ADVANCES®
The Robert Wood Johnson Foundation Quarterly Newsletter

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ISSUE 4, 2003

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

Sprawling Environments Contribute To Sprawling Waistlines

It is not often that an urban planner has an article published in a medical journal, but then, the connection between the design of our communities and our overall health has only recently become clear.

That connection came into sharp focus in September when both the *American Journal of Health Promotion* and the *American Journal of Public Health* devoted special issues to an examination of how community design affects health. The Robert Wood Johnson Foundation supported the study and the joint release of the two journals.

The *Health Promotion* article, the first ever to link community health directly with the design of that community, found that people who live in more sprawling areas generally weigh more and are more likely to have high blood pressure than those who live in more compact communities.

The article represents an unusual collaboration between urban planner Reid Ewing, Ph.D., of the National Center for Smart Growth Research and Education at the University of Maryland in College Park, and several public health researchers. It is an association likely to occur more often as the two fields—public health and urban planning and design—intersect around the issue of health, particularly as it relates to obesity.

"We talk all the time about the things people need to do to have a healthier lifestyle," notes RWJF President and CEO Risa Lavizzo-Mourey, M.D., M.B.A., "but when everything in an environment works against a person, it is that much harder to do. That is why the Foundation sees sprawl as a serious issue."

Sprawling communities are plagued with a lack of sidewalks, isolated housing developments far removed from shopping and business centers, busy roads that prevent children from walking or riding their bicycles to school, and an absence of anywhere to walk to, limiting residents' opportunities for daily physical activity. These are major reasons why just 13 percent of children in the United States walk or bicycle to school compared to 66 percent in 1970, and one reason that barely one-third of Americans get the 30 minutes of moderate activity at least five days a week needed to maintain health.

For the *Health Promotion* article, researchers used U.S. Centers for Disease Control and Prevention data to examine health characteristics of more than 200,000 people living in 448 U.S. counties in major metropolitan areas. They assessed the degree of sprawl in each county, using U.S. Census and other federal data, and found that people living in the most sprawling counties were likely to weigh six pounds more than people in the most compact county (New York County), and were more likely to be obese.

See **Sprawling Environments**—page 2

Photo by Dan Burden/pedbikeimages.org

Bikers and walkers in Long Beach, Calif., enjoy safe, distinct paths, away from automobile traffic.

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From **Sprawling Environments**—page 1

"Six pounds might not sound like a lot," says J. Michael McGinnis, M.D., an RWJF senior vice president and director of the Foundation's Health Group, "but it is an important part of the obesity puzzle." In the past two decades, the prevalence of obesity in the country has doubled, with 64.5 percent of Americans, including 14 percent of adolescents, either overweight or obese. These frightening and fast-growing statistics resulted in the addition of childhood obesity as a primary objective for RWJF, a natural outgrowth of the years of programming the Foundation has conducted in community health and chronic illness.

While many factors go into the emerging health crisis of obesity, the *Health Promotion* study confirms that the kinds of communities that have been built in America during the past 20 years—in which opportunities for daily physical activity have been systematically engineered out—are partly to blame. According to Katherine Kraft, Ph.D., an RWJF senior program officer, that evidence adds greatly to the Foundation's efforts in childhood obesity.

"If you have a community where children and the elderly can walk, then almost everyone can walk," says Kraft. "So finding out how our development patterns impact people's ability to be mobile is important."

Kraft says children are a key piece of the puzzle. Designing communities that get the children who live there to become more active—through walking to school, riding their bikes, walking to the store for a quart of milk or a loaf of bread—is likely to result in more active families. "Children are an indicator, an avenue into the entire family," she says.

It is important that people understand they don't have to be captive in their cars, adds McGinnis. "If we enable people to get from point A to point B without putting the key in the ignition, we are going to greatly improve the quality of life," he says.

Accomplishing that requires a different way of designing communities, which the Foundation supports through several of its national programs, most notably, *Active Living by Design*, a $16.5-million initiative that seeks to bring transportation and urban planners together with public health officials to design more livable communities.

"We need to focus our communities around places that are convenient for biking and walking, and provide people with destinations they can reach on foot," says Barbara McCann, of McCann Consulting, who co-authored with Ewing a report exploring the implications of the *Health Promotion* study, "Measuring the Health Effects of Sprawl: A National Analysis of Physical Activity, Obesity and Chronic Disease."

"One big barrier is that everything is too far away from everything else. In fact, that might be the simplest definition of sprawl: that everything is too far away from everything else," McCann says.

Such sprawl, which prevents people from walking to the store or the post office, biking to the park or running errands on foot, prevents the kind of daily physical activity that the *Health Promotion* study found is even more essential than formal exercise to maintaining a healthy weight.

"We found that even people who met the required exercise levels still had a higher body mass index than people in more urban, compact areas," says McCann. "So we are quite confident that what is going on here is that people in those areas of sprawl are not walking as much because it is more difficult to walk, and that is showing up in their health."

Reversing this trend, she says, will take rethinking the way we build communities and design transportation systems. "The transportation and development communities have to look up from their highway blueprints and see the wider world."

—DEBRA GORDON

For more on how community design influences health, including the reports mentioned in this article, see www.rwjf.org/special/sprawl.

Sprawl, Body Mass Index (BMI) and Expected Weight

COUNTY	COUNTY SPRAWL SCORE	EXPECTED BMI	EXPECTED WEIGHT OF AVERAGE PERSON (5'7")
New York, NY	352.07	25.23	161.1
San Francisco, CA	209.27	25.72	164.2
Suffolk, MA	179.37	25.83	164.9
Cook, IL	150.15	25.93	165.5
Delaware, PA	125.34	26.01	166.1
McHenry, IL	100.08	26.10	166.6
Clay, FL	87.51	26.14	166.9
El Dorado, CA	85.67	26.15	167.0
Hanover, VA	74.97	26.19	167.2
Isanti, MN	70.12	26.20	167.3
Walton, GA	69.61	26.20	167.3
Geauga, OH	63.12	26.23	167.5

Source: "Relationship Between Urban Sprawl and Physical Activity, Obesity and Morbidity," *American Journal of Health Promotion*, September/October, 2003.

Ambassador, Innovator and Champion of Grantees

In his many years at The Robert Wood Johnson Foundation, Terrance Keenan has quietly, modestly and indefatigably transformed philanthropy and health care.

"Terry Keenan is a legend," says Steven Schroeder, M.D., former president of RWJF. "He has distinguished himself over the four decades he has worked in philanthropy by his selflessness, his values, his tenacity."

In December, Keenan is leaving RWJF after 31 years. He has been at the Foundation from the beginning, first as vice president for special programs and then as special program consultant. Before arriving at RWJF, Keenan was associated with the Ford Foundation and the Commonwealth Fund. During his tenure, he helped expand RWJF from a fledgling organization to an influential leader in improving the health and health care of Americans.

At the time Keenan joined RWJF, "philanthropy was held suspect by many people who believed wealthy individuals were establishing foundations to use as tax write-offs," recalls Edward Robbins, former director of the Foundation's Office of Proposal Management. "Foundations were not proactive, with a mission and a program. That has changed."

Keenan helped accomplish that. "He was an ambassador at large for the world of philanthropy," says Robbins. "Anyone who ever came into contact with Terry felt differently about philanthropy afterwards. He cares about people, particularly those who are downtrodden, and that really comes across."

Keenan also encouraged other philanthropies working in health care to talk about common issues and work together. The result was Grantmakers in Health, a nonprofit organization that fosters communication and collaboration among foundations. Each year, the organization presents the Terrance Keenan Leadership Award in Health Philanthropy to an outstanding individual from a foundation or corporate giving program.

Within RWJF, Keenan's influence can be judged by the number of once-controversial ideas that he championed and eventually brought into the mainstream. As an example, Keenan's longtime friend and colleague Frank Karel, RWJF's former vice president for communications, points to the *Local Initiative Funding Partners Program*.

When RWJF first started making grants nationwide, Karel says, "We would parachute into a community, give some money to start something and then when our three or four years of support were up, the people we had funded would start knocking on doors looking for more money. Some of the small local foundations were getting upset. Terry was very sensitive to that, and picked up on it when nobody else had. He started a program calling for proposals from local and community foundations: 'If you've got something in your community that falls within our guidelines, we will match whatever local money can be brought together, up to $500,000.'

"It was an absolute stroke of genius," Karel says. "No big foundation had ever done anything like this. But who knows better what's needed and where it's needed than the local foundations?"

"*Local Initiatives Funding Partners Program* was an outstanding contribution," agrees Schroeder, now Distinguished Professor of Health and Health Care in the Department of Medicine at the University of California–San Francisco. "Terry nurtured it at a time when it wasn't that popular. Now it's part of RWJF's DNA."

Similarly, Keenan saw nurses as skilled medical professionals when most of the medical community viewed them as support staff. "Terry has been a huge friend to nursing, because he believed in bettering the care for people," says Rheba de Tornyay, Ed.D., dean and professor emeritus at the University of Washington School of Nursing in Seattle and RWJF trustee emeritus. "He single-handedly encouraged the Foundation to become interested in nursing's contributions to primary care. It made a statement to the rest of the world that this was important because The Robert Wood Johnson Foundation was behind it."

"He clicked right away in understanding what nurses are all about," adds Claire Fagin, Ph.D., R.N., program director of the John A. Hartford Foundation program, Building Academic Geriatric Nursing. "He was a wonderful consultant. He was somebody who could listen to your ideas, respond to them and then take you to the next level, if that was possible to do."

Often there is a "love-hate feeling" between grantees and the foundations that fund them, according to Schroeder. "The grantees are grateful for the money, but there's a lot of muttering about arrogance, inconsiderateness, lack of sensitivity—but never about Terry. Terry is the soul of diplomacy."

Keenan was especially appreciated by novice grant applicants, Robbins says. "Unfortunately, some really good ideas fall through the cracks because the proposals are not polished or sophisticated enough. Terry would work the hardest with those people. If they had a germ of an idea, he was willing to do the hard work to help them develop their thoughts and their plan."

"Terry is the consummate grantmaker," adds Ruby Hearn, Ph.D., former senior vice president at RWJF. "In his very quiet way, he taught us the art of grantmaking, the importance of pursuing the things that you think are important, even if they're not popular."

His friends and colleagues stress that it was Keenan's persistence, teamed with his low-key style that made him such an effective advocate for so many initially controversial programs.

"I used to refer to Terry as a walking fullback," Karel comments. "When Terry decided he wanted to do something, he would just put his head down and start walking. People would come at him from all directions, and he'd let them bounce off him and just keep walking. Pretty soon they'd get tired, and he'd carry the ball across the goal and make the grant."

"He just never gives up if he thinks something is important," concurs Margaret E. Mahoney, former senior vice president at RWJF and now president of MEM Associates in New York City.

"Terry didn't necessarily get everybody on board for everything," Karel admits. "But he understands win–win. He's able to see how to put things together in ways that no one has ever seen or thought of. And when it turns out well, he doesn't say, 'Look how smart I am.' He always remembered that it was the grantees who were doing the work. He was only providing the funds."

But Keenan's greatest legacy may be the example he set for his peers and colleagues, Schroeder says. "A number of people have told me that he's their role model. They'd like to grow up to be like Keenan."

—Elizabeth Austin

Terrance Keenan is currently working on updating his 1992 book, The Promise at Hand, www.rwjf.org/publications/keenanbook, *which examines the role of philanthropy in the United States.*

Designing Physical Activity into The Suburbs

Q&A with **Judith Corbett, M.S.**

What has absolutely no calories yet causes obesity? Suburban sprawl, says Judith Corbett, M.S., executive director of the Sacramento, Calif.-based Local Government Commission, a nonprofit group dedicated to helping government leaders create healthy, walkable communities. The Local Government Commission is a grantee of The Robert Wood Johnson Foundation national program *Leadership for Active Living*. In this interview with *ADVANCES*, Corbett talks about the ways neighborhood schools, corner stores, sidewalks and bicycle paths can be used to move suburbanites out of their cars and onto their feet.

We tend to think of tree-lined suburbs as healthy living environments. Yet people who live in crowded cities tend to walk more—and be trimmer and healthier—than their suburban counterparts. How can you persuade people that the bucolic suburbs of their dreams aren't as healthy as they look?

CORBETT—Perhaps by having them take a look at the lifestyle they're leading. We need to help them realize how much of their time is spent fighting traffic on a crowded freeway, not walking along the beautiful tree-lined streets. I think we've got to start providing places where you can have it all—those leafy streets, safe places outside for the kids to play *and* an easy walk to the store.

Many communities pride themselves on their oversized lots and residential-only ambience. Are political leaders likely to alienate grass-loving, commerce-phobic residents in the name of better health?

CORBETT—It's going to be a very slow process to change the suburbs from what they are today to what they need to be. We're seeing some progress, like turning strip malls into mixed-use developments that include housing and retail. We're trying to relocate schools in neighborhoods instead of pushing them out to the edge of town, and we're trying to encourage higher population density within existing communities. It helps that the new, walkable, mixed-use developments sell very well, to the point that they're not really affordable anymore. It becomes a point of prestige, so that people think, "Wouldn't it be nice if I could make my own neighborhood more prestigious by adding the flower shop and the grocery store?" But it's going to take a while.

Many people would love to walk more, but their daily commute to work requires up to two hours of sitting in the car each day. How can you help those people get fitter?

CORBETT—We need to model our communities on the suburbs that were built back when people owned one car at most, and got along by walking and taking mass transit. There are a variety of techniques that we can use. They're putting in rail systems in the Los Angeles area, and many people are using it. They are also experimenting with bus rapid transit—a less expensive, smaller vehicle that can go more places, but with separate lanes and limited stops, like a rail line.

Many inner cities do have sidewalks—which no one uses because of fears of crime. That's one reason so many low-income children are obese. How can you encourage inner-city residents to venture outside?

CORBETT— There's a really strong correlation between lower crime rates and a sense of community. The idea is to establish a stronger sense of community so that fear is reduced, crime is reduced and kids can get outside again. The city of Seattle has a wonderful program, giving grants to groups of people who want to do something with their neighborhoods—building community gardens, turning an old school into a community center or putting up a sculpture, establishing a sense of community and actually reducing crime.

Even people who ride their bikes on weekends may hesitate to cycle to work Monday through Friday. What are the barriers to bicycle commuting, and how can they be resolved?

CORBETT—There are some examples here in California of companies installing showers and bike racks for their employees. You also need bike lanes to get you to and from work safely, but I don't think a bike lane is really appropriate on a major arterial street. The traffic goes past too fast. You need off-street biking lanes. Here in the city and county of Sacramento, we have a bike lane that runs along the American River and reaches from outlying communities right into downtown Sacramento. A huge number of people are using it.

In many communities, it's hard to find parks that are big enough to support soccer games, cyclists and joggers simultaneously. How can we increase recreational space in neighborhoods that are already completely built out?

CORBETT—Actually, there was a problem with that in Los Angeles, which has way too few parks. One Latino group created a jogging path through and around a cemetery. We can adjust.

How do zoning laws affect fitness?

CORBETT—In more ways than you can possibly imagine. Zoning laws say we need to separate buildings that have separate uses, so houses and stores are built far away from each other, which makes it impossible to walk or ride a bike. So we all need to drive, which means the roads get wider and wider, and become more and more impassable by pedestrians. So your only choice is to get into that car—and then you have traffic jams, so you're spending your life sitting still on the freeway.

Many sprawling suburbs feature drive-to health clubs (with big parking lots) that make physical activity an event instead of a regular part of life. How can you persuade those health club members that they'd be in better shape if they walked to and from the train every day instead of driving to the club twice a week?

CORBETT—The health club method simply isn't working. People don't have the time to go to the gym every day to get all the exercise they need to stay healthy and fit. That's the reason RWJF is working on programs to integrate exercise into daily life. I recently was diagnosed with high blood pressure. So I chose a parking space that's 12 blocks away from work, so I know I'm going to get that walk in every day. If physicians and journalists and health educators keep up that message, "You have to exercise more," I think it will start to penetrate. I've really seen progress on this issue in the past year or two as the message about the health risks of sprawl has gone from nowhere to the front pages.

—INTERVIEW BY ELIZABETH AUSTIN

For more information on *Leadership for Active Living,* see *www.leadershipforactiveliving.org.* For more information on the Local Government Commission, see *www.lgc.org.*

To see summaries of more research funded by The Robert Wood Johnson Foundation, including links to the full text, visit the new RWJF Research Center at

www.rwjf.org/research

SCHIP Making Gains as More Children Are Eligible and Enrolled

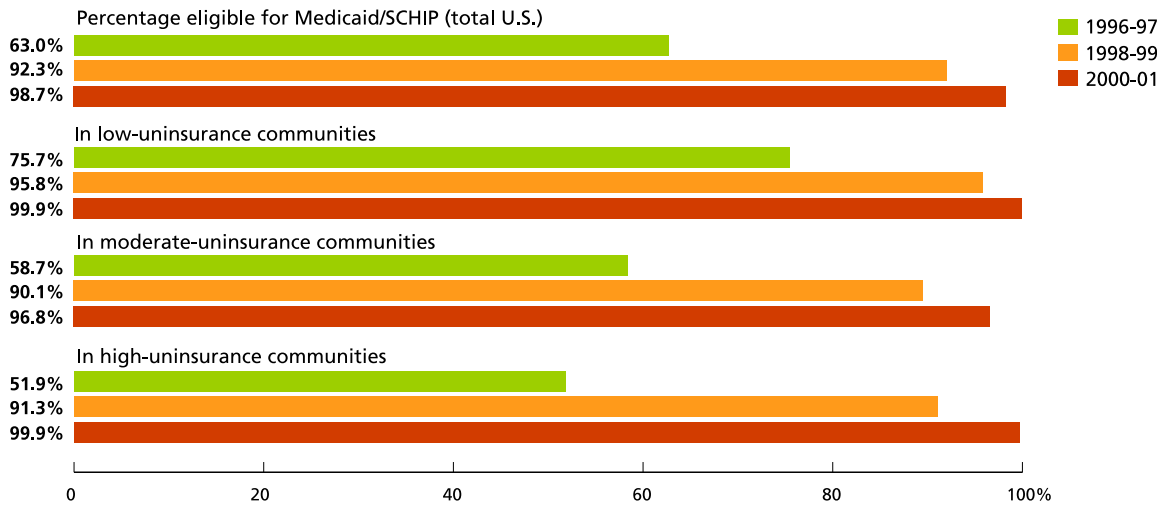
Since its inception in 1997, the State Children's Health Insurance Program (SCHIP) has enrolled more than 4 million low-income children. However, disparities in uninsurance rates among children still exist across the country—and SCHIP participation may actually lag in communities with the highest overall uninsurance rates. Because many children in these communities meet SCHIP eligibility requirements, the greatest potential for gains in coverage exists in such areas. However, eligibility alone isn't enough. Often there are significant barriers to enrollment, including a burdensome application process, immigration status concerns or a feeling of greater stigma about accepting government-sponsored health coverage.

This study used data on about 28,000 children from three rounds of The Robert Wood Johnson-funded Community Tracking Study—the 1996–97, 1998–99, and 2000–01 household surveys—to examine changes in children's health insurance coverage since SCHIP. The surveys track changes in the health care system over time in 60 communities and the effects of those changes on individuals. The 60 communities are grouped by children's uninsurance rates as of 1996–97: low-uninsurance communities have uninsurance rates of less than 8 percent; moderate communities have uninsurance rates of 8 to 15 percent; and high-uninsurance communities have uninsurance rates of 16 percent or higher. Within these communities, the investigator examined changes in SCHIP participation over the first five years of the program and, in particular, coverage changes in communities with the highest uninsurance rates.

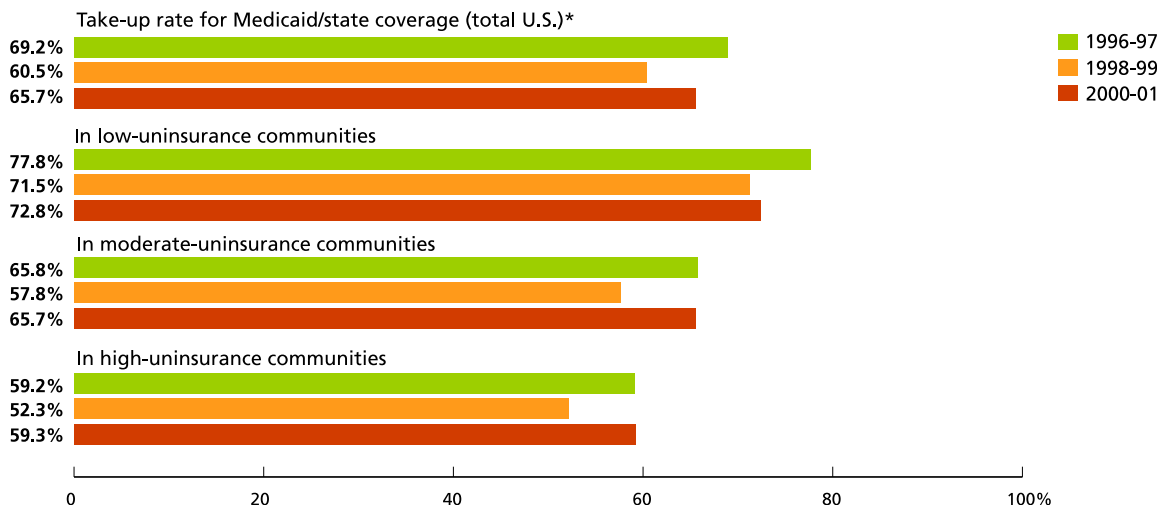
The findings show that three years into SCHIP, children's uninsurance rates began to drop. About 20 percent fewer children were uninsured in 2000–01 than in 1998–1999—and almost all the decline occurred in communities with moderate and high uninsurance rates. In fact, "the percentage of low-income uninsured children decreased from 20.6 percent to 14.6 percent in moderate-uninsurance communities and from 29.5 percent to 22.8 percent in high-uninsurance communities," the author writes.

These coverage gains were driven by significant increases in both enrollment and eligibility among low-income children in communities with higher uninsurance rates. Enrollment in public health insurance programs—either

Low-Income Children's Eligibility for Private and Public Coverage By Level of Uninsurance in the Community



Low-Income Children's "Take-Up" Rates for Medicaid/SCHIP By Level of Uninsurance in the Community



Source: Community Tracking Study household surveys.

*Defined as those eligible who do not have private insurance and are enrolled in Medicaid or SCHIP.

Research Note

Alcohol Magazine Ads Increase With Teen Readership

Is the alcohol industry marketing to teens through magazine ads? The answer is yes, at least inadvertently, according to a study of ad placements in 35 of the nation's leading magazines. Researchers matched the frequency of beer, wine and liquor ads placed from 1997 through 2001 among 35 of 48 major magazines that track adolescent readership. During that time, the alcohol industry spent $696 million on advertising in the 35 publications.

The study found 1.6 times more beer ads and 1.3 times more liquor ads for each additional 1 million readers aged 12 to 19. There was no association between teen readership and the frequency of wine ads. "Both beer and distilled liquor advertisements appeared more frequently in magazines with higher adolescent readership," according to the study, "with the frequency of advertising increasing exponentially as adolescent readership increased."

The findings raise questions about the ability of the beer and liquor industries to regulate their advertising behavior absent of any federal restrictions, despite the fact that the beer, wine and liquor trade associations have created codes that pledge to avoid advertising to teens, the study notes. Researchers, however, were unable to discern if the ad targeting was deliberate or unintentional.

Teen drinking is a major public health concern linked to a range of social ills including driving fatalities, injuries, suicides, unsafe sex and sexual assault. In 2002, 20 percent of eighth-graders, 35 percent of 10th-graders and 49 percent of high school seniors reported having had a drink in the past 30 days. In 1999, teen drinkers accounted for nearly 20 percent of all alcohol consumption, researchers note. Prior studies have found that the likelihood of adolescents drinking increases with their exposure to alcohol ads.

Researchers conclude that if the alcohol industry's efforts at self-regulation remain poor, a third party might be given authority to monitor alcohol ad placement in mass media.

Garfield CF, Chung PJ and Rathouz PJ. "Alcohol Advertising in Magazines and Adolescent Readership." *Journal of the American Medical Association*, 289(18): 2424–2429, 2003.

Craig Garfield, M.D., M.A., and Paul Chung, M.D., M.S., were Robert Wood Johnson Clinical Scholars at the time of this research.

Medicaid or SCHIP—increased from 28.9 percent in 1996–97 to 36.7 percent in 2000–01 among low-income children. Over the same time period, eligibility among low-income children jumped from 63 percent to almost 99 percent. Between 1996 and 2001, differences in the percentage of low-income children eligible for public health insurance coverage in low-uninsurance communities and higher-uninsurance communities virtually disappeared. In fact, by 2001, almost 99 percent of children in all communities surveyed by the Community Tracking Study were eligible for some type of public insurance coverage.

"With the substantial gains in eligibility, the problem of uninsured children is primarily a problem of getting them enrolled in programs they are eligible for," the author contends. To understand how successful communities were in getting eligible low-income children enrolled in public coverage, the investigator looked at changes in participation levels—also known as "take-up" rates. Take-up rates for low-income children increased from 60.5 percent in 1998–99 to 65.7 percent in 2000–01, with most of the increase in moderate- and high-uninsurance communities, the same communities that saw the largest decreases in uninsurance rates. However, over the study period, low-uninsurance communities had the highest overall take-up rates, reflecting the obvious link between enrollment and uninsurance rates: The more eligible children a community moves into public coverage, the fewer uninsured children it has.

The bottom line according to the investigator: SCHIP has made substantial progress in reducing uninsurance rates among children. However, enrollment barriers remain and impose a ceiling on take-up rates. In addition, states' budgetary pressures in this time of economic uncertainty—which often reduce or eliminate enrollment efforts—may impede SCHIP's progress.

Cunningham PJ. "SCHIP Making Progress: Increased Take-Up Contributes to Coverage Gains." *Health Affairs*, 22(4): 163–170, 2003.

Patients and Physicians Rarely Discuss Out-of-Pocket Costs

When it comes to discussing out-of-pocket costs, although most patients and their physicians say the topic should be aired, these conversations often do not occur.

According to a study of 484 patients and 133 internists in the Chicago area, 63 percent of patients said they wanted to talk with their physicians about out-of-pocket costs before receiving a test or treatment; 79 percent of physicians acknowledged that patients want such a discussion; and 90 percent of physicians said they should consider patients' costs when making treatment decisions. Yet only 15 percent of patients and 35 percent of physicians reported ever having discussed out-of-pocket costs with each other.

The researchers explain the importance of this issue. Patients shoulder about 20 percent of all health care costs through deductibles, copayments and payments for uncovered services. Patients with unmanageable out-of-pocket costs are more likely to forgo needed treatment and medications. Without a discussion of costs, physicians may not know when, and why, patients do not follow recommended care. Of patients in this study, 25 percent said they were burdened by out-of-pocket medical costs, 14 percent reported a problem paying medical bills and 16 percent said they skipped taking medication sometime during the past year due to cost, a finding that is consistent with previous studies.

While patients who felt burdened by out-of-pocket costs and those seen in community practices were more likely to report discussions on the topic with their physicians, the study still found that 75 percent of such patients remained quiet.

Most patients (84 percent) in the study believed their doctors weren't aware of the magnitude of their out-of-pocket costs, and most were right. Only 21 percent of physicians reported that in general they were aware of their patients' out-of-pocket costs. However, among those patients burdened by costs, physicians were aware of the problem with 80 percent of those who had discussed costs with them, as compared with only 51 percent of burdened patients who had not discussed the issue.

"Possible barriers to discussions that were reported by patients and physicians included discomfort discussing financial issues, insufficient time, and a belief that there were not viable solutions to patients' concerns," note the study authors. The authors also suggest that patients may not be aware of their out-of-pocket costs at the time that a treatment is recommended.

But there are steps that doctors can take to reduce patients' out-of-pocket costs. Chief among them is the use of generic and lower-cost brand name prescriptions, when appropriate, according to the researchers. Recently, AARP launched a media campaign encouraging seniors to discuss generic medicines with their doctors, following a survey that revealed that the general public knows little about them.

The researchers also encourage policy-makers to take note of their findings. While insurers impose out-of-pocket costs to reduce health care utilization, the strategy "may lead to decreased demand for both nonessential and essential health care."

Study authors conclude by recommending that more research be conducted to better understand the reasons why doctors and patients do not discuss out-of-pocket costs, as well as the impact of improved doctor–patient communication on patient satisfaction, care utilization and health outcomes. "Continued increases

in out-of-pocket costs for many U.S. residents make these issues particularly salient," they state.

Alexander GC, Casalino LP and Meltzer DO. "Patient–Physician Communication About Out-of-Pocket Costs." *Journal of the American Medical Association*, 290(7): 953–958, 2003.

G. Caleb Alexander, M.D., was a Robert Wood Johnson Clinical Scholar at the time of this research.

Hospice May Reduce Bereaved Spouses' Death Risk

Stress reduction and social support can reduce illness risk not only for individual patients, but also for their family members. In the first large-scale study of its kind, researchers have found that spouses whose partners died with the aid of hospice were more likely to be alive 18 months after their loss than those whose spouses died without hospice.

One-and-a-half years after the deaths of their husbands, 5.4 percent of wives whose husbands did not use hospice died, while 4.9 percent of wives whose husbands used hospice care died. The death rate was 13.7 percent for bereaved husbands whose wives died without the aid of hospice, compared with 13.2 percent for husbands whose wives died using hospice. The researchers say the effect is statistically significant for wives, but not for husbands, because the sample size was too small to be able to generalize findings from it.

According to the study, the size of this effect for surviving wives is nearly as large as the relationship between immediate beta blocker use and survival rates among heart attack victims, and similar to the strength of diet and exercise changes the wives would make to prolong life.

Researchers note that the death of a spouse is a stressful event that is compounded by the survivor's loss of a major source of social support. This trauma is believed responsible for the "widow/er effect," which is the increased likelihood that a surviving spouse will die shortly after the death of his or her partner. This phenomenon is far more common among surviving husbands than wives. Of the overall study sample of 195,553 elderly couples, 19 percent of the bereaved wives and 41 percent of the bereaved husbands were themselves dead 18 months after the death of their partner.

"Our hypothesis was prompted in part by the clinical observation that patients who die 'good deaths' often impose less stress on their families," say the researchers. Hospice care provides pain relief, symptom management, family and bereavement support and strives to allow the patient to die at home. Study authors suggest that hospice care both reduces the trauma of the death and "partially replaces the support lost due to the death of the spouse."

The study is based on Medicare claims data of 61,676 couples in which a partner died between 1993 and 1997. Half of the couples used hospice care; half did not. Of deceased spouses who used hospice care, husbands spent 22 days and wives 25 days in hospice before dying. Spouses were followed at least 18 months after their partner died.

The authors note the clinical and policy implications of their findings. Physicians concerned with the impact of patients' deaths on their spouses "have another tool at their disposal beyond bereavement counseling or medication; namely, they can attend to the specific manner of death of the sick partner *before* it occurs." In addition, greater spousal survival should be considered in the cost-effectiveness formula for the hospice model. Finally, they state, the type of health care given to a patient can have health effects on members of their social network.

Christakis NA and Iwashyna TJ. "The Health Impact of Health Care on Families: A Matched Cohort Study of Hospice Use by Decedents and Mortality Outcomes in Surviving, Widowed Spouses." *Social Science and Medicine*, 57: 465–475, 2003.

Managed Care and Indemnity Plans: Quality of Care Differences

Managed care and indemnity plans have their own unique financial incentives that may ultimately affect health care utilization patterns. Managed care organizations (MCOs) encourage members' regular use of primary care services through a minimal copayment. In contrast, indemnity plans require patients to cover part of the expense of care—even routine primary care—from the beginning, by meeting a deductible and paying as much as 20 percent of the bill.

How might these incentives play out in practice patterns? While the structure of financial incentives under managed care is intended to facilitate utilization patterns appropriate to the patient's condition and to avoid unnecessary services, the financial incentives inherent in indemnity plans may cause subscribers to delay using routine health care services until emergency care or hospitalization is required.

Then how does this affect quality of care? The research results are mixed: While some studies show that managed care plans provide care that is better than that in indemnity plans, others show it is equivalent or worse. This recent study set out to try to clarify the managed care–indemnity quality conundrum.

Using claims records from 1993 through 1997 for more than 80,000 patients with asthma, diabetes and congestive heart failure, a team of seven investigators compared health care utilization patterns for MCOs and indemnity plans in a single northeastern city. Although quality "encompasses the extent to which appropriate services are used, the skill with which the services that are used are provided, and their relation to certain clinical outcomes," these investigators looked only at the service-provision

Research Note

Obesity Is in the Eye of the Beholder

With over half of the adult U.S. population overweight, obesity is now considered an epidemic. Researchers in this study sought to find out how closely people's perceptions of their weight matched the truth, and whether any particular characteristics predicted how people viewed themselves. Patients' responses to whether they thought themselves to be overweight, underweight or the right weight were compared with how they rated according to medical standards, given their actual body mass index.

Researchers found that, overall, more than one-quarter of 15,593 respondents misjudged their weight; the accuracy varied by gender, age, race, income, marital status and education. Overall, while 62.3 percent of women described themselves as overweight, 50.6 percent actually were. In contrast, while 59.6 percent of men were overweight by medical standards, 48.9 percent thought they were about the right weight. The data were drawn from the federal government's Third National Health and Nutrition Examination Survey, taken between 1988 and 1994.

Young women (age 20 to 34) were three times as likely, and young men 1.4 times as likely, to believe they were heavier than they were as compared with women and men at or above age 55. Interestingly, while being married had no effect on women's weight perceptions, never-married men were less likely than married men to think of themselves as heavier than they actually were.

Meanwhile, blacks and Mexican Americans were less likely than whites to overestimate their actual weight, with blacks having the least likelihood of overestimating. At the same time, having an income at or above $20,000 increased by 55 percent the women's odds of overestimating their weight. Women high school graduates were more than twice as likely as dropouts to believe they were heavier than they were. These trends were not as pronounced in men.

"Modern U.S. society is commonly thought to have an intense preoccupation with the body, imposing rigorous standards of beauty and fitness. Here it is shown that these standards are not distributed or accepted homogeneously throughout the population," the researchers conclude. These different perceptions may explain why some people do not follow their clinicians' guidance on weight control, they note.

Chang VW and Christakis NA. "Self-Perception of Weight Appropriateness in the United States." *American Journal of Preventive Medicine*, 24(4): 332–339, 2003.

Virginia Chang, M.D., Ph.D., was a Robert Wood Johnson Clinical Scholar at the time of this research.

side of quality. Specifically, they examined variations in the use of four common services: visits to primary care providers because they are "the preferred point of entry into the health care system"; visits to specialists who have the experience and expertise to care for individuals with complex chronic conditions; visits to hospital emergency departments; hospital admissions; and prescription drugs. The researchers limited their analysis to patients with chronic conditions because they typically use a similar set of health services so that comparisons could be made primarily on the difference in health insurance coverage. In addition, the researchers separated their findings into two age groups: individuals under age 65 who may or may not have had a choice of managed care or indemnity coverage and those 65 and older who did have a choice with Medicare coverage.

For all three chronic conditions, managed care patients of all ages were more likely than indemnity patients to have had at least one visit each year to both primary care physicians and specialist physicians, but they were less likely to have visited a hospital emergency department or to have had a hospital admission for complications related to their chronic illness. In addition, managed care patients were more likely than indemnity patients to fill prescriptions for drugs—even newer and more expensive ones—to treat their conditions.

Because good primary care should reduce the need for both emergency department services and hospital admissions, the authors contend that indemnity patients' higher emergency department use—which was up to four times higher in some cases than that of managed care patients—and hospitalization rates "suggest a lower probability of appropriate care patterns." In contrast, because managed care patients were more likely to have visited a primary care physician, they "had a greater chance of receiving appropriate patterns of care…and higher quality of care than indemnity patients."

The researchers conclude that the utilization patterns they observed are consistent with the financial incentives of the two types of plans—and can serve to quell the fear that "managed care subscribers [are] systematically denied access to specialty services."

Davidson SM, Davidson H, Miracle-McMahill H, Oakes JM, Crawford S, Blumenthal D and Valentine DP. "Utilization of Services by Chronically Ill People in Managed Care and Indemnity Plans: Implications for Quality." *Inquiry,* 40: 57–70, 2003.

Research Note

Parental Education and Income Are Strong Predictors of Teen Smoking

Although education, income and occupation are strong predictors of adult smoking, the link between parental socioeconomic status and adolescent smoking is less clear. While some studies show that lower parental socioeconomic status is associated with higher rates of smoking among teens, others suggest that personality traits and adolescents' own "self-perceived socioeconomic position among their peers" are stronger predictors of their smoking behavior.

Using data from the 1993 Massachusetts Tobacco Survey, which included interviews with 1,308 adolescents, this study examined the association between parental education and income, and adolescent smoking. In addition, the investigators looked at other factors—such as smoking by parents or close friends, adolescent disposable income, and adolescent depression and rebelliousness—that might strengthen or weaken this association.

After taking into account the effects of age, sex and race, the researchers found a significant inverse relationship between parental education and income and adolescent smoking: The lower the parent's education or income level, the higher a teen's risk for smoking. Teenagers whose parents lacked a high school diploma were 28 percent more likely to smoke than adolescents whose parents had completed high school. Likewise, adolescents from families with an annual household income of $20,000 or less were 30 percent more likely to smoke than adolescents from families with a household income between $20,000 and $30,000 a year.

Having a parent who smoked weakened the effect of parental education and household income on adolescent smoking by 10 percent and 19 percent, respectively. In contrast, having a close friend who smoked, and being rebellious or depressed had no significant effect on the strength of the relationship between parental socioeconomic status and adolescent smoking—although independently they increase the likelihood that a teen will smoke.

According to the authors, "In contrast to the findings of other studies, we found that a relatively sizable and significant inverse association between parental socioeconomic status and adolescent smoking persisted even after parental smoking status, adolescent disposable income and other important predictors of adolescent smoking such as age and race/ethnicity were taken into account." This finding supports a smoking prevention strategy of targeting lower socioeconomic populations and, in particular, implementing smoking cessation programs for adults within this population.

Soteriades ES and DiFranza JR. "Parent's Socioeconomic Status, Adolescents' Disposable Income, and Adolescents' Smoking Status in Massachusetts." *American Journal of Public Health*, 93(7): 1155–1160, 2003.

Clarifying the Link Between Asthma Diagnosis and Insurance Coverage

Passaic, N.J., a northern industrial community with a significant uninsured Hispanic population, saw an increase in asthma-related absenteeism among school-age children in the late 1990s. The Passaic Asthma Reduction Effort, initiated in 1998 by Passaic Beth Israel Hospital in response to the problem and funded by The Robert Wood Johnson Foundation, screened elementary school children for asthma and related respiratory conditions. This study reports their findings on the relationship between childhood asthma diagnosis and treatment and health insurance coverage.

From 1998 through 2001, the investigators surveyed the parents of nearly 4,400 children in grades 2 through 5 in Passaic public and private schools. The questionnaire, written in both English and Spanish, asked about respiratory symptoms, environmental asthma triggers, asthma diagnosis, respiratory medications, insurance coverage and health care sources. The findings were analyzed by year to understand how the availability of state-sponsored children's health insurance affected asthma diagnosis and treatment. Shortly after the start of the Asthma Reduction Effort, the state-funded children's health insurance program began enrolling uninsured children who were ineligible for Medicaid; many of Passaic's Hispanic children fit into this category.

Consistent with the timing of the children's health insurance program, the data showed an increase in health insurance coverage among children in Passaic in 2000 and 2001. However, insurance coverage varied across ethnic groups. Although more than 90 percent of young blacks and whites had coverage during all four years of the study, only 34 percent of Mexican children had insurance coverage in 1998, climbing to 66 percent by 2001.

The link between insurance coverage and asthma diagnosis and management was clear in the findings. In 1998, children with insurance were two to three times more likely than those without insurance to have been diagnosed with asthma. In addition, over the entire four years of the study, insured children were 1.5 to three times more likely than uninsured children to use respiratory medications.

"The Passaic Asthma Reduction Effort was able to identify individuals and groups of individuals whose respiratory health may be compromised by lack of access to acute care and asthma management protocols," the researchers conclude. They suggest that this information and continued monitoring of the community can guide future health outreach efforts.

Freeman N, Schneider D and McGarvey P. "The Relationship of Health Insurance to the Diagnosis and Management of Asthma and Respiratory Problems in Children in a Predominantly Hispanic Urban Community." *American Journal of Public Health*, 93(8): 1316–1320, 2003.

DISCUSSION WITH RWJF PRESIDENT AND CEO RISA LAVIZZO-MOUREY

The Foundation's Tobacco-Control Strategy

The Robert Wood Johnson Foundation has played a major role over the past decade in initiatives to prevent youth and adults from starting tobacco use and to improve treatment efforts to help smokers quit. In the coming years, the Foundation will continue its commitment to advancing those goals through a focused strategy with two principal objectives: 1) to sustain a strong state and national tobacco policy change infrastructure, with an emphasis on bringing new funding and partners to tobacco control; and 2) to maintain policy gains and momentum through targeted grantmaking. RWJF President and CEO Risa Lavizzo-Mourey, M.D., M.B.A., explains the Foundation's current strategy in this important field.

RWJF has been a major player in tobacco control for many years. Can you talk about some of the recent successes in the field?

The most important success is that the rates of smoking are going down; that's the ultimate outcome we want. Since 1995, tobacco prevalence has declined 12.6 percent for adults and more than 18 percent for youth. The decrease in the numbers of people who are using tobacco is not as large as we would like, but the numbers are going down.

Among the most significant reasons for the drop in smoking prevalence is the increase in the tax on tobacco products in 31 states and the District of Columbia over the past two years. We know that as tobacco products become more expensive, fewer people will use them, particularly young people. At the same time, there is a growing number of courageous policy-makers who have been made aware of the risks of secondhand smoke. The states of Delaware, New York, Connecticut and Maine have gone smoke-free. As the environment becomes more supportive for people who want to stay smoke-free, I think smoking rates will continue to decrease.

What are the Foundation's plans for tobacco control in the future?

We are committed to reducing the prevalence of tobacco use and are focusing on a number of ways of doing that. The main way is to continue supporting the work that our grantees have done in policy change so far. Our emphasis will be on efforts to educate the public and policy-makers about the positive health results of increasing the excise tax on tobacco products, increasing the proportion of people covered by smoke-free environments and promoting tobacco treatment coverage for people who are struggling to quit. That is the kind of work we absolutely want to continue.

The Foundation plans to reduce its funding level for tobacco-control programs going forward. What are the reasons for that reduction?

Our mission is to improve health and health care. When you look at the causes of preventable mortality in this country, smoking and tobacco use rival lack of physical activity and obesity for the number one and number two slots. Many of the chronic diseases that plague us, like cardiovascular disease, hypertension, diabetes, stroke and many cancers, are related to those two unhealthy behaviors.

Obesity, especially in children, is on the rise, associated with a decline in physical activity. Consistent with our mission, we need to focus our prevention resources on the areas that are the biggest threats. We think it's important to add obesity, particularly among children, to our prevention portfolio.

Does the funding reduction reflect failure to meet the Foundation's objectives in any way?

Absolutely not. We are extremely proud of the tremendous gains our grantees have accomplished in reducing the use of tobacco and therefore saving thousands and thousands of lives. The reason we are trying to balance our prevention efforts is that there are now new problems on the horizon. We have seen some decrease in the prevalence of smoking, so we can and should shift some of our attention to these new threats. We will not abandon tobacco- and substance abuse-related prevention, but we would be remiss if we didn't pay attention to obesity, a growing threat.

You have said the Foundation should do everything it can to make programs self-sustaining and continue their momentum. How does this approach apply to the tobacco strategy?

The strategy that we're using in our work in tobacco is to further the momentum of policy change that we've helped establish. Our plan is to sustain the policy infrastructure, that network of talented people and the research base that they use to do their work. We are investing in a cluster of grants, programs and communications projects that all are designed to work together to sustain that infrastructure. As long as there is tobacco use, we need to have a policy infrastructure and educational opportunities to let people know about its harms and to create an environment that promotes healthy choices. Over the next five years we will do everything we can to ensure the sustainability of this infrastructure and help find other ways for it to sustain itself.

There have been rumors that the Foundation was getting out of tobacco control altogether. Would you address those concerns?

The numbers speak for themselves. Over the next two years, we have $72 million of grant-making targeted to tobacco control, with an additional $30 million in grants from 2006 through 2008. So we are not getting out of tobacco control. We are balancing our resources across a number of areas where we need to address prevention to meet our mission of improving the health of people in this country.

What will be the role of the Foundation's tobacco team from now on?

The role of the tobacco team remains absolutely essential. Over the years, these dedicated staff members have accumulated a wealth of information and expertise that they are eager to employ to maintain the considerable progress made so far. They see themselves, appropriately, as a resource to the field, to organizations and individuals who are either entering or trying to sustain this work. Our staff has developed strong and positive relationships with people throughout the world who are interested in and focused on tobacco-control issues. They will be instrumental in creating linkages and introductions between people who have an interest and may not know how to get fully engaged. Our team will play a vital, ongoing role in providing information to people and organizations working in tobacco control.

What do you see as the game plan in the coming months?

In the near term, we want to be clear in communicating the tobacco strategy and in voicing strongly the importance of working together, using our combined intellectual, financial and other resources to continue to reduce the prevalence of tobacco use. Through technical assistance to our grantees, we will help them sustain their important work and monitor closely both trends in prevalence and the vitality of the programs working on tobacco policy change. It is unequivocal that smoking is harmful and that the policy interventions that we have long supported make a difference in reducing tobacco use. I will continue to champion this important health message in every way I possibly can.

—INTERVIEW BY LAURIE JONES

For full text of this interview, see
www.rwjf.org/special/tobaccostrategy

Grant Results Reports

Since August 2003, two National Program Reports and 42 new Grant Results Reports were posted to the RWJF Web site, *www.rwjf.org.* These reports, organized by topic area, detail the results of RWJF grants that are now closed. Among the newly posted reports are the following:

- ***The Health Privacy Project.*** The Institute for Health Care Research and Policy at Georgetown University published a compilation of health privacy statutes in all 50 states and a consensus document of best principles shaping health privacy policy. The report, *Best Principles for Health Privacy*, and the revised state profiles can be downloaded at *www.healthprivacy.org/resources.* See the Grant Results Report at *www.rwjf.org/reports/grr/040780.htm.*

- ***Creation of a Chronic Disease Management System for Primary Care Practice.*** Researchers at Stanford University School of Medicine developed and evaluated a disease management/patient self-care program for patients with chronic disease. Much of the content derived from these self-management workshops is described in a book, *Living a Healthy Life with Chronic Conditions,* which lists for $18.95 and is available through major book retailers. See the Grant Results Report at *www.rwjf.org/reports/grr/031162.htm.*

- ***Creating New Mountains: A National Asian American/Pacific Islander Tobacco Control Network.*** A national network aimed at reducing tobacco use among Asian Americans and Pacific Islanders trained local leaders to engage in anti-tobacco activities in their communities in the United States and Pacific Island territories. The 140 leaders initiated approximately 80 community anti-tobacco projects. The network, Asian Pacific Partners for Empowerment and Leadership, a project of the Association of Asian Pacific Community Health Organizations, launched a Web site, *www.appealforcommunities.org,* which provides information for tobacco-control advocates in Asian American and Pacific Islander (AAPI) communities. It also produced a 62-page policy manual, *A Policy Framework for Preventing and Reducing Tobacco Use in the AAPI Community*, which outlines local, regional and national responses to tobacco issues affecting Asian American and Pacific Islanders. To request a free copy of the policy framework, e-mail *appeal@aapcho.org* or call (510) 272-9536. See the Grant Results Report at *www.rwjf.org/reports/grr/031989.htm.*

- ***Study of the Effects of Welfare Reform on the Health of Urban Families.*** Researchers at the Manpower Demonstration Research Corp. (MDRC) examined and analyzed the effects of welfare reform on the lives of low-income families. Legislation enacted in 1996 ended the Aid to Families with Dependent Children program, the country's major safety-net program for low-income families, and replaced it with the state-administered Temporary Assistance for Needy Families (TANF). Research findings were published in 15 reports and a number of journal articles, and researchers made more than 75 presentations to policy-makers, including the U.S. Senate Finance Committee's first hearing on welfare reform reauthorization. As data continue to be analyzed, the researchers plan to issue additional reports and in-depth analyses of each city's experience with welfare reform. The executive summary of the report, *Big Cities and Welfare Reform: Early Implementation and Ethnographic Findings from the Project on Devolution and Urban Change,* can be downloaded at *www.mdrc.org/publications/55/execsum.html*. The full report is available for $12 plus $3.50 shipping and handling by calling MDRC at (212) 532-3200. See the Grant Results Report at *www.rwjf.org/reports/grr/031089.htm.*

— Hedda Colossi

Gearing up for May 2004 Cover the Uninsured Week

The Robert Wood Johnson Foundation and a diverse group of national and local organizations are planning the second Cover the Uninsured Week, to be held May 10–16, 2004. Former Presidents Gerald Ford and Jimmy Carter continue to serve as honorary co-chairs; former surgeons general and secretaries of Health & Human Services also have endorsed the event. Actor Noah Wyle, of the television drama "ER," will serve as national spokesperson for Cover the Uninsured Week 2004.

The week will build on the success of Cover the Uninsured Week 2003, which brought together more than 800 national and local organizations to sponsor nearly 900 public events in all 50 states and the District of Columbia. Cover the Uninsured Week 2004 will commence with a national kickoff, followed by more than 1,000 events—including health fairs, educational forums, workshops for small business owners and volunteer efforts by physicians and others—in communities from coast to coast.

The 2004 effort also will feature a "National Call to Care," which will encourage physicians, nurses and other health professionals to donate a portion of their time during the week to care for those who are uninsured. The nation's faith community is expected to play a leading role and will make its collective voice heard in declaring health care coverage a common community value according to the teachings of diverse faith traditions.

To learn more about Cover the Uninsured Week 2004, visit *www.covertheuninsuredweek.org.*

— Maureen Cozine

Lienhard Award Winners. The Institute of Medicine (IOM) of the National Academies presented the 2003 Gustav O. Lienhard Award to two leaders in the advancement of personal health services: National Commission on Correctional Health Care (NCCHC) co-founders Bernard P. Harrison, a lawyer (below at left), and B. Jaye Anno, a criminologist (below at right). Both were honored for their contributions to improving the quality and humanity of medical care systems for the incarcerated. As NCCHC co-founders, they are responsible for developing the first comprehensive standards for health services in jails, prisons and juvenile detention facilities, and for initiating the concept of voluntary accreditation as the incentive for states, counties and the federal government to upgrade health care conditions in correctional facilities.

The Lienhard Award, funded by an endowment from The Robert Wood Johnson Foundation, presents a medal and $25,000 to each recipient for outstanding achievement in improving health care services in the United States.

For more information about the award and the nomination process, contact the Office of Health Policy Programs and Fellowships at the IOM at (202) 334-1506 or visit *www.iom.edu/lienhard.*

SELECTED GRANTS

Active Living, Obesity and Nutrition

- *Leadership for Active Living.* Renewal awards to two sites, totaling $459,141.

Alcohol and Drug Addiction Prevention and Treatment

- *A Matter of Degree: Reducing High-Risk Drinking Among College Students.* Awards to two sites, totaling $936,000.
- *Paths to Recovery: Changing the Process of Care for Substance Abuse Treatment.* Awards to 10 sites for implementation, totaling $2 million.
- *Reclaiming Futures®: Communities Helping Teens Overcome Drugs, Alcohol & Crime.* One renewal award of $333,540 for annual leadership meetings to Portland State University Graduate School of Social Work.
- *Substance Abuse Policy Research Program.* Awards to two sites, totaling $180,288. One renewal award of $318,890 for improving treatment for Medicaid beneficiaries with co-occurring mental illness and substance abuse disorders to Dartmouth Medical School, Hanover, N.H.

Building Human Capital

- *Better Jobs, Better Care: Building a Strong Long-Term Care Workforce.* Awards to five sites for demonstration, totaling $3.5 million. Awards to eight sites, totaling $2 million, for applied research projects aimed at understanding the effects of various policy and practice changes on getting and keeping quality frontline workers in long-term care.
- *Developing Leadership in Reducing Substance Abuse.* One renewal award of $3.3 million for support for fellows and mentors to Portland State University Graduate School of Social Work.
- *Innovators Combating Substance Abuse.* One award of $300,000 for studying the trans-theoretical model of change to evaluate treatment outcomes to University of Maryland, Baltimore County, Department of Psychology.
- *Investigator Awards in Health Policy Research.* One award of $199,214 for investigating consumer culture and the changes in modern American medicine to the Stony Brook Foundation, Stony Brook, N.Y.
- *Scholars in Health Policy Research Program.* One award of $4.6 million to Harvard Medical School, Boston.
- For expanding education programs to help minorities and the disadvantaged pursue careers in health professions, $229,240 to the Foundation of the University of Medicine and Dentistry of New Jersey, Somerset.

End-of-Life Care

- *Center to Advance Palliative Care.* Award of six $750,000 Palliative Care Leadership Center grants, totaling $4.5 million:
  - University of California, San Francisco, School of Medicine
  - Fairview Foundation, Minneapolis
  - Medical College of Wisconsin, Milwaukee
  - Mount Carmel Health System, Columbus, Ohio
  - Palliative Care of the Bluegrass, Lexington, Ky.
  - Virginia Commonwealth University, Massey Cancer Center, Richmond
- For improving residency training in end-of-life care, a renewal award of $297,500 to the Medical College of Wisconsin, Milwaukee.

Health Insurance Coverage

- *Covering Kids and Families.* Award of 19 Access Initiative grants, totaling $2.5 million. States awarded: Arkansas, California, Connecticut, Idaho, Maine, Maryland, Minnesota (Minneapolis), Minnesota (Rochester), New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania (Philadelphia), Pennsylvania (Pittsburgh), Texas (Bellaire), Texas (Progreso), Virginia, Washington and West Virginia. Award of three Special Opportunity grants, totaling $182,692.

Public Health Leadership and Capacity

- *Changes in Health Care Financing and Organization.* Awards to three sites, totaling $1.1 million.
- *State Health Leadership Initiative.* A renewal award of $3 million to the National Governors Association Center for Best Practices, Washington. For the State Legislator Forum Access Project, $749,931 to the National Conference of State Legislatures, Washington.
- For developing state policy fellows in long-term care, $297,686 to University of Minnesota School of Public Health, Minneapolis.
- For information on state health policy legislation, $343,710 to the National Conference of State Legislatures, Washington.

Quality Health Care

- *Depression in Primary Care: Linking Clinical and System Strategies.* Awards to four sites for leadership, totaling $399,980.
- *Health E-Technologies: Assessing New Tools for Chronic Disease Management and Health Behavior Change.* Award of 10 methodology and design grants, totaling $854,905. Award of eight outcome evaluation grants, totaling $3.9 million.
- *Improving Chronic Illness Care.* Awards to five sites, totaling $1.5 million. One renewal award of $150,000 for evaluation of the program, Phase I, to University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick.
- *Prescription for Health: Promoting Healthy Behaviors in Primary Care Research Networks.* Awards to 17 sites, totaling $2.1 million.
- For testing the practice systems assessment survey as a quality improvement tool, $288,140 to the National Committee for Quality Assurance, Washington.

Tobacco Use

- For eliminating children's exposure to secondhand smoke, one renewal award of $399,951 to Kids Involuntarily Inhaling Secondhand Smoke, Roseville, Calif.
- *Policy Advocacy on Tobacco and Health: An Initiative to Build Capacity in Communities of Color for Tobacco Policy Change.* Awards to nine sites, totaling $1.5 million.

Vulnerable Populations

- *Children's Futures.* One award of $10.6 million to the Children's Futures Support Fund, Trenton, N.J.
- *Faith in Action.* Awards to 37 sites, totaling $1.3 million.
- *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* One supplemental award of $269,436 for evaluation of the program to Wake Forest University Health Sciences, Winston–Salem, N.C.
- *Local Initiative Funding Partners Program.* Awards to 16 sites, totaling $6.7 million. One renewal award of $290,000. Two grants from the Special Opportunities Fund, totaling $275,516.
- For activities to support healthy steps for young children, a renewal award of $300,000 to MEM Associates, New York.

Other

- For New Jersey policy forums on health and medical care, $748,560 to Forums Institute for Public Policy, Princeton, N.J.
- For a revitalization program for the city of New Brunswick, N.J., $550,000 to the New Brunswick Development Corp.
- Support for the 2003–2004 annual campaign drive, $679,800 to United Way of Central Jersey, Milltown.

People

Christine Clayton joined the Communications Department in October as an administrative assistant. Before coming to the Foundation, she was an executive assistant at the YWCA in Princeton, N.J.

Leonie Infantry joined the Foundation in October as a program administrative assistant with the Health Care Group, which she had been working with since July. Infantry previously held several temporary appointments in the pharmaceutical industry.

Doreen Laskow joined the RWJF Communications Department in October as a communications assistant.

Laskow has more than 25 years of administrative and project management experience, primarily with IBM and Integrated Systems Solutions Co., an IBM subsidiary.

Jan Malcolm joined the Foundation in September as a senior program officer focusing on public health. Most recently, Malcolm served as commissioner of health for the State of Minnesota. She is the former director of policy and development at American MedCenters; vice president of PARTNERS National Health Plans; senior vice president of HealthPartners and vice president of the Allina Health System.

Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of The Robert Wood Johnson Foundation, has been featured in the October issues of both *Ebony* and *Essence* magazines. The *Ebony* article, "Women on the Cutting Edge of Health Care and Research," features Lavizzo-Mourey and six other women in the health care field who are working to remove disparities in both access to and quality of health care for the black community. The *Essence* article, "50 Women Who Are Shaping the World," focuses on women from fields as diverse as corporate America, politics, entertainment and health care who are working to end poverty, racial injustice and disease. Lavizzo-Mourey shares the spotlight with women such as Oprah Winfrey, Judith Jamison, Shirley Franklin, Condoleezza Rice and Toni Morrison. *Essence* credits these women with changing the way the world sees black women.

Rebecca Moore became an administrative assistant in the Communications Department in October. Prior to joining RWJF, she was a staff assistant for Factiva in South Brunswick, N.J.

Kathryn Muessig became a research assistant in the Research and Evaluation Unit in September.

Previously, Muessig was an English teacher at the Dalian University of Technology in China. In joining RWJF, she returns to Princeton, having received her undergraduate degree in anthropology from Princeton University.

Jaimie Nally began working at the Foundation in October as a Web editorial associate in the Communications Department. Previously, Nally was the manager of Web development at NUI Corp. in Bedminster, N.J.

Anita Roberts joined the Foundation in September as a program administrative assistant for the Research and Evaluation Unit. Formerly, Roberts was a program assistant at the Local Initiatives Support Corp. in New York City.

Judith Vautravers joined the Health Group in October as a program administrative assistant working with the Obesity Team. She has held various temporary assignments within the Foundation since 2001. Previously, she was an executive assistant to the CEO and president of SimStar Internet Solutions in Princeton, N.J.

Congratulations

Peter Goodwin, treasurer for the Foundation, has accepted the new position of vice president for National Program Affairs. Goodwin will continue in his role as treasurer until a replacement is found.

Tedi Nessas was promoted to administrative coordinator for the Communications Department.

What's New on the RWJF Web Site

Want to know more about research funded by RWJF? Check out the new online Research Center, an effort to gather important findings in one place at *www.rwjf.org/research.* The center is still in its infancy, but is expected to grow quickly.

- The RWJF Web continues to launch new interactive tools and applications, including the Sprawl Checklist, produced to coincide with the release of RWJF-funded research showing the relationship between urban sprawl and physical activity. To check it out, visit *www.rwjf.org/news/special/sprawlIntro.jhtml.*
- Also on the RWJF Web site find a clickable map showing the availability of adult day services by state and county at *www.rwjf.org/news/special/adultdayServicesReport.jhtml.*
- *The Shape We're In*, a five-part newspaper series supported by RWJF and distributed by Knight Ridder/Tribune Information Services, is available, including a Spanish translation, at *www.rwjf.org/news/special/shape/shape.jhtml.*
- And here's a first: RWJF-supported *Join Together*, a national resource for communities taking action against substance abuse, has sponsored a country music CD, "SHARE—Songs of Hope, Awareness and Recovery for Everyone." Some 30 country artists contributed. Proceeds from the sale of the CD will go to drug- and alcohol-abuse organizations around the country. One of the music selections, "When Love Rules the World," is available for listening on the RWJF Web site *at www.rwjf.org/news/special/share.*
- Several new additions to the RWJF Television Health Series are available at *www.rwjf.org/news/videos.jsp*. New profiles are available at *www.rwjf.org/news/profiles.jsp.*

—Jeffrey Meade