Wouldn't a conversation about a good death be devastating to a patient who is still fighting to live?**

**PERES**—Palliative care, which can be an important part of end-of-life care, doesn't mean giving up.

# Creating a Good Death

We need to talk about supportive care as an important factor at all stages of illness. If we had a system that supported patient-centered care, we'd realize that this is not an either-or choice.

### How do Medicare policies affect the way Americans die?

**PERES**—In some ways, dying is a Medicare issue. About 2.5 million Americans die each year; 80 percent of them are Medicare beneficiaries. Of the \$262 billion spent on Medicare each year, 27 percent is spent in the last year of life, and much of that care is not necessarily beneficial. When Medicare was founded in 1965, it was based on an acute-care model. So people are placed in hospitals because that's where prescription drugs are covered, and that's the way the system works, but it doesn't serve the needs of a growing chronically ill population. There are some 70 million of us baby boomers. Right now we don't have a system that could support our chronic illnesses and dying in any kind of good way.

### What makes a hospital a bad place to die?

**PERES**—Curing disease and prolonging life are the central missions of our hospitals. Within that culture, hospitals regard death as a failure. Because of that, and because of the incentives built into the system, patients may find themselves in the intensive care unit (ICU), receiving care that makes them uncomfortable and does not reflect their wishes. Certainly, life-sustaining treatments can be welcome at any age. But there is a crossing point where life-sustaining treatment becomes death-prolonging treatment. People do not want to die in isolation, hooked up to tubes. In

one study, 55 to 75 percent of people in the ICU said that they were hungry and thirsty, and in moderate to severe pain. That's not how people want to die.

Then there are hospital protocols, where patients are disturbed and awakened at times for routine care when they're finally getting some rest. Some hospitals are intractable in their rules. They don't allow 24-hour visiting, so patients are separated from their families. That contrasts with a hospice, where people can bring in pizza, put it on the bed and everybody hangs out together. In hospitals, there's also the shared room, so you don't have privacy—which is a big marker for patients when they talk about being comfortable near the end. There are innovative hospitals that are working hard to offer good comfort care in the dying process, but you have to work hard to find them.

### As you say, some hospitals do a great job in providing supportive care for terminal patients. What makes the difference?

**PERES**—You get good care in one place because of the strength of that institution's leadership, or perhaps because some money has been bestowed in that particular area. To me, that's one of the major flaws of the system. We don't want our end-of-life care to depend on the prevailing winds at a particular institution. You need a culture where everyone is a believer and working to improve the care. There are many, many award-winning hospitals and

groups scattered across the country that are doing just that. The question is, why isn't everyone?

### What makes hospice care a better option for the terminally ill?

**PERES**—The key to good end-of-life care is constant monitoring. One of the main reasons that hospice continues to be the gold standard is that it provides 24/7 coverage. If a

patient's pain control falls

apart at 3 a.m. on

Sunday, there is

someone who can

help her right

away, instead of

waiting for the

doctor's rounds

on Monday

morning.

*"While you can have a very good death in a hospital or a nursing home, that's not what most people say they want."*

**Fewer than 10 percent of African Americans accept hospice care. Does this reflect a different cultural vision of a good death, or is it evidence that outreach on end-of-life care hasn't been adequately focused on this part of the population?**

**PERES**—The African-American community has a historic suspicion of the health care system, especially with regard to withholding any kind of treatment. Some recent work suggests that African Americans get more medical services in the last year of life than other groups. If you've never enjoyed full access to medical care, you don't want to give up that access when all of a sudden, thanks to Medicare, it's finally available at the end of life.

—INTERVIEW BY  
ELIZABETH AUSTIN

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## The Role of Marketing In Teen Smoking

Despite three decades of public health education on the dangers of tobacco, adolescents continue to take up smoking. Many different factors contribute to their use of cigarettes—and research shows that tobacco industry marketing is one of them. In fact, several surveys found that teens disproportionately smoke the brands that are advertised most heavily. Two recent studies looked at tobacco industry marketing and teen smoking. The first examined the role marketing plays in adolescents becoming full-fledged smokers and the second looked at changes in tobacco industry marketing practices after a

nationwide ban on billboard advertising.

In the first study, investigators interviewed nearly 3,400 California adolescents between the ages of 12 and 17, first in 1993 and again in 1996, to identify changes in their smoking habits. Teens were asked how many cigarettes they had ever smoked. Those who had tried smoking but smoked fewer than 100 cigarettes during their lifetime were defined as experimenters and those who had smoked at least 100 cigarettes were considered established smokers. The researchers also asked adolescents about the number of peer and family members who smoke, their relationship with their family, attendance at religious services,

school performance and their perceptions about the general prevalence of teen smoking. In addition, the investigators categorized teens as highly, moderately or minimally receptive to tobacco marketing based on their ability to name a favorite cigarette advertisement or their use of tobacco industry promotional items, such as T-shirts. Highly receptive teens had used or would use a promotional item, while minimally receptive teens could not name a favorite tobacco advertisement or any advertised cigarette brand.

Overall, nearly one-third of adolescents moved from just experimenting with cigarettes in 1993 to smoking on a more regular basis by 1996. Teenagers who were highly receptive to

### RESEARCH NOTE

#### The Effect of Smoking Bans on Restaurant Business

Restaurant smoking restrictions are not universally well regarded in the communities that adopt them. Restaurant owners worry about the loss of business and restaurant employees are concerned about the potential loss of jobs. Although research has shown that these fears are unfounded—that restrictive smoking policies are not economically harmful to restaurants or restaurateurs—tobacco and restaurant industry-funded studies report that job losses and declining sales go hand in hand with smoking bans. This study looked at restaurant businesses in Massachusetts communities that adopted restrictive smoking policies—both before and after their implementation—to better understand the impact.

The researchers identified cities and towns in Massachusetts that enacted highly restrictive restaurant smoking policies during the seven-year period January 1992 through December 1998. They defined highly restrictive policies as those that banned smoking restaurant-

wide or limited it to an enclosed, separately ventilated area. Using restaurant meals tax receipts collected by the Massachusetts Department of Revenue, the investigators then compared restaurant business before and after the implementation of smoking bans. They subsequently contrasted these findings with trends in restaurant sales during the same time period in communities without highly restrictive smoking policies. Because of the strong link between drinking and smoking, the researchers separately analyzed findings on restaurants serving alcohol, theorizing that these establishments might be disproportionately affected by smoke-free policies.

Across the state, the general trend in all restaurant business between 1992 and 1998 was one of growth; sales increased on average slightly less than 4 percent each year. Overall, neither highly restrictive nor less restrictive smoking policies had a significant effect on restaurant sales—this was true for both alcohol-serving and non-serving establishments. Other factors, however, did

affect restaurant sales. Business fluctuated seasonally, as would be expected with or without the bans. Per-capita income also affected restaurants. Those in wealthier communities generated more sales. In fact, among all restaurant types, each 1 percent rise in county per-capita income translated into an 0.18 percent increase in per-capita meal receipts.

The authors' findings are consistent with survey research that showed that "most of the state's residents would continue to dine in establishments once they are smoke-free and many would frequent smoke-free establishments more often." They conclude: "We find claims of community-wide restaurant business decline under highly restrictive smoke-free policies to be unwarranted."

Bartosch WJ and Pope GC. "Economic Effect of Restaurant Smoking Restrictions on Restaurant Business in Massachusetts, 1992 to 1998." *Tobacco Control*, 11(Supplement II): ii38–ii42, 2002.

tobacco marketing were 70 percent more likely than minimally receptive teens to have progressed to established smoking by 1996. In addition, adolescents who believed they could quit smoking anytime were nearly twice as likely to become full-fledged smokers as teens who lacked confidence in their ability to quit. Slightly more than 50 percent of adolescents who were *both* highly receptive to tobacco marketing and believed they could stop smoking at will became established smokers by 1996. Other factors that predicted adolescents' progression from experimentation to regular smoking included having friends and family members who smoked, attending religious services irregularly or not at all, perceiving that smoking is the norm among teens and having poor relationships with family members.

According to the authors, these study findings, combined with findings from several earlier studies, show that "tobacco advertising influences *not only* smoking experimentation, but also progression from early smoking behavior to regular smoking."

In the second study, investigators observed changes in tobacco marketing after the April 1998 moratorium on cigarette billboard advertising in some 3,400 tobacco retailers in 191 communities. Using data collected by trained field research teams, they speculated that the ban on billboard advertising would prompt the tobacco industry to transfer advertising dollars to advertising and promotion activities at the actual point of purchase in and around stores selling cigarettes. Indeed, this was the case. After the billboard ban, the researchers noted significant increases in tobacco advertising inside and outside stores that sold cigarettes. They found significant

increases in promotional activities that offered smokers gifts with a purchase, cents-off promotions and discounts when purchasing multiple packs, as well as increases in the number of objects in the store such as clocks or shopping baskets labeled with a cigarette brand.

They conclude: "As long as tobacco advertising restrictions are incomplete, significant reductions in overall marketing efforts are unlikely to be achieved." Given the shift of marketing dollars from billboard advertising to point-of-purchase advertising, "the intended effect of the . . . ban may not be realized because overall exposure to advertising and promotions may not be reduced."

Both studies call for a more complete ban on tobacco advertising: the first because the evidence shows that tobacco advertising may motivate some teens to progress from sporadic experimentation with cigarettes to established smoking, and the second because tobacco marketers merely switch advertising media in the face of an incomplete ban. At the very least, the finding from the first study—that beliefs about the ability to quit smoking influence smoking initiation and progression—"argues for including advertisements that focus on nicotine addiction in mass media anti-smoking campaigns."

Choi WS, Ahluwalia JS, Harris KJ and Okuyemi K. "Progression to Established Smoking: The Influence of Tobacco Marketing." *American Journal of Preventive Medicine*, 22(4): 228–233, 2002.

Wakefield MA, Terry-McElrath YM, Chaloupka FJ, Barker DC, Slater SJ, Clark PI and Giovino GA. "Tobacco Industry Marketing at Point of Purchase After the 1998 MSA Billboard Advertising Ban." *American Journal of Public Health*, 92(6): 937–940, 2002.

## Hospital Care for the Very Old: Are They Getting What They Want?

Today in the United States, people are living longer, many well into their 80s. When faced with a hospital stay at an advanced age, what kind of care do patients want to receive? Are their care preferences met? The Hospitalized Elderly Longitudinal Project (HELP), an RWJF-funded prospective study of the prognoses, care preferences and decision-making of hospitalized patients aged 80 and older examined these issues. HELP enrolled more than 1,200 patients aged 80 and older hospitalized at four large teaching hospitals from January 1993 to November 1994. Researchers reviewed patients' medical records and interviewed patients and their surrogates several times. They collected data on patients' health; ability to bathe, dress and care for

themselves; quality of life; and their preferences for comfort care versus life-extending care.

This analysis, which is part of HELP, looked specifically at the use of extraordinary or life-sustaining treatments—such as cardiopulmonary resuscitation (CPR), ventilators, surgery and blood transfusions—among 72 elderly patients who died during the course of hospitalization. The patients who died were older, had a higher disease burden and functional impairment, and were more likely to have a do-not-resuscitate order than patients who survived beyond the study period. However, their care preferences were no different from all other patients: Nearly 70 percent of all patients—those who survived and those who did not—said they would rather receive comfort care or pain relief than life-sustaining treatment.

Despite this overwhelming preference for palliative care, 63 percent of the patients who died during hospitalization received at

### The Use of Selected Interventions in Hospitalized Patients 80 Years and Older

Treatments	Died during index hospitalization %	Died during one year follow-up %	Alive at one year %	Total %
Admission to Intensive/Coronary Care	54	20	18	21
Ventilator	43	6	5	8
CPR	18	1	1	2
Tube Feeding	18	6	3	5
Surgery	17	11	18	16
Right Heart Catheterization	15	4	4	5
Transfusion	14	12	9	10
Hemodialysis	6	2	1	1
Hyperalimentation	3	2	2	2
Received one or more of the above treatments	63	29	27	30



least one life-sustaining treatment. In fact, 54 percent were admitted to an intensive care or coronary care unit, 43 percent were placed on a ventilator, 18 percent received CPR, 18 percent were tube fed, 17 percent had surgery, 15 percent had a right heart catheterization, 14 percent received blood transfusions and 6 percent had hemodialysis. The patients who died received more of these life-extending treatments—with the exception of blood transfusions and tube feeding—than the surviving patients.

In addition, the analysis showed that intensive care—the life-extending treatment most commonly provided to these very old patients—“did not contribute significantly to survival time.” Other research has shown that life-prolonging treatments can actually have the reverse effect among the elderly. In SUPPORT (Study to Understand Prognoses and Preferences of Outcomes and Risks of Treatment), another RWJF-funded study that examined decision-making and care outcomes among the elderly, right heart catheterization and tube feeding in critically ill very old patients resulted in higher death rates.

The authors caution that “neither this study nor other current data define the optimal use of invasive treatment modalities in the very old.” However, they conclude that the gap between what elderly patients want—which is comfort care for the most part—and what they receive—which is often life-extending care—warrants attention. They suggest that “further research is needed to understand the risks and benefits of life-sustaining interventions in very old patients, to measure the effect on patient outcomes, and to understand the interaction of preferences and decisions.”

Somogyi-Zalud E, Zhong Z, Hamel MB and Lynn J. “The Use of Life-Sustaining Treatments in Hospitalized Persons Aged 80 and Older.” *Journal of the American Geriatric Society*, 50(5): 930–934, 2002.

## Disadvantaged Teens See Future Improved By Education, Jobs

Being a teenager in the inner city often means growing up against a backdrop of drugs, crime, violence, unemployment, poverty, teen pregnancy and homelessness. Many adults believe that the best way to help these children succeed is to reduce the risks presented to the youths by their environment and their own behavior. A large group of adolescents in Philadelphia, however, believes otherwise.

A survey of more than 1,700 eighth-, ninth- and 12th-graders in poor neighborhoods in Philadelphia asked students to identify and rank the solutions they believe would most help them to achieve a positive future. While a group of city officials believed that focusing on teen pregnancy and violence were paramount, the highest-rated items among all students were solutions that promoted education or better job opportunities.

The survey was conducted as part of the planning process for a city urban health initiative to give adolescents a voice in deciding how program funds intended to benefit them would be targeted.

The students’ top-rated solutions varied somewhat between grade levels. The 417 eighth-grade respondents reported that their best hope for a successful future lies in more jobs, better education, more scholarships and safer schools. Top priorities among the 1,022 responding ninth-graders were better college opportunities, more jobs, more job training programs, dropout-prevention efforts, and better books and computers in schools. The top four solutions listed by 322 high school seniors were help getting into college, more jobs for teenagers, stronger punishments for serious criminals and more job training programs. “The message which these inner-city youth seem to be sending is ‘If you want us to be successful, give us the opportunities that come with a good education, good jobs, and meaningful connection with

adults,’” according to the study.

The need for more police involvement was high on the self-generated priority list for all respondents. Low on every grade’s list were items such as less graffiti, fewer drug dealers and better housing. Respondents across grade levels also placed a premium on participating in recreation programs and activities that involved adult interaction. Freshmen specified the need for religious programs and seniors called for more adult role models—both in the community and through more minority leaders in government.

Whether students were involved in adult-run programs influenced their ranking of priorities. For instance, ninth-graders in adult-run programs rated religious involvement and fewer drug dealers higher than ninth-graders not in such programs. Eighth-graders in adult-run programs believed that fixing up the schools was more important than did noninvolved eighth-graders. And seniors in adult-run programs signaled that more police, more minority leaders and

## RESEARCH NOTE

### Minorities Less Likely to Receive Experimental Care for AIDS

While people with AIDS are more likely to receive experimental treatments than those with other serious diseases, racial disparities exist in the rate of treatment enrollment.

In this study, researchers interviewed a sample of 2,864 of the 231,400 adults being treated for HIV infection in 1996, and found that blacks were 50 percent as likely, and Hispanics 58 percent as likely, to be participating in experimental treatments as whites. Blacks, those who never completed high school, people privately insured through health maintenance organizations, and patients receiving primary care eight miles or more from a major clinical-trial center were each 50 percent less likely to be participating in an HIV medication trial than other HIV-infected patients. Women were

not underrepresented in research trials.

Overall, the study found that 14 percent of adults receiving HIV care had participated in a formal medication trial or study, 24 percent had received experimental medications, and 8 percent had tried but failed to receive experimental treatments.

“There are important reasons to be concerned about disparities among groups of patients with HIV in terms of enrollment in medication trials and expanded-access programs,” according to the study. “Society and future patients benefit when participation in research is broad enough that results may be generalized to the patients receiving care who will eventually use the drugs.”

Between 1996 and 1998, the period that the sample group was observed, blacks were more likely than other groups to

withdraw from experimental trials they had started. Some 53 percent of whites who began a trial in 1996 were still participating two years later, compared with 25 percent of blacks. Participation rates after two years were also higher for college graduates (65 percent) than high school graduates (39 percent) and for those with private fee-for-service insurance (62 percent) than the uninsured (37 percent).

Gifford A, Cunningham W, Heslin K, Anderson R, Nakazano T, Lieu D, Shapiro M and Bozzette S. “Participation in Research and Access to Experimental Treatments by HIV-Infected Patients.” *New England Journal of Medicine*, 346(18): 1373–1382, 2002.

Allen Gifford, M.D., is a current Robert Wood Johnson Generalist Physician Faculty Scholar.

better school security were more important.

The survey also found that ninth-graders who participated in adult-run programs were more likely to believe that their future was positive, although study authors caution that their data cannot determine whether the programs inspire hope or whether hopeful teens seek the programs.

Researchers further qualify their findings, noting that the use of the word “positive” in the survey question and the fact that respondents were not dropouts may have influenced why respondents believed that positive actions (such as improved education and training) would do more to improve their future than the elimination of risks.

They also note that while it is uplifting to receive such a clear positive message prioritizing education, jobs and connectedness from inner-city youth, “it is unduly idealistic to only hear the optimistic message they offer. The study participants are clearly affected by the devastation they say surrounds them. Much as the resiliency approach considers not just protective factors but also the amelioration of risk factors, the adolescents also seem to recognize this balance.”

Ginsburg K, Alexander P, Hunt J, Sullivan M, Zhao H and Cnaan A. “Enhancing Their Likelihood for a Positive Future: The Perspective of Inner-City Youth.” *Pediatrics*, 109(6): 1136–1143, 2002.

## “Virtual” Counseling Gets Couch Potatoes To Exercise, at Least For a While

While national health experts recommend that adults spend at least 30 minutes a day doing moderate-intensity exercise, 75 percent of adults fall short of this goal. Can a computerized telephone counseling system inspire us to get off the couch? Yes, at least for the short term, according to a study involving nearly 300 members of a large group practice in Boston.

Researchers tested the effects of a totally automated physical activity counseling system on self-reported levels of exercise among middle-aged sedentary people. “We expected that [the automated system] would overcome problems with scheduling and attending to face-to-face meetings. However, unlike human counselors, [the system] would be accessible at any time and less likely to be perceived as judgmental,” the study states.

During the first half of the six-month study, 150 members enrolled in Harvard Vanguard Medical Associates were told to report once a week via telephone for a 10-minute check-in with a computer that would ask such questions as what barriers may be keeping them from exercising, and how often and how long they participated in moderate-intensity exercise. They were asked to report every other week during the remaining three months. The results for this group were compared with results for another 148-member group chosen to interact with a similar automated system about eating habits.

Results were measured in three ways: motivational readiness to exercise, increased levels of moderate-intensity exercise, and recommended levels of moderate exercise as called for by the Centers for Disease Control and Prevention and the American College of Sports Medicine.

At three months, a higher proportion of the exercise call-in group met recommended levels for moderate exercise than the eating habits group (26 percent vs. 20 percent). However, there were no differences between the groups in motivational readiness and increased levels of moderate exercise. Also, the positive effects were not sustained at six months.

Researchers noted a high dropout rate for the exercise call-in group after the first three months. Some 58 percent of the group used the system at least once in the first three months; 25 percent used it at least once in the following three months. Interestingly, one-third of the subjects did not call the system at all. Overall, those who participated in the eating habits counseling program made a mean of 9.3 calls during the

study, compared with 5.6 calls among the exercise group.

Those who completed the entire study showed stronger results in the first three months on all measures than those who dropped out. But again, the effects were not maintained at six months.

Researchers noted that a major weakness of the system was that subjects had to initiate the calls. They believe participation may have dropped off because people grew weary of it, had trouble using the system or thought there was nothing more to gain from making additional calls.

Among the suggestions participants offered on how to improve the system were using a human counselor, developing an easier-to-use system and reminding people to call in.

Pinto B, Friedman R, Marcus B, Kelley H, Tennstedt S and Gillman M. “Effects of a Computer-Based, Telephone-Counseling System on Physical Activity.” *American Journal of Preventive Medicine*, 23(2): 113–120, 2002.

Matthew Gillman, M.D., was a Robert Wood Johnson Generalist Physician Faculty Scholar at the time of this research.

## RESEARCH NOTE

### Most Areas of Country Oversupplied with Neonatologists

When it comes to the science of saving fragile newborns, much has changed in the past 30 years. Once scarce and primarily based in university medical centers, neonatologists and neonatal intensive care units are now widely available in hospitals across the country. This study suggests, however, that neonatal care resources today are maldistributed—poorly serving a small number of regions while over-serving most others.

Researchers from Dartmouth Medical School, the Veterans Affairs Outcomes Group and the National Center for Health Statistics set out to test whether there was an association between rates of neonatal deaths (up to 27 days after birth) and supply of neonatologists, as well as neonatology

units, in 246 regions around the country. In earlier studies they had found that the supply of neonatal intensive care beds and neonatologists per newborn varied by a factor of more than four across regions of the United States. This study found that need—as measured by numbers of high-risk newborns per region—did not account for this variation.

In measuring neonatologist supply, regions were ranked into five categories from very low to very high (2.7 to 11.6 physicians per 10,000 births). The study found that the mortality rate was greater in very low supply areas than in low supply areas, but that deaths did not decrease appreciably in areas that employed more than 4.3 providers per 10,000 births.

When analyzed by birthweight, very low provider supply was linked with a higher death rate

for only the smallest babies (between 500 and 999 grams). For babies weighing more than 1,000 grams, death rates did not decrease appreciably as physician supply increased.

“These findings suggest that, in the case of infants with extremely low birth weights, some neonatal intensive care units may have an inadequate supply of neonatologists, whereas most other regions have an adequate supply or a surplus,” according to the researchers.

Goodman D, Fisher E, Little G, Stukel T, Chang C and Shoendorf K. “The Relation Between the Availability of Neonatal Intensive Care and Neonatal Mortality.” *The New England Journal of Medicine*, 346(20): 1538–1544, 2002.



# Improving Diabetes Care Through Self-Management

Diabetes affects nearly 17 million Americans, is a leading cause of death and results in some \$100 billion a year in health care expenditures in the United States. To help people with this chronic condition live healthier lives, The Robert Wood Johnson Foundation has created a two-year, \$6.3-million initiative to improve the most challenging, yet critical component of good diabetes care—patient self-management.

Proper self-management, which includes eating a healthy diet, exercising, eliminating smoking, taking recommended medications, and ongoing monitoring—among other measures—can effectively decrease the major complications of diabetes. The challenge is that the onus for these lifestyle changes rests mostly on patients and their families. Successful management of diabetes, therefore, requires education and continued support, which the health care system is not well equipped to provide. RWJF's *Diabetes Initiative* aims to address this issue by helping health care providers develop and test comprehensive self-management programs and by helping minority communities, which are disproportionately affected by the disease, take steps to support people with diabetes and those at risk of getting it.

*Advancing Diabetes Self-Management* is one of the two national programs that make up the initiative. This program will bring together up to six primary care sites over 18 months to develop and pilot comprehensive self-management programs to help patients manage their condition. The primary care-based program will identify elements common to ideal self-management programs and allow each site to tailor its approach to its patient population.

"Self-management looks a lot different for a 70-year-old who has had type 2 diabetes for 20 years and a 45-year-old who has been newly diagnosed," says Edwin B. Fisher, Ph.D., director of the *Diabetes Initiative* National Program Office

and director of the Division of Health Behavior Research at Washington University in St. Louis. "But each of these self-management programs will have common elements, such as helping patients set and prioritize their goals and providing ongoing support and encouragement."

The primary care sites will reflect diversity in patients' race, ethnicity and age, and will include rural and urban locations. "At the end of this program," Fisher says, "we hope to have a number of good self-management programs that have been demonstrated to be effective in real-world settings."

The *Building Community Supports for Diabetes Care* program, the other half of the *Diabetes Initiative*, will work with up to eight community partnerships over a 12-month period to plan and pilot relevant community activities. These partnerships will work together to

See *Initiative*—page 12

## Sound Partners Public Radio Model Expands to Public Television

When the credits roll at the end of a public television program on a health issue, you're likely to see that funding was provided by a number of philanthropies, including sometimes The Robert Wood Johnson Foundation. But after the television set is turned off, there is so much more that even a single hour of programming can accomplish—it's called outreach, getting a local community involved in a health issue, leveraging the media message or even repackaging the film into video segments that can inform, educate and act as a catalyst to meaningful change.

*Sound Partners for Community Health*, an RWJF national program, has for the last five years funded local public radio stations that want to produce special health care programming and work with local partners for outreach in their communities. Now the model that worked so well in radio is being tested in television.

"Typically, the model for public outreach in television is a top-down model," says Beth Mastin, co-director of the program. "Local stations get packets of material that they can use in their community. But so often the community has health issues that might never be addressed in a meaningful way by the national programming.

"As we've done with radio, we've given public television a rare opportunity to become a platform for rich, community-relevant content and dialogue that meets local needs," says Mastin.

Television station KQED in San Francisco is a good example of how the outreach component works. This fall the station aired the one-hour documentary "Hope on the Street," about the stigma of mental illness and its impact on the city's homeless. With a *Sound Partners* grant, the one-hour show will be leveraged into a major public and professional outreach program. Among the components: repackaging the program to reach journalists, practitioners and consumers, and a Web site.

"Television production is so expensive that the kind of seed money that *Sound Partners* provides encourages other funding and yields huge returns," Mastin says.

KQED is one of seven television stations, 29 public radio stations, and their community and media partners that are grantees in the \$1.7-million third round of funding for *Sound Partners*. In all, over the last five years, 68 public radio stations have received funding. A primary mission is to give voice to people who are underrepresented in typical media coverage.

"Increasingly the voices in the U.S. media are determined by a handful of behemoths. *Sound Partners* is essential, because it's rarer and rarer to have locally controlled media and stories," says Mastin.

Radio station grantees have produced broadcasts and audio diaries of families affected by cuts in welfare payments or lack of health insurance; they have also produced weekly programs featuring local health care providers, therapists and teachers discussing issues affecting children and families. Spanish-language radio station KDNA in Granger, Wash., broadcast stories about the availability of food stamps for legal immigrant farmworkers, set up an office at the station one day a week for farm-workers to apply, and, with partners, promoted a project where health vans brought basic preventive care to migrant camps and other isolated areas.

Since the program's inception, *Sound Partners* grantees have received 62 national, local and regional awards for excellence in community service broadcasting.

More information on the project, along with audioclips, can be found at [www.soundpartners.org](http://www.soundpartners.org).

# Informatics Institute to Enhance Public Health Cooperation Through Information Systems

Imagine nearly 3,000 separate, similar entities spread across the United States. Some communicate by mail using postcards, some rely mainly on fax machines, and still others use computer systems. The computer users rely on a wide variety of software systems, many of which cannot exchange information with the other systems.

Such is the current state of the nation's state and local public health agencies. There is no uniform information infrastructure serving the nation's 55 state and territorial health departments or its 2,883 local health departments.

This communication problem has developed over many decades as states and localities established their own individual systems. Public health officials have known for years that the issue needs to be addressed. But with health departments struggling for adequate funding even for basic functions, and with no existing, impartial, nongovernmental body to take the lead, it seemed as if little could be done to coordinate public health information systems across the nation.

Then came September 11th and the anthrax attacks.

The incidents thrust public health agencies into the spotlight. It became clear that the ability to detect and rapidly communicate disease symptoms and other information from clinical and laboratory settings to public health officials would be essential to protecting the nation from bioterrorist attacks.

Congress approved \$1.1 billion to bolster the nation's efforts against bioterrorism. That is where The Robert Wood Johnson Foundation saw an opportunity to make a critical difference. A significant portion of that money is expected to go toward improving the information systems of state and local public health agencies.

In November 2001, the Foundation funded a study to examine the need for and feasibility of establishing a neutral entity that would help public health agencies design, test, share and support information system tools. Public health leaders, state information chiefs and private software companies expressed strong support.

In July 2002, the Foundation approved a grant to create the Public Health Informatics Institute. The \$2.8-million

grant will fund the initiative's first phase, from September 2002 through February 2004.

"Public health preparedness and capability to respond to natural disease and health problems and, nowadays, man-made interventions like bioterrorism are going to require more sophisticated information systems than existed in the past," says David Ross, Sc.D., director of the Public Health Informatics Institute.

The institute will:

- Define requirements for next-generation public health laboratory information management systems.
- Establish a national clearing-house to assess information technology vendors and products, using objective criteria.
- Develop a process for evaluating and sharing software among states.
- Host skill-building workshops on information technology management for public health executives.

- Create a business plan for the institute to become self-sustaining.

The infusion of federal funding is an important opportunity that must be handled carefully, says Ross. The decisions that state and local public health officials make about information technology systems will affect how their departments operate and how they work with other departments for years to come.

"One of our main goals is to help officials determine how to spend the federal money in a way that enables the public health agencies to work in the most coordinated, efficient and rapid manner possible," says Ross.

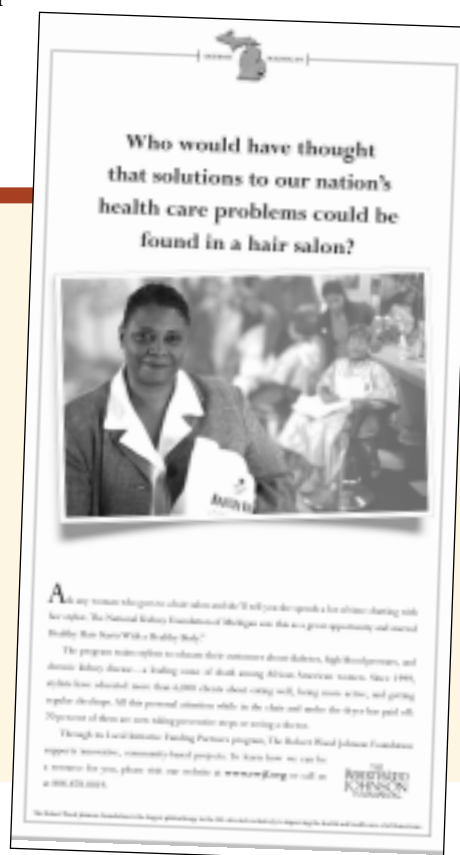
While the bioterrorism threat created a sense of urgency, Ross and RWJF officials emphasize that the institute's efforts also will help public health agencies improve their ability to coordinate other day-to-day responsibilities, from updating immunization records to testing for potential environmental health hazards to disease surveillance.

"Understandably, bioterrorism is getting a lot of attention right now," says Stephen Downs, an RWJF senior program officer working with others at the Foundation on the Informatics Institute program. "But for a long time, there's been a growing sense that there needs to be better communication and more collaboration among public health departments. The Foundation sees funding the institute as a way to help foster that collaboration and, consequently, to help improve public health."

—LAURIE JONES

**An ad campaign in *Roll Call***, a twice-weekly newspaper circulated on Capitol Hill and widely read by members of Congress and their staffs, is telling the stories of the important work that RWJF grantees are doing in their states and districts. Each ad identifies a specific locale and individual. The narratives describe the work of RWJF grantees who are "finding solutions to the most pressing health and health care issues confronting Americans today."

The ad shown at right features Healthy Hair, Healthy Bodies, a project funded by the *Local Initiative Funding Partners Program* that takes an innovative approach to helping women in Michigan improve their health. Other ads feature an *Injury Free Coalition for Kids*® program in California; a program fighting child neglect and abuse in New Jersey; and a public health partnership in Oklahoma that opened a community health clinic. By February 2003, the ads will have featured more than 20 RWJF grantees.



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

- For "How Does the Community Environment Influence Health Status and Access: The California Health Interview Survey," \$1.1 million to the University of California, Los Angeles, Center for Health Policy Research.
- *Pipeline, Profession and Practice: Community-Based Dental Education.* Awards to 10 sites, totaling \$14.2 million.
- For evaluation of *Pipeline, Profession and Practice: Community-Based Dental Education*, \$1.85 million to the University of California, Los Angeles, School of Public Health.
- For improving information on access to coverage for vulnerable consumers, a renewal award of \$250,000 to Georgetown University Medical Center, Washington.
- *Covering Kids and Families.* Awards to eight sites, totaling \$5.7 million.
- *Southern Rural Access Program.* One renewal award of \$808,450 to the State of Georgia Department of Community Health for the Rural Enrichment and Access Program for Georgia.
- *State Solutions: An Initiative to Improve Enrollment in Medicare Savings Programs.* Awards to five sites, totaling \$1.8 million.

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

- For workshops for Medicaid/SCHIP managed care organizations on managing pediatric asthma, \$483,003 to the Center for Health Care Strategies Supporting Organization, Lawrenceville, N.J.
- For developing and testing a Web-based approach to improving quality health care, \$550,000 to the Institute for Healthcare Improvement, Boston.
- For an adolescent component of the National Comorbidity Survey, \$366,972 to the University of Michigan Institute for Social Research, Ann Arbor.
- For improving quality of life in assisted living, \$287,839 to the Nursing Home Community Coalition of New York State, New York.
- For measuring chronically ill consumers' active participation in their health care, \$257,245 to the University of Oregon School of Architecture and Allied Arts, Eugene.
- For a qualitative evaluation of the *Allies Against Asthma* program, \$304,907 to the University of Michigan School of Public Health, Ann Arbor.
- *Community Partnerships for Older Adults.* Awards to 13 sites, totaling \$1.9 million.
- *Faith in Action II.* Awards to 49 sites, totaling \$1.7 million.

- *Improving Chronic Illness Care.* For testing a managed care approach using group visits in disadvantaged patients with type 2 diabetes, \$466,908 to the Medical University of South Carolina, Charleston.
- *Promoting Excellence in End-of-Life Care.* Two renewal awards for the communications component, totaling \$582,720.
- *Rewarding Results: Aligning Incentives with High-Quality Health Care.* Awards to four sites, totaling \$3.7 million.
- *Targeted End-of-Life Projects Initiative.* Award of five program grants, totaling \$1.2 million.

### Projects to Promote Healthy Communities and Lifestyles

- For evaluating the links among physical activity, health, transportation and land use, \$720,000 to the National Academy of Sciences, Washington.
- For a study on the demographic changes among the U.S. Hispanic population and their influences on health, \$350,000 to the National Academy of Sciences.
- For developing a model for evaluating and ranking the public health impact of food-borne disease, \$346,204 to Resources for the Future, Washington.
- For planning and designing the New Jersey Walks and Bikes program, \$249,998 to Rutgers University Foundation, New Brunswick, N.J.
- For adding a "Strong for Life" physical activity component to *Faith in Action* projects, \$603,407 to Wake Forest University Health Sciences, Winston-Salem, N.C.
- For developing indicators of family well-being, \$752,446 to Family Support America, Chicago.
- For community projects for *Children's Futures*, \$3 million to Children's Futures Support Fund, Trenton, N.J.
- *Leadership for Active Living.* One award of \$377,030 to San Diego State University Foundation.
- *The Robert Wood Johnson Health & Society Scholars Program.* Awards for six sites, totaling \$27.7 million.
- *State Health Leadership Initiative.* One renewal award of \$918,991 to the National Governors' Association Center for Best Practices, Washington.

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

- For communications campaigns to address substance abuse prevention and treatment, \$15 million to the Partnership for a Drug-Free America, New York.
- For evaluation and dissemination of results from a community-based adolescent tobacco use prevention program, \$392,268 to Health Research, Buffalo, N.Y.
- For strengthening leadership in substance abuse treatment and prevention, \$392,771 to the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, Tryon, N.C.

- *A Matter of Degree: Reducing High-Risk Drinking Among College Students.* Awards to two sites, totaling \$934,729.
- *Helping Young Smokers Quit: Improving Treatment of Youth Tobacco Use and Dependence.* One renewal award of \$729,988 to the University of Illinois at Chicago School of Public Health.
- *Innovators Combating Substance Abuse.* Awards to three sites, totaling \$899,997.
- *SmokeLess States®: National Tobacco Policy Initiative.* One renewal award of \$561,122 to MATCH Coalition, West Hartford, Conn.
- *Substance Abuse Policy Research Program.* Awards to seven sites, totaling \$641,325.

### Other Programs and Those That Cut Across Foundation Goals

- For planning and testing a co-management learning network—Phase I, \$1.5 million to the Health Research and Educational Trust, Chicago.
- For health and health care reporting by National Public Radio, \$3.2 million to National Public Radio, Washington.
- *State Forums Partnership Program.* Awards to two sites, totaling \$249,930.
- *Changes in Health Care Financing and Organization.* Awards to two sites, totaling \$438,926.
- *Local Initiative Funding Partners Program.* Awards to 19 sites, totaling \$7.4 million.
- *New Jersey Health Initiatives.* Award of three grants, totaling \$231,565.
- *The Robert Wood Johnson Community Health Leadership Program.* A renewal award of \$6.5 million for the awards to Third Sector New England, Boston.
- *The Robert Wood Johnson Health Policy Fellowships Program.* Awards for seven fellows, totaling \$1 million.
- *Scholars in Health Policy Research Program.* Renewal awards to two sites, totaling \$10.6 million.
- *Investigator Awards in Health Policy Research Program.* Awards to two sites, totaling \$549,790.
- *Sound Partners for Community Health.* One award of \$1.7 million to the Benton Foundation, Washington, for support for sites under the program.
- For improving mental health services in primary care, \$562,996 to America's Health Together, Washington.
- For expanding education programs to help minorities and the disadvantaged pursue careers in health professions, a renewal award of \$200,953 to the Foundation of the University of Medicine and Dentistry of New Jersey, Newark.



# PEOPLE

**JAMIE BUSSEL, M.P.H.**, joined the Foundation in September as a program associate assigned to the Health and Behavior

Team. Formerly, Bussel held the position of health program analyst at the University of Medicine & Dentistry of New Jersey School of Public Health, where she was responsible for evaluating elements of the state's tobacco control work. She received her M.P.H. from UMDNJ.

**TEDI NESSAS** joined the Foundation in July in the position of



production administrator for the Grants Results Reporting Unit. Previously, Nessas was a consultant to the Foundation.

**RADHA REDDY, M.S.**, joined RWJF in September as a senior programmer analyst in Information Technology. Reddy had been a senior software developer at mFormation Technologies in Edison. She earned her master's degree in computer and information science from the New Jersey Institute of Technology.



## BOARD OF TRUSTEES

**NANCY-ANN DEPARLE, J.D.**, joined the RWJF Board of Trustees in July 2002. Her broad health care experience includes serving as administrator (1997 to 2000) of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) of the U.S. Department of Health and Human Services in Washington, where she oversaw Medicare, Medicaid and the State Children's Health Insurance Program. DeParle is an independent health policy consultant. She currently serves as an adjunct professor of health care systems at the Wharton School of the University of Pennsylvania, a senior adviser for J.P. Morgan Partners and a member of the Medicare Payment Advisory

Commission. From 1993 to 1997 she was associate director for health and personnel of the White House Office of Management and Budget. DeParle received her law degree from Harvard Law School and was a Rhodes Scholar in politics, philosophy and economics.

**RALPH S. LARSEN**, former chairman of the board and CEO of Johnson & Johnson, became a member of the RWJF Board in September 2002. Larsen, who joined J&J in 1962, advanced through a series of increasingly responsible positions in manufacturing and distribution and in 1986 was named a company group chairman. Later that year he became vice chairman of the executive committee and chairman of the consumer sector. Larsen was elected to the J&J board of directors in 1987, was named chairman of the board and CEO in 1989, and stepped down as chairman and CEO in April 2002.

## New Grant Results Reports Posted

Since July 2002, 48 new Grant Results Reports and two National Program Reports have been posted at the RWJF Grant Results Reports Web page. 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 newly posted reports:

- **Oral Histories of Medical Generalism in America.** The People-to-People Health Foundation published "Big Doctoring in America: Profiles in Primary Care," the oral histories of 15 primary care practitioners, including providers other than physicians. The book, intended to stimulate clinicians, policy-makers, educators and medical leaders to consider how to preserve and strengthen generalist health

care delivery, is available for \$29.95 from the University of California Press at [www.ucpress.edu/books/pages/9081.html](http://www.ucpress.edu/books/pages/9081.html). See the Grant Results Brief at [www.rwjf.org/reports/grr/027985.htm](http://www.rwjf.org/reports/grr/027985.htm).

- **Pediatric Asthma: Promoting Best Practice Initiative.** To promote best practices in the management of pediatric asthma, which affects nearly 5 million children nationwide, the American Academy of Allergy, Asthma & Immunology published diagnosis and management guidelines for primary care providers. The guidelines can be downloaded from the academy's Web site at [www.aaaai.org/members/resources/initiatives/pediatricasthma.stm](http://www.aaaai.org/members/resources/initiatives/pediatricasthma.stm). See the Grant Results Brief at

[www.rwjf.org/reports/grr/033546.htm](http://www.rwjf.org/reports/grr/033546.htm).

- **Medicare Primer for the Public, Media and Policy-Makers.** The Concord Coalition, a nonpartisan nationwide organization advocating federal spending constraints while ensuring that Social Security, Medicare and Medicaid remain secure, published "A Primer on Medicare." The primer explains in layperson's terms how Medicare works and analyzes the problems that lie ahead, potential reform options and requirements for controlling Medicare costs. It is available free of charge at [www.concordcoalition.org/medicare/MedicarePrimer.pdf](http://www.concordcoalition.org/medicare/MedicarePrimer.pdf). See the Grant Results Brief at [www.rwjf.org/reports/grr/038850.htm](http://www.rwjf.org/reports/grr/038850.htm).

—TEDI NESSAS

From *Initiative*—page 9

remove the barriers to appropriate diabetes care and support that exist in their respective communities. "When you talk with clinicians who are working in low-income neighborhoods and caring for people with diabetes, they tell you that their biggest concern is what happens outside their walls," says Anne Weiss, M.P.P., RWJF senior program officer. "They can tell their patients to eat right and exercise, but if there are no grocery stores in the area and if there are no safe places to exercise, these recommendations won't be followed." These partnerships will work together to advocate for change in their communities, use communications efforts to raise awareness about symptoms of diabetes and encourage people at risk to get tested.

Grantee sites for both programs in the *Diabetes Initiative* will be announced in late 2002.

—RAY RIGOGLIOSO