

The
Robert
Wood
Johnson
Foundation
Quarterly
Newsletter

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Give Programs
“Wings”**

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Warning: The State of Public Health in America Not So Healthy

The inhalation anthrax death of a 63-year-old Florida photo editor, followed by four similar deaths and a string of nonfatal cases, caught the country’s public health system off guard. Some say it was just a matter of time.

After years of inadequate funding, training and staffing, experts say there is no way the U.S. public health system could have coordinated a timely national response to anthrax: not on the heels of September 11th and not with the emergence of 20 new diseases in the past 20 years. Now, with certain essential childhood vaccines in short supply, environmental toxins infecting the nation’s health and bioterrorism looming, the charge is clear: The American public health system must strengthen itself.

It is both a major opportunity and a difficult task, given the relative neglect of the system, says Michael McGinnis, M.D.,

senior vice president and director of the Health Group at The Robert Wood Johnson Foundation (RWJF). “The enhanced complexity of the challenge has led to a public health system that is in a very precariously perched position,” McGinnis says.

Since 1988, when the Institute of Medicine (IOM) issued its report *The Future of Public Health*, which described

the U.S. system as fragmented and “in disarray,” RWJF and other members of the public health community have been trying to remedy the many gaps.

For example, 80 percent of public health departments lack the information infrastructure necessary to communicate with their central state health department or with local providers, McGinnis says. “Only one-third of the population is effectively served by an intact public health system — and that’s being generous,” says McGinnis.

Public health hasn’t always been so strained. From the 18th to the mid-20th centuries, public health succeeded in virtually eradicating infectious diseases such as polio and smallpox through widespread vaccination campaigns and environmental cleanup. More recently, it has taught Americans to protect themselves against heart disease and some cancers by exercising, eating well and not smoking, and against HIV/AIDS by practicing safe sex.

Ironically, shifting its focus from infectious to chronic diseases weakened the public health system, says Robert

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Americans’ Views of the Most Important Health Care Problems, 2001 Percentage of Americans Saying the Issue Is One of the Two or Three Most Important Health Care Problems



Source: Harvard School of Public Health/The Robert Wood Johnson Foundation/International Communications Research Polls (May 2001 and November 2001).

Note: Sums add to less than 100 percent because when asked about health care, many Americans mentioned diseases as a top concern.

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Blendon, Ph.D., professor of health policy and political analysis at the Harvard School of Public Health.

"What we let completely collapse [in the 1970s] was our system for monitoring and responding to epidemics of airborne or waterborne infections and our screening, detection and monitoring centers to get people tested and treated for other epidemics," Blendon says.

Shifting economic and political priorities also weakened the system. Reduced health spending — rather than public health preparedness — became the national priority, Blendon says. "There was a sense biowarfare couldn't happen." That sense, however, along with confidence in the public health system, has dwindled.

After conducting an RWJF-supported survey of public attitudes toward health care problems, Blendon found that Americans are more worried than they were before September 11th about major illnesses — cancer, heart disease, HIV/AIDS. And now they also are worried about health problems resulting from terrorist attacks.

Blendon found that while most Americans don't think they or their family members will contract anthrax or smallpox, more than half of respondents from households where there is a postal service employee are worried about contracting anthrax through the mail. Most have taken precautions, either when opening mail or by stocking supplies of food, water or clothing.

Such precautions aren't likely to help swarms of people suddenly in need of emergency care, says Elin Gursky, Sc.D., senior fellow at the Johns Hopkins Center for Civilian Biodefense Studies in Baltimore <www.hopkins-biodefense.org>. "There is no surge capacity in our public health or medical system," Gursky says. "We have cost cut ourselves into a lack of capacity to respond."

To be efficient, the public health system needs surveillance, warning and communication systems. Doctors not trained to diagnose

rare infections, like anthrax, should be able to contact a local public health department immediately for help.

The diagnosis should then be validated by the Centers for Disease Control and Prevention, which should alert public health departments nationwide. "We have to train people to respond, and this is going to cost money," Gursky says. "Congress has to understand that."

Learning how to educate Congress and other policymakers about the urgency of strengthening and preparing the public health system is the goal of a Foundation-sponsored project at Hopkins' biodefense center. Staff from the Center have testified before Congress about public health's dire need for increased funding.

Public health also needs guidance in how it educates and trains its workforce, says Pamela Russo, M.D., senior program officer at RWJF. Russo is working with the IOM on an RWJF-sponsored project that explores strategies for closing the gaps between public health education and training, and practice.

"Schools of public health are predominantly producing academics and researchers, but they're not focused on practice," Russo says. "Only 20 percent of public health school graduates go to state and local health agencies, while a lot go to federal agencies."

Two RWJF-funded programs offer enhanced training for public health professionals. The Management Academy for Public Health, delivered by the School of Public Health and the Kenan-Flagler Business School of the University of North Carolina at Chapel Hill, teaches how to manage people, data and money. It offers classroom work and distance learning. Another program, the *State Health Leadership Initiative*, with its National Program Office at the National Governors' Association Center for Best Practices in Washington, seeks to accelerate the development of the leadership capacity of state health officers as policymakers, administrators and advocates for public health.

Lack of coordination is not unique to the U.S. public health system, according to Victor G. Rodwin, Ph.D., director of the World Cities Project, sponsored by RWJF to compare public health systems in Paris, New York, Tokyo and London.

While London and Paris have made primary health services like prenatal care and immunizations accessible through nationalized health insurance, their public health systems are fragmented, says Rodwin, a professor of health policy and management at New York University's Wagner School. London's 33 boroughs don't even have health departments. Instead, environmental health officers monitor environmental health hazards and conduct restaurant inspections. "There is not much connectivity," Rodwin says.

Connecting public health services within communities and states is the aim of RWJF's *Turning Point: Collaborating for a New Century in Public Health* <www.turningpointprogram.org>. By bringing technical assistance to local and state public health departments and other agencies, the program is working to improve the health of communities, says Bobbie Berkowitz, Ph.D., director of the *Turning Point* National Program Office at the University of Washington School of Public Health in Seattle (see *Profile*, page 4).

"The state of public health varies by location," Berkowitz says. Rural public health systems, for example, are often more stressed than urban ones. Many lack the technology to track disease outbreaks or to connect health departments with hospitals and the public. Some even have trouble attracting a public health workforce, Berkowitz says. "We're concerned with how communities respond to and prepare for threats to health."

While public health preparedness in America is uneven at best, there is hope that September 11th and its aftermath will not be remembered as one more unheeded warning. Says Gursky, "Biodefense has got to be the clearest wake-up call we've had."

— ANDREA KOTT

Communications Activist, Mentor and Colleague; Frank Karel Retires from RWJF

Talk to people in the foundation world and it quickly becomes clear that Frank Karel's impact has been felt far beyond the walls of The Robert Wood Johnson Foundation.



"I think I was in my new job as public affairs director at The Pew Charitable Trusts for all of one day when Frank, whom I had never met, called offering to buy me a cup of coffee," says David Morse, M.A., RWJF's new vice president for communications. "He came to Philadelphia the very next day and spent a couple of hours teaching me — with many memorable anecdotes — about the players and the issues facing the field. It was a terrific learning experience and the kind of gesture for which Frank is legendary."

Dot Ridings, M.A., president of the Council on Foundations, tells a similar tale.

"When I took this job, my first trip to visit a council member was to RWJF, to spend a few days with Frank and learn from him," says Ridings. A former Florida journalist, like Karel, Ridings found in him "an inspiration and a guide" to the more activist role for communications that she sought for her organization.

Frank Karel was vice president

for communications at RWJF for 21 years — from 1974 until early 1987 and then again from 1993 until his retirement at the end of 2001. During those interim years, he served in the same capacity at the Rockefeller Foundation. What Karel brought to both these foundations was a keen sense of how communications could be used to leverage a foundation's programmatic investments.

Two decades ago, "communications" at RWJF — as at most foundations — meant little more than answering the stray media call, and putting out an annual report and occasional summaries of completed National Programs. "We're not selling anything," RWJF's first chairman, Gustav O. Lienhard, would say. Lienhard, whose career at Johnson & Johnson coincided with its becoming the world's leading health products company, knew something about selling — and he didn't picture it going on at the Foundation, where ideas are the stock-in-trade. Although Karel didn't start out to prove Lienhard wrong, he did successfully sell the ideas and the work of the Foundation and its grantees to a broader audience.

"Most people still think of communications as dissemination," adds former RWJF Senior Vice President Ruby Hearn, Ph.D. "Frank really understands and articulates the power of communications as an intervention" — a rich menu of opportunities for foundations to do their work more effectively, reach more people, make the most of their investments and change the climate in which important personal, institutional and public decisions are made.

One of Karel's first steps was making sure that the Foundation's Calls for Proposals elegantly stated

the problems that the programs were attempting to address, selling the ideas behind the programs from the beginning. "Frank gave the Foundation the courage to communicate about the problems it was working on," says William Walch, an assistant vice president for communications in RWJF's early days. "He helped the staff understand that communicating would not bring a great flood of challenges and grant applications, but would enhance their programs." The ability of a philanthropy to articulate what it is trying to accomplish — and why — is essential to effective grantmaking. Thanks to Karel, that concept is now well known.

Karel's next step was shoring up the communications capacity for programs and projects in the field. With more than 2,000 active grants and a rapidly growing roster of National Programs in the 1980s and 1990s, the Princeton-based staff was stretched too thin.

Communications had to be built into grants and programs whenever possible. RWJF communications staff now participate on all program development teams, so that planning for communications can take place up front. Because some National Programs offer tremendous communications opportunities, the Foundation now encourages the hiring of communications officers within National Program Offices, where appropriate. When RWJF held the first meeting that brought all these far-flung communications professionals and consultants together

with the Princeton staff, the attendees numbered about 20. A decade later, the attendance at such meetings has increased more than sixfold.

As he pushed communications into an integral role in program planning, announcement and implementation, Karel continued to build on the traditional role of communications. David Rogers, M.D., RWJF's first president, in an early annual report message, said: "We are incorporating broader communications efforts in our programs so that the most important lessons gained can be shared with those who can benefit from this knowledge."

Sharing what we've learned is simply the last step in the process of encouraging change. "Whether you call it social marketing or something else, hatching a program idea isn't enough," says RWJF President Steven Schroeder,

M.D. "We have to give it wings, whenever the evidence warrants."

Karel helped give many programs wings, and his impact has been broad and deep.

"How many people can claim that they created an entire professional field?" asks Andrew Burness, M.B.A., an RWJF

communications officer in the early 1980s. "Frank not only invented the field, but then stuck around to show the rest of us how the game should be played."

— VICTORIA WEISFELD





The recent anthrax outbreaks focused the nation's attention on our public health system — and what we saw was deeply troubling, says Bobbie Berkowitz, Ph.D., chair of the University of Washington's Department of Psychosocial and Community Health and director of The Robert Wood Johnson Foundation National Program Office for *Turning Point: Collaborating for a New Century in Public Health*. For too long, policymakers have failed to fund public health, jeopardizing the system's capacity for emergency response. In this interview with *ADVANCES*, Berkowitz talks about how we have failed our public health system, and what needs to be done to rescue it.

What is the biggest problem facing the public health system today?

BERKOWITZ — If I can choose only one, I'd have to say funding. About 99 cents of each national health dollar goes into health care, and only about one cent goes into public health. So when you think about what it takes to keep the population healthy — preventing disease, promoting health, protecting the environment from health threats — that entire system has only 1 percent of the federal health funding.

Why has there been so little political support for maintaining and improving the public health system?

BERKOWITZ — The public has only a limited awareness of what the public health system is and what it does. That's partly because, if we do a good job of prevention, it's not obvious. If you go to a restaurant, eat your meal and don't get sick, you really don't think, "The reason I didn't get sick is the public health system." Or if you go swimming and don't get infected by a bug in the water, you don't think, "That's because the water has been tested by the public health department." We've reached a point in America where people just don't think about these things, whether it's *E. coli* in hamburgers or the threat of bioterrorism, until there's a crisis that makes us aware of how vulnerable we really are.

Despite public fears about anthrax and smallpox, doesn't it make good economic sense to focus our limited health care dollars on the major illnesses, such as heart disease and diabetes, that are actually killing millions of Americans?

BERKOWITZ — It is extremely important to invest resources and energy in finding ways to prevent and treat chronic disease — and I

want to stress the prevention aspect, which is part of the historic mission of public health. But we have neglected a system that needs to be in place to respond swiftly and effectively to an anthrax threat, a smallpox threat. If we had been sufficiently resourced all along, we'd be prepared to meet those threats. Now, when we need it, that system is not where it needs to be. We need to focus on system preparedness, so we don't get into a situation where we have to spend enormous, unnecessary amounts of money to respond effectively in a time of crisis.

The public health system was widely perceived as stumbling in the initial response to the anthrax outbreaks. What went wrong?

BERKOWITZ — In public health, we are in the information business. People want to be able to call their local health department and say, "I'm worried about being exposed. What should I do?" But those answers are not always easy to give, even though the questions seem relatively basic. If you think about smallpox, there's a whole science that has to do with how much immunity currently exists in the population, and how long it would take to get enough vaccine developed to respond to an outbreak. Managing the flow of information is also very complicated. It's not always as simple as asking a health official a question and getting an answer. Health and politics are closely intertwined, especially when national security is at issue. Government officials aren't always willing to say, "I don't know the answer to that question." We need to be prepared for a crisis, to anticipate all the various scenarios and develop communication strategies to provide the public with the information they need. Which brings us back to the issue of the system being underfunded.

Could the anthrax scare end up refocusing political and public attention on the need for a fully funded public health system?

BERKOWITZ — I think it has rattled the foundations of people's belief that they're safe from things like anthrax, and I think it has raised Congress' awareness about this lack of capacity in the system. When people are feeling like they're pretty healthy and their families are pretty safe, it takes a long time to get them all steamed up about systems change. When people are worried, they act. The question remains, what are we going to do about it? We have this opportunity to make gains in this whole area of preparedness, rather than just stockpiling Cipro®. It's critical that the right decisions be made.

What's needed to get the public health system up and running right?

BERKOWITZ — We're scientists, not marketers. We need to start reaching out and bringing many, many other partners — educators, business people and faith communities — to the table. Public health can articulate its problems, concerns and issues, but we need partners to translate those issues to the public. We also need to remember that the general public includes policymakers. People in government need to understand what the public health system is capable of doing, and what we need to do that job right. For more information, see <www.turningpointprogram.org>.

— INTERVIEW BY
ELIZABETH AUSTIN

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Racial Disparities in Access to Care Pervasive in Managed Care Plans

Racial and ethnic minorities historically have had less access to health care than whites in the United States. Given the dominance of managed care and higher enrollment of minorities in these types of plans, investigators set out to learn whether such disparities exist in tightly managed care plans, and whether the gaps in access to medical care between minorities and whites are as wide in managed care as they are in other types of health plans. Their findings were sobering.

In a survey of more than 60,000 individuals, investigators found that Americans of all backgrounds have better access to care under managed care plans. However, ethnic disparities are about as pervasive in managed care plans as they are in other types of health plans.

The Community Tracking Study (CTS) is conducted by the Center for Studying Health System Change, a Washington-based policy research group funded solely by RWJF. Investigators used the 1996–97 CTS Household Survey to assess differences in access among whites, Hispanics and African Americans. Investigators asked questions about the following five access measures: having a usual source of care; having a regular provider; visiting a physician in the previous year; number of visits to the

emergency department in the previous year; and whether the last physician visit was to a specialist. In particular, investigators wanted to learn whether managed care’s feature of ensuring a primary care doctor and having primary care providers (PCPs) refer patients to specialists would reduce racial disparities in access to and use of medical care.

Certain overall trends existed across both plan types. For instance, Hispanics scored lower than whites on all five measures of access. African Americans scored

used emergency care more frequently than Hispanics (10 percent compared with 8 percent). With the exception of specialist visits, all groups reported better access under managed care than under other plan types, but the range in their differences remained fairly constant between plan types.

In particular, the survey found that visits to primary care providers and specialists were particularly low for Hispanics, regardless of health plan type. In plans without PCP and referral requirements (gatekeeping),

Differences in Access to and Use of Medical Care Among Whites, Hispanics and African Americans in Plans with or without Gatekeeping†

Measures of Access and Use	Plans without PCP and Referral Requirements			Plans with PCP and Referral Requirements		
	African American	Hispanic	White	African American	Hispanic	White
Has a usual source of care	84.1 ^{*,**}	85.0 ^{**}	89.7 ^{**}	89.0 ^{*,**}	88.9 ^{**}	93.0 ^{**}
Has a regular provider	70.2 [*]	72.9	77.2 ^{**}	73.9 [*]	74.0 [*]	80.5 ^{**}
Visit to physician in last year	77.5 ^{**}	72.1 [*]	78.7 ^{**}	82.9 ^{**}	76.0 [*]	83.1 ^{**}
Proportion of physician visits in ER during the last 12 months	10.3 [*]	8.7	6.4 ^{**}	9.4 [*]	7.1	5.7 ^{**}
Last physician visit to a specialist	26.9	24.6 ^{**}	29.5 ^{**}	24.0	20.5 ^{**}	25.0 ^{**}

Source: Community Tracking Study 1996–97 Household Survey

Note: * Significantly different from white persons within gatekeeping arrangement category, P < 0.05

** Significant difference between gatekeeping and non-gatekeeping arrangements within racial or ethnic category, P < 0.05

† Percentages are weighted to account for the complex design of the Household Survey. Multivariate analysis was used to adjust for patient age, sex, education, marital status, health status, income relative to the Federal Poverty Level, attitudes toward risk and cost/choice trade-offs, public or privately purchased insurance, and CTS survey site.

lower than whites on all measures except on physician visits, where scores between the two groups were about equal. When compared with Hispanics, African Americans were significantly more likely to have seen a doctor in the previous year (80 percent compared with 74 percent) and to have seen a specialist (26 percent compared with 22 percent). At the same time, African Americans

72 percent of Hispanics visited a physician in the previous year compared with 78 percent of African Americans and 79 percent of whites. Under managed care, 76 percent of Hispanics saw a physician, compared with 83 percent of blacks and whites.

Investigators conclude that managed care, particularly with its policies to promote primary care, could do better in reducing ethnic

and racial disparities in access to care. Plans could improve their performance by starting to collect data on access measures by ethnicity, but what seems to be missing is any motivation to do so. “It is not clear that health plans have incentives to encourage such response to racial and ethnic disparities in access and use of care beyond their own mission to manage health care services in a cost-effective fashion.”

Hargraves JL, Cunningham PJ and Hughes RG. Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans. *Health Services Research* 36(5): 853–868, 2001.

Does Methadone Maintenance Work in a Primary Care Setting?

For heroin users and individuals dependent on other opioid drugs, methadone maintenance is the most effective medical treatment. However, this therapy can only be provided in federally licensed narcotic treatment programs (NTPs) — which some contend marginalizes and stigmatizes the medical care. In fact, fewer than 25 percent of opioid addicts enter treatment. Policymakers and clinicians suggest that restructuring methadone maintenance therapy by bringing it under the auspices of patients’ primary care physicians may increase the number of opioid users entering treatment while enhancing their quality of care.

In this study, researchers compared the effectiveness of methadone maintenance therapy provided in primary care physician offices and in NTPs. As part of the six-month clinical trial, 46 clinically stable opioid-dependent patients were randomly assigned to either office-based treatment or continuing treatment in an NTP.

Six general internal medicine physicians cared for patients assigned to office-based

methadone maintenance; all of these physicians first received specialized addiction training. Patients visited the office weekly to receive their methadone supply, met monthly with physicians for counseling sessions and provided random urine samples. Patients treated in the NTPs followed a similar regimen, although some visited their NTP more often — up to three times a week for methadone — and participated in monthly counseling sessions.

The investigators looked at the difference in relapse rates between the two groups. They measured patients’ use of illicit drugs during the clinical trial by urine and hair toxicology testing. These tests were supervised and done both randomly and on a scheduled monthly basis. Patients also self-reported their use of drugs and satisfaction with the treatment program.

Some 55 percent of patients in the office-based care relapsed to drug use during the study, compared to 42 percent of the patients in the NTP therapy. Yet, office-based patients expressed significantly higher levels of satisfaction with both treatment and quality of care. Some 77 percent of office-based patients were very satisfied with their treatment compared to 38 percent of NTP patients. Almost all of the office-based patients said they would like to continue treatment under their primary care physician and were satisfied with the timeliness and convenience of appointments and the courteousness and respect shown by physicians and their staff.

“Our results support and extend prior research that has demonstrated the efficacy of transferring stabilized opioid-dependent patients to physicians,” the authors state. However, they caution, in any treatment setting, ongoing clinical evaluation and monitoring by physicians are vital.

Fiellin DA, O’Connor PG, Chawarski M, Pakes JP, Pantaloni MV and Schottenfeld

RS. Methadone Maintenance in Primary Care: A Randomized Controlled Trial. *The Journal of the American Medical Association* 286(14): 1724–1731, 2001.

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

Getting Rid of Gatekeeping: The Impact on Utilization

Managed care and gatekeeping go hand-in-hand. Primary care physicians, typically internists, family practitioners and pediatricians, serve as gatekeepers, patients’ portal to specialty care. These physicians must give their approval and often complete a written referral order before a patient can see a cardiologist, orthopedic surgeon, neurologist or other specialist. From the managed care organization’s (MCO) perspective, gatekeepers ensure that patients’ health care needs are routinely met at the first and least-expensive rung in the health care ladder.

However, conflicting opinions and evidence suggest that gatekeeping may not always work as intended. It does not always reduce utilization of specialists, and many patients dislike the policy that requires them to see a primary care physician before they can see the specialist they feel they really need. In response, a handful of MCOs have eliminated gatekeeping.

This study examined the impact of the removal of gatekeeping in a large health plan. In April 1998, Harvard Vanguard Medical Associates (previously known as Harvard Community Health Plan), a large, multispecialty group practice, eliminated its 25-year-old gatekeeping system. On their own, patients could schedule appointments with any specialists in the practice.

The investigators found “only small differences in the mean numbers of visits to generalists

and specialists” among adult patients before and after gatekeeping. On average, patients visited a primary care physician 1.21 times in a six-month period under gatekeeping and 1.19 times after the removal of gatekeeping. The average rate of visits to specialists did not change with the elimination of gatekeeping, remaining at .78 visits per patient in a six-month period. First-time visits to a specialist rose slightly from .19 visits per patient per six months to .22 visits, an increase of about 30 first-time consultations for every 1,000 enrolled adults. The only significant change was an increase in the number of visits to occupational or physical therapists and orthopedists for low back pain. This visit rate changed “substantially” with the removal of gatekeeping, jumping from 64.5 visits to 71.4 visits for every 1,000 adults in a six-month period. Given the prevalence of back pain in the general population, this finding is not surprising, the researchers contend.

The authors conclude: “We found little evidence of substantial changes in the use of specialty services among adults in the first 18 months after the end of gatekeeping.” Some possible explanations are offered. Because habits change slowly, it may take longer than a year and a half for new care patterns to emerge. Or, these patients — either through “self-selection, experience, or acculturation” — were less likely to seek access to specialty care directly even when they had the ability to do so.

Ferris TG, Chang Y, Blumenthal D and Pearson SD. Leaving Gatekeeping Behind: Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization. *The New England Journal of Medicine* 345(18): 1312–1317, 2001.

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

Spirituality Important to African Americans in Treating Depression

In a small study of patients in an urban, university-based primary care clinic, African Americans were three times more likely than whites to rate spirituality as an extremely important dimension of depression care.

This finding comes from a survey of 49 whites and 27 African Americans. Survey respondents were asked to rate the importance of 126 aspects of depression care.

Thirty of the aspects rated most important by both groups came from the following nine categories: health professionals' interpersonal skills, primary care provider recognition of depression, treatment effectiveness, treatment problems, patient understanding about treatment, intrinsic spirituality, financial access, life experiences and social support. Most aspects of depression care were rated similarly by both ethnic groups, with the exception of items that concern spirituality.

African Americans cited personal issues of spirituality — faith in God, belief in God's forgiveness, and prayer — as being among the 10 most important aspects of depression care. White participants rated these same aspects below the top 24 in importance. Less personal displays of faith, such as church attendance, rated below the top 30 across the entire sample.

Researchers note that disparities in mental health care usage, quality and outcomes between whites and African Americans are long-standing and well documented. Along with cost issues, the fear of social stigma, mistrust toward mental health professionals and fear of antidepressant or psychotropic drugs may prevent some African Americans from seeking depression care. Further, studies

find that, when compared with whites, African Americans are more likely to drop out of psychotherapy, less likely to take their medications routinely and less likely to be referred to mental health specialists, even though they report favoring counseling over medication to treat depression.

Even though African Americans are using more general medical services for mental health problems, studies show that they are not adequately treated for depression. Researchers believe the illness is poorly recognized by patients and providers.

The investigators say findings from their survey and previous studies indicate that patients with strong beliefs want physicians to discuss faith and spirituality during treatment. Yet physicians say they lack the time and training to do so. The researchers suggest that physicians could make referrals to pastoral counselors, with patients' consent. They say this exploratory study suggests that acknowledgment of spirituality within the context of care for depression may be particularly important for African Americans.

Cooper LA, Brown C, Vu HT, Ford DE and Powe NR. How Important Is Intrinsic Spirituality in Depression Care? *Journal of General Internal Medicine* 16(Sept.): 634–638, 2001.

Dr. Cooper was a fellow in the Robert Wood Johnson Foundation Minority Medical Faculty Development Program at the time of this research.

Providing Quality Pain Management for the Elderly

Among the elderly — especially those in nursing homes and long-term care facilities — pain is a common complaint. Chronic pain, defined as “persistent or episodic pain of a duration or intensity that affects the function or well-being of the patient,” may cause depression, sleep disturbances and difficulty in

walking or getting around. In addition, elders in pain often use more health care services.

While most elderly patients seek relief from their pain, the risks and benefits of treatment options must be assessed continually by patients and physicians. In fact, there is little consensus among clinicians on specific pain management techniques for individual illnesses or conditions.

Using a comprehensive literature review and an expert panel, the investigators in this study developed the following seven quality indicators for management of chronic pain. The indicators focus specifically on screening, general management and follow-up for chronic painful conditions.

- **Indicator 1:** All elderly persons should be screened for chronic pain during new patient visits because they often suffer pain that goes unrecognized by health care providers.
- **Indicator 2:** For this same reason, all elderly patients should be screened for chronic pain every two years. The very old, elders who are cognitively impaired, minority elderly and those who take multiple medications are less likely to receive adequate pain management.
- **Indicator 3:** Elderly patients with new chronic painful conditions should have a physical examination and targeted history within one month of the time they notice or report the condition.
- **Indicator 4:** When physicians prescribe a non-steroidal, anti-inflammatory drug for the treatment of chronic pain in the elderly (often for osteoarthritis) they should indicate in the medical record whether the patient has a history of gastrointestinal ulcers. Ulcers and gastrointestinal bleeding are common side effects of these drugs.
- **Indicator 5:** When physicians prescribe opioids for the treatment of chronic pain in the elderly, they should explain to

them, and document in the medical record, the increased risk of constipation.

- **Indicator 6:** When elderly patients have a new chronic painful condition, physicians should offer pain treatment because it can potentially provide pain relief and improve the quality of life and health.
- **Indicator 7:** Elderly patients who are treated for painful chronic conditions should be reevaluated every six months to assure that treatments are effective and appropriate and result in the best possible outcomes.

The authors suggest that these seven indicators can “potentially serve as a basis to compare the care provided by different health care delivery systems and changes in care over time.”

Chodosh J, Ferrell BA, Shekelle PG and Wenger NS. Quality Indicators for Pain Management in Vulnerable Elders. *Annals of Internal Medicine* 135(8): 731–735, 2001.

Dr. Chodosh was a Robert Wood Johnson Clinical Scholar at the time of this study.

Using Emergency Department Visits to Identify the Needs of Elderly Patients

Oftentimes, a visit to the emergency department (ED) can either precipitate or signal the beginning of a quick decline in older patients' abilities to care for themselves. Yet specialists in geriatrics and emergency medicine often don't know how best to coordinate care and services for these patients. Investigators in this study designed and tested a program for ED staff that successfully identified at-risk elderly patients and addressed their needs.

The program, called Systematic Intervention for a Geriatric Network of Evaluation and Treatment (SIGNET), began in 1998 in four ED sites in the Cleveland area. SIGNET identifies at-risk elderly patients, designs a

care plan for those returning home and links patients with other health care providers as well as local social service agencies for the elderly. The program defines at-risk elderly patients as being in danger of a return ED visit, an unplanned hospital stay or a nursing home placement.

Under SIGNET, the process begins with an initial questionnaire by an ED triage nurse who screens older patients for risk factors such as cognitive impairment, trouble walking and recent hospital stays.

A geriatric nurse specialist in the ED then reviews the findings of patients considered at risk. The specialist assesses their needs more thoroughly and recommends either contacting a primary care provider, other social services in the community or a geriatric management and assessment center for further evaluation. If the patient consents to the recommended help, the specialist makes the appropriate phone calls and referrals.

During an 18-month evaluation, triage nurses screened 28,000 elderly patients. About 6,700 were considered at risk as they returned home. Overall, SIGNET reduced repeat ED visits by up to 7 percent, and participating agencies reported a sixfold increase in their number of referrals. Nearly 90 percent of elderly patients who could benefit from a referral accepted help.

Mion LC, Palmer RM, Anetzberger GJ and Meldon SW. Establishing a Case-Finding and Referral System for At-Risk Older Individuals in the Emergency Department Setting: The SIGNET Model. *Journal of the American Geriatrics Society* 49(October): 1379–1386, 2001.

Labor-Management Funds Can Do More to Cut Blue-Collar Smoking Rate

Labor-management health and welfare funds, which cover an estimated 9 million smokers in the United States, are an untapped

resource for reducing smoking rates among blue-collar workers, according to a recent study. In a survey of 67 health and welfare fund administrators, only 28 percent reported that their plans covered any type of smoking-cessation service. Research finds that blue-collar workers are more likely to smoke, to smoke more heavily and to fail at quitting smoking than their white-collar or service industry peers. In 1997, 36 percent of blue-collar workers smoked compared with 21 percent of white-collar workers.

Researchers surveyed 58 business managers and 67 fund administrators of the Laborers' International Union of North America, which represents about 800,000 construction, health care, service, public sector and environmental laborers in the United States. Of the administrators who reported such coverage, 84 percent covered the nicotine patch, 47 percent covered nicotine gum and 11 percent covered smoking-cessation classes.

Researchers also assessed the administrators' and managers' level of concern about members' smoking and its impact on the health plan (known as a health and welfare fund), as well as the number of members who have requested smoking-cessation services. Some 65 percent of business managers, who represent members' interests in health insurance, reported concern about members' use of tobacco, while only 27 percent of fund administrators thought that trustees (who make coverage decisions) share this concern. Similarly, 67 percent of business managers, compared with 39 percent of fund administrators, reported that members' smoking had a financial impact on health plans. Over the past year, about half of managers and administrators reported that at least one union member had requested smoking cessation; the coverage rate was higher among plans whose administrators

received requests. As a result of this finding, researchers suggest that more union members should request such services.

When it comes to providing a smoking-cessation benefit, health and welfare funds are not too far behind other health plans. According to a recent survey of managed care plans, only 39 percent had partially implemented government guidelines on smoking-cessation coverage. The federal Agency for Health Care Research and Quality advises that counseling, along with pharmacological treatment, be a fully paid benefit. Only 9 percent of the managed care plans surveyed had fully implemented the guidelines.

Barbeau EM, Li Y, Sorensen G, Conlan KM, Youngstrom R and Emmons K. Coverage of Smoking Cessation Treatment by Union Health and Welfare Funds. *American Journal of Public Health* 91(9): 1412–1415, 2001.

Banning Stadium Beer Sales: Its Mixed Effect on Students and Ticket Holders

On campuses across the nation, college students routinely binge drink, consuming four or five drinks in a single sitting. In fact, many drink just to get drunk. University officials are left to deal with the consequences, which range from assaults, vandalism and accidents to injuries, alcohol poisoning and even death. As a result, many colleges have taken steps to limit alcohol availability on campus, hoping to deter both excessive drinking and the unsafe behaviors that accompany it.

In fall 1996, the University of Colorado at Boulder instituted a ban on beer sales at football games. After the 1996 and 1997 football seasons, the university's Office of Planning, Budget and Analysis surveyed students and season ticket holders by e-mail and mail, respectively, to assess

their satisfaction with the ban, their perception of its effect on crowd behavior and its impact on ticket sales. The investigators also examined changes in the number of game-day security incidents — including ejections from the stadium, arrests, assaults and student referrals to the judicial affairs office — before and after the beer sales ban.

In both 1996 and 1997, season ticket holders were neutral about the ban and its effect on their enjoyment of the game. However, they were satisfied with its effect on crowd behavior. Season ticket holders were even more satisfied with the effect of the ban on crowd behavior in 1997 than they were in 1996. Those who chose not to renew their tickets the following season said the cost of tickets, not the beer ban, was the primary reason.

Students, on the other hand, expressed dissatisfaction all the way around — with the ban, their enjoyment of the game and the ban's effect on crowd behavior.

The security data substantiated season ticket holders' perceptions about crowd behavior: The researchers found "significant and dramatic" decreases in incidents. In fact, ejections decreased by 50 percent and arrests by 45 percent the year after the ban. The number of security incidents remained low in subsequent years compared with the pre-ban year.

The authors conclude: "The Folsom Field beer ban offers an example of what can be achieved when alcohol is eliminated from an environment that often fosters disorderly and disruptive behavior."

Bormann CA and Stone MH. The Effects of Eliminating Alcohol in a College Stadium: The Folsom Field Beer Ban. *Journal of American College Health* 50(2): 81–88, 2001.



The ad at left is one of several that will appear in national newspapers and magazines as part of **Covering The Uninsured**, a public education and advertising campaign sponsored by The Robert Wood Johnson Foundation and 12 other national organizations. The \$10-million campaign, launched in mid-February, is designed to raise the profile of the issue of the uninsured and to encourage the search for solutions for the 39 million Americans who have no health care coverage. In addition to print ads, two TV spots have been developed and will air during network news shows and on cable news networks. The campaign highlights the economic and health consequences of being uninsured through the stories of individuals whose lives would turn out very differently if they or a loved one were uninsured. The 12 organizations cosponsoring the campaign are: the U.S. Chamber of Commerce, the AFL-CIO, the Business Roundtable, the Service Employees International Union, the American Medical Association, the American Nurses Association, the Health Insurance Association of America, Families USA, the American Hospital Association, the Federation of American Hospitals, the Catholic Health Association of the United States and AARP. For more information see <www.coveringtheuninsured.org>.

IN MEMORIAM

John Slade, M.D., an expert on the treatment of alcohol, tobacco and drug addiction, and one of America's pioneer advocates for tobacco control, died Jan. 29 at the age of 52. Dr. Slade suffered a stroke last July.

An internist by training, Dr. Slade had a deep, personal concern for people struggling with addiction, and he devoted his life's work to fighting that public health pandemic. He provided treatment to patients as director of the Program for Addictions at the University of Medicine and Dentistry of New Jersey School of Public Health. Dr. Slade also directed two National Programs of The Robert Wood Johnson Foundation, *Developing Leadership in Reducing Substance Abuse* and *Innovators Combating Substance Abuse*. He worked ardently for global changes in smoking laws and spoke out vigorously about the advertising and promotion of tobacco products.

Dr. Slade was a member of the team that conducted the first scholarly analysis of previously secret documents from the Brown and Williamson Tobacco Co., which formed the basis for the film "The Insider." His analysis led to a landmark series of articles in *The Journal of the American Medical Association* in 1995 as well as a book, *The Cigarette Papers*.

His groundbreaking research to prove that cigarettes are nicotine delivery devices helped make it possible for the Food and Drug Administration to claim regulatory authority over tobacco products.

National Partnership to Help Pregnant Smokers Quit

Asking a pregnant woman if she smokes seems straightforward. But given the stigma of smoking during pregnancy, the best way to help a pregnant smoker quit may be to give her a chance to respond with something besides a "yes" or "no" answer.

"One way to get around a pregnant smoker's reluctance to admit her smoking is for the health care provider to offer the woman a range of responses, such as 'I cut down a little when I found out I was pregnant' or 'I've tried quitting but I'm having trouble,'" says Cathy Melvin, Ph.D., M.P.H., director of the National Dissemination Office of *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy*, a National Program of The Robert Wood Johnson Foundation. "It sounds simple, but it can be a sensitive topic and if it's not approached in

the right way, you may miss a chance to offer assistance and guidance. The idea is to raise the issue in a way that makes the woman feel as if you want to help her, not criticize her."

That's just one example of numerous messages and strategies RWJF aims to convey with its National Partnership to Help Pregnant Smokers Quit. More than 40 organizations are joining forces with the Foundation for this program.

It's estimated that 20 percent of women smoke during their pregnancies. The partnership has three major goals: to reduce the proportion of pregnant women who smoke to 2 percent or less by 2010; to assure that all pregnant women in the United States will be screened for tobacco use; and to assure that all pregnant smokers are offered counseling as recommended by the U.S. Public Health Service Clinical Practice Guideline.

The effort will focus on prenatal health care providers, but the strategies will also target family, colleagues, insurers and the larger society to increase the social and practical support offered to pregnant smokers trying to quit.

Research has shown that every percentage point decline in the prevalence of smoking during pregnancy will prevent 1,300 low-birthweight babies and save \$21 million in direct health care costs each year.

"We have an extraordinary opportunity to help ensure the health of developing infants, newborns and mothers and to reduce health care spending at the same time," says Tracy Orleans, Ph.D., RWJF senior scientist and senior program officer.

For more information, see <www.smokefreefamilies.org>.

— LAURIE JONES

Hispanic Health Care Initiative Along the Texas/Mexico Border

Along the dusty, rutted dirt roads of south Texas, small, isolated settlements called *colonias* appear. They are often groups of shacks put together with scrap lumber, where people who have crossed the Mexican border live with no running water or electricity.

Accessible primarily by dirt roads, *colonias* can be 10 to 40 miles from the nearest town and the nearest health clinic, making access to regular health care difficult or impossible.

A four-year, \$3.8-million project to improve the health of and the delivery of health care to *colonia* residents by the Texas A&M University System Health Science Center Research Foundation is being funded by The Robert Wood Johnson Foundation. The project is being cofunded by the federal Health Resources and Services Administration (HRSA). A key goal of the project is to coordinate the disparate elements of a health care system that rarely works as a cooperative unit. Successful elements of the project will be replicated by HRSA in other border regions.

The first line of help for *colonia* residents is their community resource center, which provides housing, jobs and training in basic skills such as reading and writing, and acts as the base for the *promotoras*, or lay medical workers, who go out and serve the residents. Health clinics, often located many miles away, provide more intensive primary care — if the residents can get there. Lack of transportation is one barrier, in addition to language (see sidebar this page). Residents also are reluctant to go to clinics for fear that they will be reported to the U.S. Immigration and Naturalization Service, or simply because they have no money to pay for medical care.

One woman wanted to have her four children immunized but a provider was charging \$5 each for immunizations. She did not have the \$20 for the immunizations and was not enrolled in any of the programs that she was eligible for, such as the Children's Health Insurance Program (CHIP), says Larry Rincones, M.Ed., regional director for the Texas A&M University *Colonias* project.

Through the project, *promotoras* will learn how to enroll eligible residents in health insurance programs and collect basic surveillance data to track health issues. They will use laptop computers to deliver health education and communicate with primary care providers. The project will fund two 15-passenger vans to provide transportation to the resource centers and, if necessary, to health clinics and other medical facilities.



Transportation may have been one of the barriers facing a 34-year-old mother of six children living in a *colonia*. A *promotora* happened to find her one day at her friend's home, lying on the floor and bleeding. The woman was taken to the hospital where she was diagnosed with advanced cervical cancer. She had never received any preventive care or gynecological checkups, says Lucy



Ramirez, director of *Nuestra Clinica del Valle*, one of the two community health clinics participating in the project. The woman's children, aged four to 16, were not enrolled in school because they had contracted head lice and had never had immunizations. The clinic arranged for the children to be treated for lice and immunized — and for hospice care for the mother.

"Her cancer could have been treated," Ramirez says. "That's something that if we can catch it in time, there's no need for people to die."

— SUSAN PARKER

Dismantling the Language Barrier

About 44 million U.S. residents speak a language other than English at home. Limited ability to speak English can make it difficult for Americans to communicate critical information to their health providers. An \$18.5-million Robert Wood Johnson Foundation program will test innovative and cost-effective uses of medical interpretation for Spanish-speaking patients, the largest group of U.S. residents whose native language is not English.

It is costly to provide interpreters. As a result, health providers often rely on patients' family members or other staff, such as janitors, to translate, which is problematic, says Yolanda Partida, D.P.A., director of the newly launched RWJF National Program *Hablamos Juntos: Improving Patient-Provider Communication for Latinos*. *Hablamos Juntos* translates to "we speak together."

"They [children and others] are not prepared to deal with the human dramas that often go along with medical care and they don't always get it right," Partida says. "And for the patients, having a child or a janitor translate some of their personal information is often pretty stressful."

Latinos are more likely than other groups to develop some serious diseases, such as diabetes and

cancer. If they can better communicate with their physicians, they may have better health outcomes, Partida says.

Hablamos Juntos will test innovative ways of providing medical interpretation to patients. One approach is a computer-based interpretation system by which patients can make appointments and receive simple medical education in Spanish. Program staff also hope to learn more about the role of interpreters. For example, do interpreters need simply to translate or also to provide cultural context for health providers?

The program will pilot demonstrations in 10 communities where the Latino population has increased by a minimum of 50 percent in the past decade. Each community must design a system-wide program that would provide interpretation services at every level of health care, from primary care clinics to pharmacies to emergency rooms.

If successful, the program may demonstrate to health maintenance organizations, state governments and other large health systems that such a system-wide approach saves money, both in spreading the cost of interpreter services across a large group of providers and in achieving better health outcomes, Partida says.

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

- For improving disaster relief Medicaid, \$750,000 to United Hospital Fund of New York.
- *State Coverage Initiatives.* For providing assistance to governors, \$298,444 to National Governors' Association Center for Best Practices, Washington.
- *Communities in Charge: Financing and Delivering Health Care to the Uninsured.* One renewal award of \$568,017 to Coordinated Health System of Jefferson County, Birmingham, Ala.
- *Covering Kids and Families.* Awards to 12 sites, totaling \$11.5 million.
- *Hablamos Juntos: Improving Patient-Provider Communication for Latinos.* Two awards from the Special Opportunities Fund, totaling \$702,720.
- *Southern Rural Access Program.* Award of one grant of \$481,000 to South Carolina Healthcare Recruitment and Retention Center, Columbia.
- *State Coverage Initiatives.* Awards to four sites, totaling \$3.9 million.

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

- For planning documentary and instructional videos on health care quality, \$392,929 to Film Arts Foundation, San Francisco.
- HMO Care Management Workgroup: Transitions of Care, \$369,594 to AAHP Foundation, Washington.
- Studying value-based health care purchasing, \$688,801 to Harvard University School of Public Health, Boston.
- For a national membership program for local interfaith coalitions, \$400,000 to Interfaith Caregivers Alliance, Kansas City, Mo.
- *Allies Against Asthma: A Program to Combine Clinical and Public Health Approaches to Chronic Illness.* Renewal awards to seven sites, totaling \$9.4 million.
- *Center to Advance Palliative Care.* Award of two grants, totaling \$996,040.
- *Faith in Action II.* Awards to 71 sites, totaling \$2.5 million.
- *Improving Asthma Care for Children.* One award of \$500,000 to Children's Mercy Hospital/Truman Medical Center Family Health Partners, Kansas City, Mo.

Projects to Promote Healthy Communities and Lifestyles

- For developing indicators of family well-being, \$378,167 to Family Support America, Chicago.
- For improving the U.S./Canada comparability of health survey statistics, \$325,000 to National Center for Health Statistics, Department of Health and Human Services, Hyattsville, Md.
- For an assessment of the needs and capacity of small nonprofit agencies to deliver health and health care interventions, \$296,718 to University of Pittsburgh School of Education.
- For developing a working group on integrative doctoral programs in health and social sciences, \$299,947 to Social Science Research Council, New York.

- For improving access to public health intervention reports, \$389,805 to Syracuse University School of Information Studies, Syracuse, N.Y.
- For establishing a community-wide family health development program, a renewal award of \$700,192 to HCR Cares, Rochester, N.Y.
- For transition of the Harvard Mentoring Project, \$400,000 to Harvard University School of Public Health.
- For development and dissemination of a report on urban/suburban social and health indicators, \$749,979 to the Research Foundation of the State University of N.Y., Albany.
- For development of an updated clinical preventive services guide for employers, consumers and benefits managers, \$619,608 to Washington Business Group on Health, Washington.
- *Family Support Services Program.* A renewal award of \$3.1 million to Family Support America, Chicago, for developing statewide networks of community-based family support centers.
- *Health and Society Scholars* program. Awards to six sites, totaling \$1.2 million.
- *Injury Free Coalition for Kids: Dissemination of a Model Injury Prevention Program for Children and Adolescents.* Awards to 14 sites, totaling \$5.1 million.
- *Urban Health Initiative: Working to Ensure the Health and Safety of Children.* Renewal awards to three sites, totaling \$11.6 million.

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

- For a study of alcohol marketing and children, \$5 million to Georgetown University Institute for Health Care Research and Policy, Washington.
- *Why Youth Don't Quit: Finding Answers to Design Effective Smoking Cessation Programs,* \$3.5 million to Health Research, Buffalo, N.Y.
- For evaluation of the *Reducing Underage Drinking Through Coalitions* program, \$1.4 million to University of Minnesota School of Public Health, Minneapolis.
- For an educational campaign for restaurant owners on smoke-free restaurants, \$678,819 to University of California, San Francisco, School of Medicine.
- For a conference on tobacco control interventions for youth and young adults, \$363,026 to University of Michigan School of Public Health, Ann Arbor.
- For educating the public and policymakers about the benefits of clean indoor air policies and tobacco tax increases, \$390,000 to National Center for Tobacco-Free Kids, Washington.
- For a longitudinal study of serious adolescent offenders, \$739,486 to University of Pittsburgh School of Medicine.
- For a workshop on moral issues, human rights and tobacco control, \$296,966 to Rutgers, The State University of New Jersey, School of Communication, Information and Library Studies, New Brunswick.

- For investigating the major changes in California adolescent smoking rates, a renewal award of \$399,971 to University of California, San Diego, School of Medicine.
- For a junior faculty mentoring program associated with the Tobacco Etiology Research Network, \$552,825 to University of Kentucky Research Foundation, Lexington.
- *Addressing Tobacco in Managed Care.* Awards to six sites, totaling \$1.6 million.
- *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol.* Renewal award for evaluation dissemination, \$368,411 to Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, Mass.
- *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* Renewal award for evaluation of the program, \$3.6 million to Wake Forest University School of Medicine, Winston-Salem, N.C.
- *Innovators Combating Substance Abuse.* One award of \$299,808 to Health Research, Buffalo, N.Y.
- *Partners with Tobacco Use Research Centers: Advancing Transdisciplinary Science and Policy Studies.* A renewal award of \$422,883 to University of Wisconsin—Madison Medical School.
- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy.* Renewal award of \$492,026 to University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research for the Smoke-Free Families National Dissemination Office.
- *Substance Abuse Policy Research Program.* Awards to three sites, totaling \$574,333.

Other Programs and Those That Cut Across Foundation Goals

- For the Peabody/RWJF Award for Excellence in Health and Medical Programming, \$460,971 to University of Georgia, Henry W. Grady College of Journalism and Mass Communication, Athens.
- *Changes in Health Care Financing and Organization.* Awards to 12 sites, totaling \$2.8 million.
- *Local Initiative Funding Partners Program.* One award of \$475,000 to University of California, Irvine, School of Social Ecology, for a cancer control program for Chinese and Korean communities in Orange County.
- *Minority Medical Faculty Development Program.* Awards to two sites, totaling \$730,800.
- For the New Jersey Physician Recognition Program, \$504,299 to the Medical Society of New Jersey, Lawrenceville.
- For completion of headquarters renovation program, \$367,350 to the United Way of Central Jersey, Milltown.
- For assistance to needy and indigent families, \$291,325 to the Salvation Army, New Brunswick, N.J.

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

PEOPLE

JEANE ANN GRISSE, M.D., M.Sc., came to the Foundation in November as a senior program officer in the Health Care Group. Grisso is a professor of medicine and a professor of epidemiology at the University of Pennsylvania School of Medicine. She has served on the advisory board of the Center for Aging and is a fellow of the Leonard Davis Institute. She also is a fellow of the American College of Physicians and of the American Epidemiological Society. Grisso received her M.D. from the University of North Carolina at Chapel Hill, and her M.Sc. in clinical epidemiology from the London School of Hygiene and Tropical Medicine.



DWAYNE PROCTOR, Ph.D., became a senior communications officer in January, working with the Alcohol and Illegal Drugs and Community



Health program management teams. Prior to joining RWJF, Proctor was an assistant professor, teaching health communication and urban health courses at the University of Connecticut. He was also a co-chair for the marketing division of the Hartford Call-to-Action for Behavioral and Mental Health, and served as an adviser on the social marketing and media approaches for RWJF's National Program, *Cutting Back: Managed Care Screening and Brief Intervention for Risky Drinking*. He has a Ph.D. in communication science from the University of Connecticut, and was a Fulbright Fellow in Senegal 1995–1996.

STEPHANIE BERGER, M.A.M.C., joined RWJF in December as a Web editor in the Communications Department. Previously, she was the Web/editorial assistant at the International Trademark Association in New York. Berger was a correspondent for the online edition of *The Gainesville (Fla.) Sun*. She earned her master's degree in mass



communication from the University of Florida.

JEFF MEADE came to RWJF in January as Web managing editor. Meade has more than 25 years of experience in newspapers, national magazines, cable news and the Web. Prior to joining the Foundation, he was the news director and features editor for IntelliHealth.com, an award-winning consumer health Web site.



PROMOTIONS

MINNA JUNG, ESQ., was promoted in January from communications associate to communications officer. Jung will continue to contribute to the work of the Supportive Services and Coverage program management teams.

DAVID WALDMAN, M.A., has been promoted from director of Human Resources to vice president of Human Resources. Waldman has played a lead role in developing the HR Department, encouraging staff development at all levels and addressing the many facets of organizational development at RWJF.

BOARD OF TRUSTEES

MARLA E. SALMON, Sc.D., R.N., dean and professor of the Nell Hodgson Woodruff School of Nursing and professor of the Rollins School of Public Health at Emory University, Atlanta, has been elected to The Robert Wood Johnson Foundation's Board of Trustees.

Salmon received her B.A., B.S.N. and M.S.N. from the University of Portland and her doctorate in health policy and administration from Johns Hopkins University. Early in her career, she was a Fulbright scholar at the University of Cologne in Germany, focusing on national health systems development.

Her academic administration and teaching career has involved leadership positions in both nursing and public health at the University of Minnesota, University of North Carolina and University of Pennsylvania. In addition, Salmon has worked as director of the Division of Nursing in the Bureau of Health Professions, U.S. Department of Health and Human Services, and was a U.S. delegate to the World Health Assembly. She chaired the Global Advisory Group on Nursing and Midwifery and is the founding director of the Lillian Carter Center for International Nursing at Emory.

New Grant Results Reports Posted on RWJF Web Site

In January 2002, 52 new Grant Results Reports and two National Program Reports were posted at <www.rwjf.org>. Reports are organized by topic area. The search engine allows a full-text search. Newly added reports include:

- **Southern Regional Initiative to Improve Access to Benefits for Low-Income Families with Children.** The Southern Institute on Children and Families (SICF) prepared this report, which is based on site

visits to all southern states and the District of Columbia, to improve awareness among and outreach efforts to low-income families about benefits they are entitled to receive, including Medicaid and child care. The report and other project-related publications are available free of charge at the SICF Web site <www.kidsouth.org>.

- **Safe Night USA.** The University of Wisconsin–Madison, in cooperation with Wisconsin Public Television, produced this

one-night substance abuse and violence prevention event, held simultaneously in more than 1,100 cities covering all 50 states. Approximately 1.22 million people viewed the event on the 90 percent of U.S. public television stations that participated, as well as on Black Entertainment Television. Safe Night USA activities were sponsored by local affiliates of 10 national organizations, including Boys & Girls Clubs of America, 4-H National

Council and 100 Black Men of America. Locally sponsored Safe Night activities continue. A Safe Night planning kit, media kit and promotional video are available free of charge by contacting Maria Alvarez-Stroud at alvarez-stroud@wpt.org.

These new postings bring the total to some 560 Grant Results Reports and 24 National Program Reports covering more than 1,200 grants available on the RWJF Web site.

— MARIAN BASS