Reaffirming Mission and Values

➢ *In 2002, The Robert Wood Johnson Foundation marked its 30th year of making grants to improve the health and health care of all Americans. By early 2003, those awards totaled $5 billion. We start our fourth decade with new leadership, renewed energy and a new focus on objectives whose results will be both measurable and meaningful.*

President's Message

It is difficult to express fully what an honor and a privilege it has been to serve as president of The Robert Wood Johnson Foundation for the past 12-and-a-half years. This experience has been the highlight of my professional life, one that I will look back on with tremendous satisfaction. I will wear with pride the badge of RWJF for the rest of my days. In this, my last President's Message, I want simply to close with thanks.

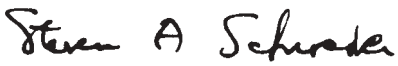
Thanks to the Trustees in 1989 for having the courage to select a relatively unknown Californian to be their third president and to the subsequent Trustees for their unfailing support of the Foundation's mission and of me personally.

Thanks to spectacular staff members, who come to work every day with energy, passion and an unquenchable will to fulfill our mission. They know all too well one of the lessons I have learned, that social change comes hard, but they never seem to lose their enthusiasm.

Thanks to our grantees, who work so diligently to help us fulfill the Foundation's mission. Not surprisingly, given our eclectic set of grantmaking strategies, our grantees come in all sorts of packages. What they share is a devotion to their work.

It is not easy for me to leave The Robert Wood Johnson Foundation. Our work here is truly precious. The work is a lot harder than many on the outside probably suspect, but the cause is glorious and the rewards are great. I depart with the mixed sense of loss of such a wonderful job and pride that the institution is stronger now than when I arrived in July 1990. My personal pride is tempered by the realization that at the end of her tenure, my successor, Risa Lavizzo-Mourey, will undoubtedly make the same statement.

Thanks to all of you for all that you have given to the Foundation, to our mission and to me. I am excited to see what paths Risa takes the Foundation down, and I will be cheering all of you on loudly, from afar.



Steven A. Schroeder, M.D.
President and Chief Executive Officer
December 2002

Chairman's Statement

Two thousand two was a successful yet bittersweet year for the Foundation. On the one hand, we said goodbye and offered a deeply felt thank you to President and Chief Executive Officer Steven A. Schroeder, M.D. On the other, we looked forward with anticipation to the years ahead under the leadership of Steve's successor, Risa Lavizzo-Mourey, M.D., M.B.A.

In the simplest numerical terms, over the past 12 years, Steve oversaw the growth of The Robert Wood Johnson Foundation's assets from $2.9 billion to $8 billion, a rise in the scale of annual grantmaking from $132 million to more than $400 million, a major facility expansion, and a substantial increase in the scope of activity and corresponding number of staff. But his real and enduring contribution goes deeper than those numbers. During his tenure, Steve took the initiative to address the compelling challenge of substance abuse and focused the Foundation on fighting the battle to reduce tobacco use, especially among teens. He pushed hard to improve access to care and better the lives of those with chronic conditions, and moved the Foundation to make health the equal partner of health care, our traditional focus. He fostered strong working relationships among staff, Trustees and grantees, attracted and retained talented and deeply committed staff, and built a culture of respect and trust.

Steve's commitment and extraordinary success put The Robert Wood Johnson Foundation in a strong position and facilitated our search for a new president. We knew that the fundamentals, based on our core values and commitments—to our mission, to our grantees, to our staff—were sound. As Steve has reminded us so often, "mission matters," and our mission—to improve the health and health care of all Americans—remains our guiding star.

The Foundation's Board is enthusiastic that Risa Lavizzo-Mourey has agreed to succeed Steve Schroeder and to begin the next phase in a rich legacy of accomplishment. Risa has a superb record in academic medicine, in her specialty of geriatrics, in government and in her most recent stint as senior vice president at RWJF. The Foundation identified Risa almost 20 years ago as an up-and-coming young leader in health care, when she was named a Robert Wood Johnson Clinical Scholar. Time and experience have only burnished our confidence in her. Risa has voiced enormous respect for the work of her predecessor and for the accomplishments of the Foundation, but it is clear that she will have her own goals and directions, as she should. We look forward to working with Risa in the years ahead to build on Steve Schroeder's exemplary record of leadership, service and achievement in fulfilling The Robert Wood Johnson Foundation's enduring mission.

Robert E. Campbell
Chairman, Board of Trustees
December 2002

Reaffirming Mission and Values

Access

To assure that all Americans have access to basic health care at reasonable cost.*

Chronic Health Conditions

To improve care and support for people with chronic health conditions.*

Health & Well-Being

To promote healthy communities and lifestyles.

Substance Abuse

To reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

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* In January 2003, the Foundation revised our access and chronic health conditions goals to reflect our commitment to improving the *quality* of care available to all Americans. The two revised goal statements are: *to assure that all Americans have access to quality health care at reasonable cost* and *to improve the quality of care and support for people with chronic health conditions.*

Foundation goal since	1972
Number of Grants and Contracts Awarded in 2002*	151
Dollar Amount of Grants and Contracts Awarded in 2002*	$101,283,753

Goals Update:

Access

Millions of Americans still cannot gain access to the health care they need because they lack health insurance. According to recent census data, more than 1.4 million people lost their health insurance in 2001, pushing the total number of uninsured to over 41 million. Contrary to widespread belief, the problem is not confined simply to unemployed or poor individuals. More than half of the uninsured report annual incomes of more than $75,000 and eight out of 10 are in working families.

The sluggish economy, sharp increases in health care costs, and rising state and federal budget deficits have put existing public and private coverage programs at risk, making the coverage problem even more precarious.

Forty-four percent of the country's large employers increased health insurance premiums and out-of-pocket expenses to their employees in 2002, with more than three-fourths expected to do the same in 2003. States facing large deficits have already started cutting back on their state-administered, publicly-supported coverage programs.

Although lack of coverage is the threshold barrier for many Americans who need health care, other Americans often find their access to services restricted in other ways. Where a person lives, the language he or she speaks and factors like race or ethnicity may have a dramatic effect on the quality of health care that a patient ultimately receives. A recent survey showed that 94 percent of health care providers rated the communication between a doctor and patient as the top issue affecting the quality of care, and more than seven out of 10 stated that language barriers limit a patient's understanding of treatment advice and of disease.

** Award amounts do not include cross-cutting grants and contracts that address more than one of the Foundation's goals.*

Getting Kids Covered

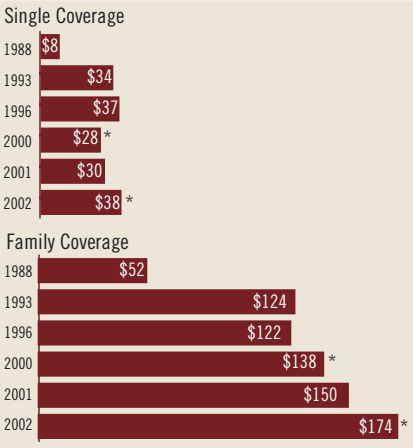
Nearly 5 million children in the United States who currently lack health insurance are eligible for low-cost or free health care coverage through the State Children's Health Insurance Program (SCHIP) and Medicaid, but they are not enrolled. Since 1997, the Foundation has been working to address this problem through its *Covering Kids* initiative. The program now supports projects in all 50 states and the District of Columbia. *Covering Kids* has funded numerous state Medicaid agencies and local coalitions that help remove barriers—some administrative, some based on perceptions about eligibility for these programs—to enrolling children in SCHIP and Medicaid.

Covering Kids recently evolved into the $55-million, four-year *Covering Kids and Families*® program, reflecting the Foundation's commitment to help states also cover parents and other adults who work in jobs that do not provide health coverage for them or their children.

In 2002, the Foundation awarded $28.6 million to 34 sites as part of the *Covering Kids and Families* program. Projects include one in Arizona, where state health officials are training emergency room, adult learning center, trade school and community college staff about the availability of public insurance and how they can help promote and assist with enrollment in these programs. Michigan began an online "e-application" process for all health coverage programs. Texas eliminated the face-to-face interview previously required of Medicaid recipients after the first six months of coverage.

A communications campaign has been instrumental to the success of the *Covering Kids and Families* program. The "Back-to-School" campaign involves advertising to raise awareness about eligibility for public coverage programs, and, each year, sponsorship by the Foundation and its partners of a late summer effort to publicize the importance of enrollment at the key time when children are returning for a new school year. The Back-to-School campaign has generated more than half a million calls into state and federal toll-free hotlines since 1997. More than 4,000 organizations nationwide have become actively engaged in finding, enrolling and retaining eligible children in Medicaid and SCHIP.

Average Monthly Worker Contribution for Health Coverage, 1988–2002



*Estimate is statistically different from the previous year shown: 1996–2000, 2000–2001, 2001–2002.
Source: Employer-Sponsored Health Benefits 2002 Annual Survey. *Kaiser Family Foundation and Health Research and Educational Trust*. Available at: *www.kff.org/content/2002/20020905a/chartpack.ppt*.

Keeping the Uninsured in the Public Eye

To complement the *Covering Kids and Families* work to expand enrollment, and to move the issue of 41-plus million uninsured higher on the national agenda, the Foundation launched a major advertising campaign, "Covering the Uninsured," in February 2002. Twelve other leading national organizations, including the U.S. Chamber of Commerce and the AFL-CIO, signed on as co-sponsors of the campaign. The campaign's series of four print ads and two television commercials, which appeared frequently in leading media markets throughout the nation, depicts the stark difference in health outcomes between those who have insurance and those who do not.

The campaign garnered attention from other major organizations and policy-makers, many of whom were eager to join the effort. The Foundation built on the campaign's momentum with funding for Cover the Uninsured Week, March 10–16, 2003. The week-long event consisted of organized national and local activities to draw attention to the problems of the uninsured and highlight possible solutions. The activities included free health care screenings for the uninsured during health fairs; special events to enroll eligible individuals in public health coverage programs; meetings in which public officials, businesses and leaders discussed the problem of the uninsured; interfaith prayer breakfasts and sermons focused on moral concerns about more than 41 million uninsured friends, neighbors and family members; and inclusion of themes about the uninsured in television shows. Many leading organizations and other foundations signed up to support the week's activities, and former Presidents Gerald Ford and Jimmy Carter agreed to serve as honorary chairs.

Institute of Medicine Studies Uninsured

In 2002, the Institute of Medicine released its first two "Surveying the Consequences of Uninsurance" reports. The Foundation-funded project will help provide objective data to highlight the effects of America's urgent coverage problem. In May, *Care Without Coverage: Too Little, Too Late* reported that working-age Americans without health insurance have poorer health and die prematurely. In September, *Health Insurance Is a Family Matter* examined the impact of being uninsured on families and on the health of infants, children and pregnant women. The report found that one-fifth of the

38 million families in America with children have at least one member who is uninsured and that the lack of insurance of just one family member adversely affects the health, emotional well-being and financial stability of the entire household.

State Coverage Initiatives

Through the Foundation's *State Coverage Initiatives* program, states can receive funding and assistance to help expand coverage options through both public and private programs. In 2002, this program's role became even more important as states began grappling with growing budgetary shortfalls created by the economic slowdown and rising health care costs. In 2002, six sites shared $4.1 million for programs such as Oregon's effort to seek federal matching funds for its Family Health Insurance Assistance Program.

Breaking Down Barriers to Health Care

While health insurance is often crucial to obtaining health care services, access can also be affected by other factors—where one lives, the language one speaks, and by one's race or ethnicity. For instance, research shows that non-English speakers are less likely to use primary and preventive care services, less likely to correctly use prescribed medications and more likely to use emergency rooms.

Hablamos Juntos is one of several Foundation projects aimed at these barriers to medical and dental care. *Hablamos Juntos*—Spanish for "we speak together"—is an $18.5-million program to enhance communication between Latino patients and their providers by improving how interpreters and translated health materials are deployed in health care settings. In 2002, the program awarded its first grants to 10 organizations, including

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Covering Kids | *Atwater, California*

Most uninsured children are eligible for low-cost or free health care coverage through the State Children's Health Insurance Program or Medicaid, but their parents are unaware of their eligibility. The *Covering Kids* national communications campaign lets families know about coverage programs for children. Ana Maria Alvarado and Pedro Royo both work, but their employers do not offer health insurance. In the past, when one of their four children got sick, the financial and emotional strain was terrible. Through a school outreach worker, Ana Maria learned about California's Healthy Families program. Now, Ana Maria's children are enrolled and getting good, affordable care.

The Alvarado family, from left: Jeanette, Pedro Jr., Vanessa, Ana Maria and Ivan. Prior to enrolling in the Healthy Families program, Ana Maria used over-the-counter products and home remedies when her children were sick. When all else failed, she would take them to the hospital emergency room because she didn't know where else to go.

Pedro is a formidable opponent for his brother Ivan as they shoot hoops on the court. Pedro is the star running back on his high school varsity football team and dreams about playing in the NFL. Without the health care coverage he receives through Healthy Families he would not have permission to play on the team.

Immediately after enrolling in the Healthy Families program, Pedro Jr. began experiencing severe stomach pains. For five dollars Ana Maria was able to take him to a doctor who diagnosed a stomach infection caused by high levels of enzymes. After receiving an antibiotic, the infection quickly cleared up.

At the local playground Pedro, Ivan and Vanessa climb on the jungle gym. In the past this sort of activity made Ana Maria nervous because, if one of them got hurt, she did not know how she would pay for their medical care. Now, since their enrollment in Healthy Families, the Alvarado children are covered should an accident occur.

hospitals, a health plan and community organizations, across the United States.

Repairing the Safety Net

People without health insurance often cannot afford regular health care and are forced to rely on the safety net—the patchwork of services offered primarily through clinics and emergency rooms—for their most acute health care needs. As a result, hospital emergency rooms are often overcrowded and unable to handle rising volumes of patients. An April 2002 national survey found that 62 percent of all U.S. hospital emergency departments were at or over operating capacity, with the proportion rising to 79 percent for urban hospitals and 87 percent for Level I trauma centers. In September 2002, RWJF unveiled a new initiative, *Urgent Matters,* to provide technical assistance to hospitals to help them reduce emergency room overcrowding. Grantees will also undertake a research-based assessment of their local safety net to serve as a springboard to raise awareness with local stakeholders about emergency room capacity and use. The program will also fund four demonstration sites to implement innovative models to improve the flow of patients through emergency departments.

Addressing Racial and Ethnic Disparities in Health Care

Although certain barriers to accessing health care exist across all racial and ethnic groups, some disparities in health care can be attributed to race or ethnicity alone. In 2002, following on the heels of a groundbreaking report issued by the Institute of Medicine on racial and ethnic disparities in health care, a report by the Henry J. Kaiser Family Foundation and the American College of Cardiology Foundation examined 81 cardiac care studies and identified disparities in care for at least one racial/ethnic minority group in at least two-thirds of the studies. This report is the central feature of the Initiative to Engage Physicians in Dialogue about Racial/Ethnic Disparities in Medical Care, co-sponsored by RWJF and the Kaiser Family Foundation. The partnership with organizations such as the American College of Cardiology Foundation and the Association of Black Cardiologists has committed $1 million to raise awareness among physicians of these disparities.

The project has two main components: an advertising campaign in major medical publications and an outreach effort to engage physicians in discussion of how to reduce racial and ethnic disparities. The program, launched in late 2002 with advertisements in 10 leading medical publications, encourages physicians to review a Web-based research report on racial/ethnic differences in cardiac care and evidence-based guidelines for quality care.

Strengthening the Oral Health Delivery System

In 2000, the first-ever Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases among certain populations, particularly those who are poor, medically disabled or geographically isolated. Research has shown that poor oral health is a key indicator of poor health overall. Experts suggest that the decline of oral health in these populations could be addressed in part through increasing the numbers of underrepresented minorities in dentistry and other health care professions.

In 2002, the Foundation awarded $15 million in five-year grants to 10 dental schools through the *Pipeline, Profession and Practice: Community-Based Dental Education* program. The goals of the program are to change the curricula of these schools to teach students about community-based dental practices, encourage schools to expand their clinical training of students in underserved areas and increase the number of underrepresented minority and low-income students training to become dentists.

In Washington state, where 25 percent of families cannot access dental care, the University of Washington dental school expects to triple the number of fourth-year dental students it places in the state's rural and urban community clinics. In North Carolina, a state with a dental workforce shortage, the University of North Carolina dental school will increase dental enrollment and expand its community-based clinical education. Other schools will offer language classes to dental students to enable them to better communicate with non-English-speaking patients.

States can also play a significant role in increasing the availability of oral health services. In 2002, the $6-million *State Action for Oral Health Access* program awarded grants to six states that had proven track records in improving public coverage programs like Medicaid and SCHIP. The grants will enable these states to test innovative approaches to improving access to oral health services for low-income, minority and disabled populations served by Medicaid, SCHIP and the public health system. Arizona, for example, is designing and purchasing mobile dental units to provide oral health access in rural parts of the state. Pennsylvania plans to expand the provider network and dental safety net for low-income people with special needs. Vermont expects to expand oral health care education to consumers and providers, establish a primary care dental home for youths incarcerated in juvenile justice programs, link registered dental hygienist assessments of schoolchildren with community dentists, and collaborate with education agencies to recruit and retain dentists. ■

Foundation goal since	1972
Number of Grants and Contracts Awarded in 2002*	327
Dollar Amount of Grants and Contracts Awarded in 2002*	$76,310,913

Goals Update:

Chronic Health Conditions

In the past century, advances in medicine led to longer life spans for most Americans. As the number of aging Americans increases, however, so does the number of Americans who live with one or more chronic conditions such as diabetes, heart disease, depression, arthritis, hypertension or osteoporosis. Recent research shows that almost half (45 percent) of all Americans have a chronic condition. The costs both to individuals and to the health care system are enormous. In 2000, care of chronic illness consumed 75 cents of every health care dollar spent in the United States.

The systems of financing and delivering medical care in this country have not yet adjusted to the complexities of caring for individuals with chronic conditions. A recent Foundation-sponsored study by researchers at the University of California, Berkeley, and the University of Chicago found that tens of millions of patients with chronic diseases are not receiving the type of integrated care proven to be most effective in managing the effects of their diseases.

Research also illustrates that the quality of health services is often substandard, even though medical practitioners are learning how to implement cost-effective, high-quality care for many of the more problematic conditions. A report issued in 2000 by the Institute of Medicine, *To Err Is Human: Building a Safer Health System,* dramatically demonstrates that as many as 98,000 hospitalized Americans die every year and 1 million more are injured as a result of preventable medical errors.

Quality of health care continues to be an issue at the end of life. Health care professionals often lack the knowledge, training and systems to enable individuals to die with dignity and support and without pain. As a result, many patients with terminal illnesses suffer needlessly in the final stages of their lives.

Finally, the nation is grappling with serious shortages in the health care workforce that are predicted to worsen. The pool of nurses and other professional caregivers—such as home health aides and personal attendants—is shrinking faster than the pool of individuals who are training for and staying in these jobs. And these problems are in part caused by low job satisfaction and lack of training and support for people in these positions.

** Award amounts do not include cross-cutting grants and contracts that address more than one of the Foundation's goals.*

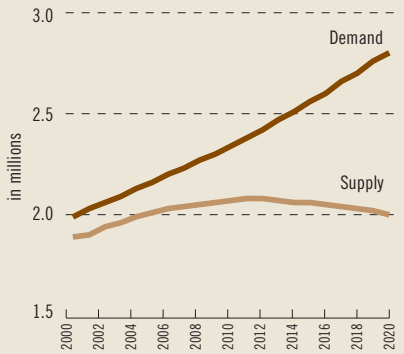
Pursuing Quality

At Tallahassee Memorial HealthCare in Florida, doctors used to write prescriptions on paper slips and deliver them to the hospital pharmacy. The pharmacy prepared the drugs and delivered them to the units where a nurse verified a three-way match between the patient's ID bracelet, the drug label and the patient record with the doctor's order. It was a system rife with potential errors.

Today, however, that process has been re-engineered. Prescriptions are generated online, sent to the pharmacy electronically (nurses view them on hospital terminals) and dispensed automatically from multiple points. Eventually, nurses will use bar codes to match the drug, patient bracelet and electronic order. The pharmacy initiative is part of a system-wide revamping at Tallahassee Memorial supported by a $1.9-million grant from *Pursuing Perfection: Raising the Bar for Health Care Performance*, a Foundation program to help hospitals and physicians' organizations dramatically improve patient outcomes by aiming for zero errors in all of their major care areas. Tallahassee Memorial is one of seven health care systems that received funding in 2002 for their quality improvement initiatives.

Even if systems strive to improve health care quality, their efforts can be hindered by a reimbursement system designed to reward expensive procedures, rather than prevention or improved outcomes. A Foundation-supported report found that providing financial and nonfinancial incentives for those on the front lines of health delivery is critical to improving quality. A new $8.8-million Foundation program, *Rewarding Results: Aligning Incentives with High-Quality Health Care*, in which the California HealthCare Foundation is a partner, seeks to support health plans that encourage and reward high-quality health care. One such plan, Blue Cross Blue Shield of Michigan, offers hospitals a reimbursement bonus if they meet certain quality goals, such as reducing surgical and hospital-acquired infection rates.

National Supply and Demand Projections for Full-time Employed Registered Nurses, 2000 to 2020



Source: Projected Supply, Demand and Shortages of Registered Nurses 2000–2020, National Sample Survey of Registered Nurses 2000. *Health Resources and Services Administration, Bureau of Health Professions.* Available at: *http://bhpr. hrsa.gov/healthworkforce/rnproject [July 2002].*

Improving Chronic Care

When Premier Health Partners of Dayton, Ohio set out to improve the care and outcomes of patients with diabetes, it started with physicians. The plan gave doctors a comprehensive Diabetes Innovation Tool Kit, which contained materials to help streamline medical records and keep physicians up-to-date on the latest diabetes research. Premier also improved the quality of diabetes care by outfitting examination rooms with the necessary tools to conduct foot exams, which are critical to appropriate management of the disease. The health plan worked collaboratively with medical staff to support patients in self-management of the disease. All of these efforts were supported by the five-year, $25-million *Improving Chronic Illness Care* (ICIC) program. ICIC has demonstrated that changes like the ones instituted by Premier Health Partners can result in better health outcomes for chronically ill patients.

The cornerstone of ICIC is the evidence-based Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. This model will be used as part of the Foundation's $6.3-million, two-pronged initiative to tackle diabetes. The Centers for Disease Control reported that diabetes reached epidemic proportions in 2001, and today, an estimated 17 million people have the disease. Most of the health care costs associated with diabetes—some $100 billion a year—could be reduced through better self-management and more coordinated care. One new program, *Advancing Diabetes Self-Management*, will award six sites up to $300,000 each to develop and test a diabetes self-management program for primary care settings. A second program, *Building Community Supports for Diabetes Care*, will award up to $125,000 for 12 months to eight provider/community coalitions to plan and test prevention and self-management activities in culturally and ethnically diverse areas.

Diabetes is just one disease in which enhancing the patient's role has generated positive results. However, few primary care practices understand how to promote this type of behavior and work in partnership with patients to develop better self-management processes. To address this gap, the Foundation launched the first phase of its Co-Management Learning Network this year, providing $1.5 million in planning grants to design and disseminate patient-centered approaches throughout the health care field.

Improving Chronic Care in Publicly-Funded Health Plans
More than half (56 percent) of those enrolled in Medicaid received care through a managed care plan in 2000, nearly a sevenfold increase from 1991. Approximately 80 percent of Medicaid resources are spent on those with chronic conditions. The Foundation's $60-million *Medicaid Managed Care Program* focuses on that managed care segment of the Medicaid arena. The program, based at the Center for Health Care Strategies, supports Medicaid managed care plans to develop new ways to deliver quality, coordinated chronic care services. For example, a plan in Minnesota has improved the coordination of care for up to 500 enrollees with physical disabilities.

Caring for the Caregiver
Many Americans with chronic conditions, including millions of frail elders, require some assistance with the activities of daily living, such as bathing and getting dressed. This help is often provided by paid paraprofessional caregivers, such as nursing assistants, home health aides and personal care attendants. However, research conducted in 2002 shows that most states (42) reported difficulties in recruiting and retaining people for these positions. These caregivers, while they assist with the most necessary tasks, are often underpaid, left out of care decisions involving the patient, and receive little to no training or support to do their jobs. As the shortages of paraprofessional caregivers worsen, and the American baby boomers age, the quality and availability of care for people with chronic conditions will be significantly affected.

To address this looming crisis, the Foundation, together with the Atlantic Philanthropies, launched a new program in 2002 called *Better Jobs, Better Care*.

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Cash and Counseling | *New Jersey*

Cash and Counseling enables Medicaid beneficiaries with chronic illnesses and disabilities to purchase needed personal assistance services with cash allowances in lieu of receiving traditional agency-delivered services. The result is greater choice and autonomy in obtaining required help. Early evaluation results show increased access and improved satisfaction for *Cash and Counseling* clients. New Jersey's *Cash and Counseling* program, Personal Preference, has enrolled approximately 1,800 participants since it began in 1999. Lisa Mangieri and Dorothy Minor, despite having very different needs, both strongly prefer making their own decisions about not only the type of care they receive but who delivers it.

Lisa Mangieri lives with her mother and father, an arrangement that allows Lisa some measure of independence despite having Friedreich's ataxia, a progressively disabling disease. She has earned a college degree and is a dedicated activist for the disabled.

Cash and Counseling enables Lisa to hire uniquely qualified, multiskilled aides such as Sonia Jackson. The aides help with her personal needs and support her work as an activist by reading and typing her correspondence. Lisa also purchased a computer with program funds, allowing her to communicate more efficiently.

Because she relies upon a wheelchair to get around, Dorothy Minor needs the help of others to accomplish daily tasks although she can still do many things for herself. Dorothy appreciates the choice she can exercise to hire aides with her *Cash and Counseling* account.

Dorothy's granddaughter, Haneefah Epps, is one of the aides Dorothy employs with her *Cash and Counseling* funds. During the week, Haneefah comes after school to do household chores and help her grandmother with her hair. Like most people who need ongoing care, Dorothy prefers to have the help come from family members. *Cash and Counseling* makes this possible.

The $15.5-million effort will support improved recruitment and retention of direct care workers—nursing assistants, home health aides, and personal care attendants—who provide care and support to elderly people and those with chronic diseases or disabilities.

Planning for the Aging of America

Adults 80 and older make up the fastest growing demographic group in America today. As adults in America age, their needs for services—such as medical care and assistance with basic tasks such as grocery shopping—increase.

To better prepare communities to care for their aging populations, the Foundation's $20-million initiative, *Community Partnerships for Older Adults*, awarded grants of $150,000 each to 13 community coalitions. The coalitions will develop plans to improve the range and coordination of services for older adults in their area, with the goal of allowing them to remain in their homes and communities whenever possible.

Although the elderly and disabled receive care through organizations and from family members, more and more communities have been tapping into volunteer faith networks for help. The Foundation's *Faith in Action*® program, which funded 164 new sites in 2002, remains at the forefront of this movement. The program gives organizations from a broad spectrum of religious affiliations grants to support volunteer programs for people with long-term health care needs or disabilities. These volunteers help with quality-of-life essentials—such as grocery shopping, paying the bills and companionship. *Faith in Action* supports programs in 42 states and the District of Columbia.

Many of the Foundation's programs emphasize the values of patient choice and autonomy in determining the type of care patients receive. The *Cash and Counseling* program, which expanded beyond the demonstration model phase in 2002, allows Medicaid beneficiaries to receive direct cash allowances to pay for home care, rather than simply providing standard agency services. Beneficiaries therefore have greater flexibility and freedom to design their own care plans. *Cash and Counseling* operated as a three-state demonstration project in Arkansas, Florida and New Jersey since 1995. Many participants have used funds to pay caregivers who are family members, friends or neighbors and can help at times when they are most needed. Others have used their cash allowances to modify their homes and cars, or to pay for devices such as touch lamps that enable them to live more independently. The success of the *Cash and Counseling* program is becoming more widespread. In 2002, the Centers for Medicare and Medicaid Services announced Medicaid waivers allowing other states to replicate this individualized model of chronic care support.

The Foundation also embarked on a major research effort to better understand the needs of Americans, particularly African Americans, Hispanics and Asians, among others, in the areas of long-term care and caregiving. The first phase of the research took place in 2002. The next phase will involve a national survey of several ethnic groups. The results will be used to inform current and future RWJF programming.

Improving End-of-Life and Palliative Care

A 2002 Foundation-sponsored report by the *Last Acts*® coalition, *Means to a Better End*, evaluated the 50 states and the District of Columbia on their ability to provide care at the end of life. The report, examining practices such as palliative care, advance directives, nurse and physician training, and hospice care, found that no state did better than a mediocre job in providing end-of-life care.

Yet there are also signs of success:

- *U.S. News & World Report* included palliative care in its rankings of America's Best Hospitals for the first time in 2002.
- The American College of Surgeons will add content on end-of-life care to its board exam.
- *Last Acts*, the Foundation-supported campaign to improve end-of-life care, now has 1,080 partner organizations, up from 79 when it began in 1997.
- *Last Acts* introduced a broad set of principles designed to improve end-of-life and palliative care for children and their families in response to a July 2002 Institute of Medicine report that found significant deficiencies in this area.

The Foundation's *Promoting Excellence in End-of-Life Care* program has tested several care system improvements. For example, the University of Michigan Cancer Center integrated hospice into care planning even as life-prolonging treatment continued. The project found that patients enjoy a better quality of life when hospice is provided *before* the final weeks of life, rather than once all treatment options are exhausted.

Although a great number of Americans receive highly skilled, state-of-the-art and sometimes lifesaving care in intensive care units (ICUs), these technologically-focused settings rarely meet the full array of needs of critically ill patients and their families. A new $2.2-million Foundation initiative, *Promoting Palliative Care Excellence in Intensive Care*, seeks to integrate high-quality palliative care services in ICUs and assess their impact on the quality of care for patients and their families. ■

Foundation goal since	2001
Number of Grants and Contracts Awarded in 2002*	204
Dollar Amount of Grants and Contracts Awarded in 2002*	$92,901,579

Goals Update:

Health & Well-Being

The sedentary lifestyle and unhealthy eating patterns of many Americans are key contributors to a new and troubling national epidemic. In the past two decades, the prevalence of obesity in the United States has doubled among adults. The number of children who are overweight also has doubled, and the number of overweight adolescents has nearly tripled. Overall, 64.5 percent of adults are overweight; 30.5 percent are obese, putting them at significant risk for chronic and acute health conditions ranging from cardiovascular disease to depression to some forms of cancer. In addition to negative medical, emotional, social and economic consequences for individuals, obesity produces serious economic consequences for society, including the rising costs of treating the chronic conditions linked to obesity. The causes of this epidemic are primarily based in environmental and social factors, among which are declining physical activity levels and inadequate nutrition of the American public. More than 60 percent of adults are inactive or underactive, nearly half of America's youth ages 12 to 21 are not engaged in vigorous physical activity on a regular basis, and only 20 percent of children eat the U.S. Department of Agriculture's recommended five daily servings of fruits and vegetables.

Americans also are grappling with another threat to our nation's health. The events of September 11th and the anthrax attacks one month later alerted the nation to the serious threat of bioterrorism. While the country's 3,000 public health departments are somewhat better prepared to deal with bioterrorism than they were in 2001, they still are not equipped to handle either the overwhelming demands a major crisis would place on the public health system or the increasing burden of chronic disease.

Finally, the growing unemployment and poverty wrought by the recent economic downturn have worsened an already difficult struggle to maintain good health among families and individuals in America's more impoverished neighborhoods. The number of economically disadvantaged families rose in 2001 to 13.4 million, up 800,000 from the year before, highlighting the need to keep them connected to community-based support and services.

** Award amounts do not include cross-cutting grants and contracts that address more than one of the Foundation's goals.*

Getting Americans Moving

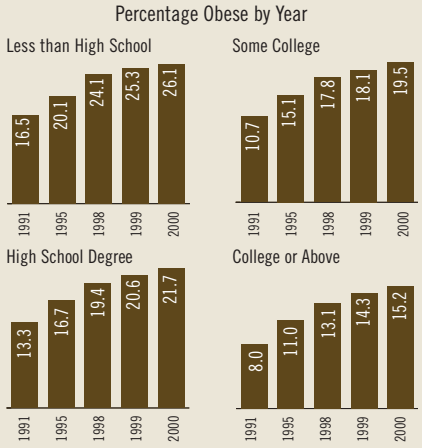
Since World War II, physical activity has been systematically engineered out of Americans' lives, with a dramatic, corresponding increase in obesity-related deaths. The communities where we live, work and play have been beset by sprawl, with development focused on accommodating cars rather than pedestrians or cyclists. In one effort to begin to look for solutions, the Foundation launched a $12.5-million program called *Active Living Policy and Environmental Studies* (ALPES). ALPES, which awarded its first round of grants in 2002, is funding research to examine how policy and environmental factors affect physical activity levels. Funded projects range from developing and validating an "e-diary" system for measuring physical activity to determining which characteristics of public recreational spaces promote the most use and activity. Findings will inform environmental and policy changes to promote active living among all Americans.

The Foundation's $16.5-million *Active Living by Design* initiative will put that research and theory into practical use when it awards five-year grants of up to $200,000 each to 25 community-based partnerships to plan, develop and implement strategies that will make it easier for people to be physically active in their communities. The first grantees will be named in 2003.

Getting Older Americans Moving

When local leaders in Madison, Wis., went for a walk through the city's downtown streets in September 2002, the numerous roadblocks in the way of pedestrians and cyclists surprised them. Volunteers in Richmond, Va., learned similar lessons in the heat of last summer while scouring 150 blocks of the city's East End to conduct an environmental assessment of its "walkability" and "bikeability." Both activities represented the launch of an RWJF partnership with AARP that is part of the Foundation's *Active for Life* initiative. The Madison and Richmond pilot projects are designed to use communications, advocacy and community-based interventions to increase physical activity among adults 50 and older. These adults are the least likely to be physically active, and yet can reap significant benefits from incorporating physical activity into their daily lives—from reducing their risk of certain chronic diseases, such as diabetes and heart disease, to improving their quality of life by making them feel more energetic and involved. *Active for Life* also tests the effectiveness of model interventions to improve physical activity among older adults. The program has authorized nine four-year grants totaling $8.7 million to community-based organizations that have experience working with adults age 50 and over. The projects begin in 2003.

Prevalence of Obesity Among U.S. Adults, by Education Level



Source: Behavioral Risk Factor Surveillance System, 1991–2000. *Centers for Disease Control and Prevention.* Available at: *www.cdc.gov/nccdphp/dnpa/obesity/trend/prev_char.htm [May 2002].*

Promoting Health Through Primary Care

Low levels of physical activity is among several lifestyle behaviors, including unhealthy diet, tobacco use, and abuse of alcohol and illegal drugs, that contribute to the leading causes of death in the United States. Changing people's behavior could go a long way toward reducing the incidence of and deaths from these conditions. But behavior change is one of the most challenging issues facing health care professionals. A new initiative approved in 2002, *Prescription for Health: Promoting Healthy Behaviors in Primary Care Research Networks*, authorizes up to $9 million over five years to develop, field test and disseminate innovative interventions for primary care-based health behavior change counseling.

Americans visit their primary care physician an average of three times a year. Research shows that they respect the advice they receive in physicians' offices and are motivated to act on it. Doctors need to know how to integrate the body of research on behavioral change into their practices, where they generally have between seven and 19 minutes per patient visit, and where little or no reimbursement is available for counseling about healthy behaviors. *Prescription for Health* calls for approaches to be tested in practice-based research networks—primary care practices that collaborate to conduct research—then widely disseminated to primary care groups throughout the country. Grantees will focus specifically on reducing the incidence of harmful behaviors such as risky drinking, physical inactivity, unhealthy diet and tobacco use. The Foundation hopes this program can help practitioners on the front lines of health care lead the way for active, healthy living.

Volunteering to Improve Community Health

As a senior volunteer in the Foundation-supported Experience Corps®, retired secretary Annette Mitchell, 69, donates her time and professional experience as a tutor and teaching assistant in her neighborhood's elementary school. Experience Corps recruits retired professionals like Mitchell to support their communities with work that is gratifying, important, and health enhancing. Experience Corps emphasizes social connections, with volunteers working in teams of eight to 10 per school. "It's what I needed," Mitchell says about the sense of personal satisfaction gained from helping a first-grader with reading difficulties improve her literacy skills.

In 2002, the Foundation awarded Public Private Ventures a $750,000 grant to evaluate the Experience Corps program. Evidence suggests the program benefits both the students and the volunteers. Formal evaluations show that children in classrooms assisted by Experience Corps volunteers improve reading scores and overall academic performance, have fewer behavior problems, and exhibit greater self-confidence and cooperation. Gerontology research indicates that strong social networks and productive activity help preserve good health among the elderly. Currently, 1,000 Experience Corps volunteers serve in 100 neighborhood schools in 14 cities. With additional support from other funders, many more sites will be developed over the next five years.

While Experience Corps volunteers work to strengthen student learning and seniors' health status, a program in Louisiana uses neighbor-to-neighbor outreach to connect people in a community with local health and social supports. In the Shreveport-Bossier Community

continued on page 22

Experience Corps | *Portland, Oregon*

The energy and experience of older adults are infrequently tapped resources in efforts to achieve local-level social change. Experience Corps connects children in at-risk environments with older members of their community to participate in a variety of mentoring activities, including tutoring, academic support and recreation. The Experience Corps program in Portland, Ore., Metropolitan Family Service, provides mentoring, tutoring, and community and family involvement services at elementary schools and youth-based organizations. A project to support graduates of the James John Elementary School helps them make the challenging transition to middle school, a time when drop-out rates are high.

One of the most rewarding things about participation in Experience Corps is the close relationship that grows between children and their mentors. Gladys Lea has helped Taniece Donley with her reading for over two years. Not only has Taniece's reading improved, she also has gained a good friend.

Evelyn Carter, an Experience Corps volunteer, has been tutoring Edgar Obisco and Anthony Alvarado every week since September and a special bond has developed among the three. The caring and consistent support Evelyn contributes to Edgar and Anthony today will increase their chances of staying in school later on.

Recent research regarding older adults indicates that strong social networks and productive activity are linked to prolonged physical and mental well-being. These are the kind of benefits Experience Corps volunteer June Terry can anticipate through her work as a tutor at the James John Elementary School. Here she reads with student Yohan Brandon Miranda.

Claire and Pierre Vireday are both retired but choose to spend some of their leisure time as Experience Corps volunteers. They gain great personal satisfaction from their work with children. Here Pierre reads with Daniel Montayo and Irene Ojeda, and Claire works on English language skills with Richie Carrasco and Ana Lilia Chavez-Garcia.

Renewal program, paid staff and volunteers establish "haven houses" as resources in distressed neighborhoods. Haven-house residents strengthen supportive relationships and decrease social isolation by helping neighbors to get to know and help one another. This project was first supported in 1995 by a grant from the RWJF *Faith in Action*® program. In 2002, the Foundation authorized $728,326 to train community leaders in Shreveport to further develop local outreach, continue a communications plan to encourage volunteering and intensify efforts to move strong families into targeted neighborhoods.

Strengthening Public Health

In late 2002, a Foundation-sponsored poll found that three-fourths of Americans were concerned that an emphasis on bioterrorism would leave the public health system ill-prepared to attend to other critical issues, such as prevention of chronic and infectious diseases unrelated to bioterrorism. Their concerns are justified. Not only are public health departments underfunded and overstretched, they lack the technological resources needed to protect effectively the health of the nation.

Eighty percent of the country's 3,000 public health departments lack the information infrastructure necessary to communicate with their central state health department or with local health care providers. During the height of the anthrax outbreak, for instance, Connecticut's state lab struggled with a 25-year-old computer system. To get the reports they needed, staff had to extract raw data three times a day and organize it by hand. Last summer in Arkansas, state public health officials had problems tracking an outbreak of West Nile virus because their outdated computer system could not communicate with other systems. The heart of the problem is that state public health departments, which will be on the front line in protecting the nation's health in the event of a bioterrorism attack or disease outbreak, rely on a haphazard and largely outdated collection of hardware and information software. This is why the Foundation established the Public Health Informatics Institute in September 2002. The $2.8-million Institute not only will help define the requirements for next-generation public health laboratory information management systems, but also will establish a national clearinghouse of information technology vendors and products and develop a process for evaluating and sharing software among states.

Investing in Future Public Health Leaders

In 2002, high school teachers throughout the country applied for awards in the first phase of the Foundation's $8.5-million Young Epidemiology Scholars (YES) program to heighten awareness of epidemiology and public health among high school students and teachers. Epidemiology is the science of discovering causes of illness and injury by interpreting patterns of their occurrence in populations. Eight teachers who submitted six models for high school epidemiology curricula were awarded a total of $75,000. In one classroom, students will solve a plague puzzle, design a disease museum and create a public information campaign using Web-based applications and research. Another curriculum involves students investigating the cause, treatment, control and prevention of type 2 diabetes. The first YES competition for students, with scholarships totaling up to $465,000 annually, will take place in the 2003–2004 school year.

In addition to nurturing future leaders at the high school level, the Foundation is helping build the nation's capacity for public health research, leadership and action through the *Robert Wood Johnson Health & Society Scholars Program*. The need for a training program that approaches population health issues broadly became more obvious with the release of a November 2002 Institute of Medicine report, *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*. The report notes that, of the more than 450,000 public health workers in the United States, only a fraction receive formal public health training. The report recommends that the training of public health professionals take an ecological approach, with graduate-level programs that include eight content areas: informatics, genomics, communication, cultural competence, community-based participatory research, global health, policy and law, and public health ethics. *Health & Society Scholars* selected six program sites in 2002: Columbia University; Harvard University; University of California, San Francisco; University of Michigan; University of Pennsylvania; and University of Wisconsin. The first class of 18 scholars for this intensive two-year fellowship program will be named in 2003. ■

Foundation goal since	1991
Number of Grants and Contracts Awarded in 2002*	179
Dollar Amount of Grants and Contracts Awarded in 2002*	$121,402,009

Goals Update:

Substance Abuse

Despite continued progress in reducing alcohol abuse and the use of tobacco and illegal drugs, substance abuse continues to take a substantial toll on human life and financial resources. Substance abuse remains the nation's top public health problem, accounting for approximately one in four (500,000) deaths annually in the United States. The economic burden, underscored by the costs of illness and crime, is equally staggering—about $414 billion a year.

In 1991, the Foundation formally adopted as a goal reducing the harm caused by substance abuse. Since then, our programs have included supporting innovative institutions, building public interest and support for policy change, creating and communicating new information about substance abuse, and integrating the most effective prevention and treatment strategies into the nation's legal and health care systems. The progress of the past decade reflects those efforts. Overall, rates of illicit drug and alcohol use are down from peak levels in the late 1970s and early 1980s, respectively, and tobacco use has declined since the mid-1960s. The most recent data released by the National Institute on Drug Abuse and the University of Michigan show that smoking among high school seniors is at its lowest level in 27 years. Public awareness of the dangers of substance abuse is up, and prevention and treatment strategies are increasingly effective.

Yet illicit drugs are still widely available, tobacco and alcohol continue to be easily accessible to underage youth, and more young people are experimenting with and using some substances. Finally, while effective prevention and treatment programs do exist, they are underused and not broadly available.

** Award amounts do not include cross-cutting grants and contracts that address more than one of the Foundation's goals.*

Strengthening the Treatment System

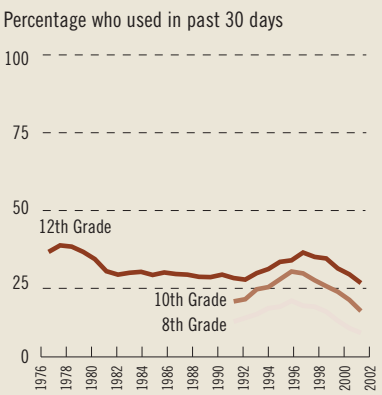
Research shows that the sooner substance abusers get into treatment and the longer they stay, the better their chance of recovery. However, current treatment resources are not meeting demand and the system itself often presents barriers to those seeking treatment.

In response to this supply and demand challenge, the Foundation awarded $1.7 million in grants in 2002 as part of the $9.5-million *Paths to Recovery: Changing the Process of Care for Substance Abuse* initiative. The program is designed to strengthen the substance abuse treatment system by re-engineering business systems and processes in nonprofit and public treatment facilities to get more people into treatment sooner and keep them there longer.

The barriers to changing the substance abuse treatment and recovery systems are legion. Too few beds, staffing shortages, financial issues or administrative bureaucracy result in long backlogs, with those seeking help often having to wait months for admission. Such delays represent a lost opportunity to treat millions of substance abusers.

While *Paths to Recovery* focuses on the point of delivery for treatment services, *Resources for Recovery: State Practices That Expand Treatment Opportunities* takes a broader view. This new $3-million initiative encourages states to identify and implement strategies to expand treatment resources and eligible populations by using current funding levels more efficiently and effectively. Up to 20 states will participate in a two-year policy forum to identify strategies to expand resources; up to five will then be awarded implementation grants to carry out selected strategies. Under this program, for example, states might divert consumers from high-cost inpatient facilities to lower-cost outpatient settings and coordinate purchasing between Medicaid and federal block grant dollars.

Trends in 30-Day Prevalence of Cigarette Use by 8th, 10th and 12th Graders



Source: Long-Term Cigarette Trends in 30-day Prevalence of Use by Subgroups for 8th, 10th and 12th Graders. In *Monitoring the Future Study, University of Michigan News and Information Services.* Available at: *www.monitoringthefuture.org/data/02data/pr02cig1.pdf [December 2002].*

Building Depth and Momentum in Adolescent Services

To catch problems early, much of the Foundation's work centers on strategies that have been shown to reduce substance use among young people—from supporting public education about the link between tobacco tax increases and reductions in smoking to structuring research-based prevention programs.

All too often, the treatment of substance abuse is isolated from the settings in which the sufferers from addiction interact—the justice system, the health care system and the welfare system. Children who abuse alcohol and drugs are more likely to behave violently, break the law or end up in court. Yet up to two-thirds of young people in juvenile justice facilities are not receiving treatment for substance abuse. The Foundation's $21-million initiative, *Reclaiming Futures®: Communities Helping Teens Overcome Drugs, Alcohol & Crime,* addresses that disconnect by supporting research and programs that integrate substance abuse treatment into the juvenile justice system.

Eleven communities received grants under *Reclaiming Futures* in 2002 to develop model programs. In Dayton, Ohio, for example, where six out of 10 young people who go through the county's juvenile court system have substance abuse problems, the RWJF-funded Mobilizing Natural Helpers project will work to redefine three major components of the system:

- How youths are assessed when they enter the system, focusing on their assets and abilities rather than their problems.
- How members of the youths' communities (family, friends, religious congregations—called "natural helpers") can assist in their rehabilitation.
- How restorative justice practices, such as activities that give back to the community, can be employed.

Unveiling Alcohol Marketing Tactics

Of course, it is best to prevent children from using drugs and alcohol in the first place. Yet the multitude of media images—including advertising that glamorizes tobacco and alcohol—make that a challenging goal. A new Foundation program will shine a light on the alcohol industry's marketing that reaches youth too young to drink legally.

The Center on Alcohol Marketing and Youth (CAMY) at Georgetown University, co-funded with the Pew Charitable Trusts, provides reliable data on alcohol companies' marketing by using standard advertising data and practices to analyze their ads and other promotional tactics.

The Center was officially launched in September 2002 and quickly produced results. CAMY provided data used by a national organization to convince a major beer manufacturer to pull a commercial airing during "The Simpsons," a television cartoon sitcom that attracts a large youth audience. A CAMY study showed that underage youth were a target of alcohol marketing in magazines and that alcohol companies spent more than half of their magazine advertising dollars on publications with large youth audiences.

Tackling Binge Drinking

The Foundation's emphasis on combating binge drinking on college campuses continued in 2002 through *A Matter of Degree: Reducing High-Risk Drinking Among College Students*, which awarded grants totaling $935,000 to the University of Iowa in Iowa City and the University of Wisconsin–Madison. Both schools have been involved in the program since its inception in 1996. Iowa City, for example, implemented an ordinance in 2002 to improve the enforcement of state laws regarding sales to minors and intoxicated persons. The new law also prohibits some drink promotions at taverns and restaurants, such as free alcohol, two-for-one and all-you-can-drink specials which, studies show, contribute to binge drinking.

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Reclaiming Futures | *Rosebud, South Dakota*

Reclaiming Futures is a new approach to helping teenagers caught in the cycle of drugs, alcohol and crime. It brings together judges, businesses, civic groups, schools and others to improve treatment for substance abuse, create systems of care, and provide social and economic opportunities for kids in trouble with the law. At Sinte Gleska University on the Rosebud reservation in South Dakota, the Sicangu Lakota people call the program Oyate Teca Owicakaya, which means "helping young people" in the Lakota language. The Sicangu Lakota are employing indigenous models to help their youth turn away from substance abuse and crime and to relearn the cultural traditions that keep them healthy.

Garan Coons, a Sicangu Lakota in his early twenties, is already an accomplished Lakota dancer. While finishing his bachelor's degree in graphic arts, he travels widely to perform at a range of venues. His performance at the Rosebud reservation illustrates to Lakota youth the power of their own traditions to heal and live strong.

Lionel Bordeaux has for thirty years been the president of Sinte Gleska University, the first tribal college in America to gain university status. At the University's annual Founders' Week, he facilitates public forums to obtain input on how the institution can better serve the community. *Reclaiming Futures*, at the University's Sicangu Policy Institute, is an important example of community service.

Calvin "Hawkeye" Waln is a diversion officer who works with youth on the Rosebud reservation under the auspices of the Wellness Court. Aside from the daily challenges of working within the juvenile justice system, he faces the difficult task of serving more than twenty remote communities.

Buffy Simmons and Ron Goodeagle, Jr., old friends from high school, reunite at the Rosebud reservation powwow. As a teen, Ron struggled with authority figures, calling himself a punk who hated conformity. Now he is deeply involved in his native traditions which keep him focused on a healthy and safe lifestyle.

In Wisconsin, tavern and restaurant owners in the area near the Madison campus voluntarily agreed to stop offering drink specials on Friday and Saturday nights for one year while Madison police tracked the number of police calls in response to disruptive and criminal behavior in the area. On campus, the university agreed not to sell alcohol at sporting events in its new arena, even though it would forfeit $500,000 in alcohol revenue during the hockey season.

Efforts to address substance abuse in young people long before they reach college received a boost in 2002 when results from the Foundation-supported, five-year study of the new Drug Abuse Resistance Education (D.A.R.E.) science-based curriculum were published. The evaluation found that this seventh-grade curriculum improved students' decision-making skills and ability to refuse drugs and strengthened their belief that drug use is socially inappropriate. The program will now be rolled out in school systems across the country.

Tobacco Prevention and Cessation Take Center Stage

Using their advocacy and communications expertise, the Campaign for Tobacco-Free Kids® and the *SmokeLess States*® program found an opportunity amidst the tough economic climate and burgeoning state deficits to advance public understanding of the effectiveness of tobacco tax increases, which can raise revenue for state tobacco prevention and cessation programs and save lives by driving down smoking rates. In 2002, 21 states, the District of Columbia and Puerto Rico increased cigarette taxes, a move that collectively should prevent more than 700,000 young people from becoming regular smokers and create more than $12.7 billion in long-term health care savings. The *SmokeLess States* program, in the second year of a three-year, $52-million authorization, continued its efforts in tobacco prevention and cessation by providing nearly $9 million in grants to 13 state tobacco control coalitions. The program currently supports a total of 42 coalitions.

Smoke-free or "clean indoor air" public education initiatives also gained momentum in 2002. Growing awareness of the health benefits of clean indoor air became evident last November when Florida voters passed a smoke-free air law that prohibits smoking in restaurants and most indoor workplaces. In the same month, all restaurants, bars and most other public indoor workplaces in Delaware became smoke-free under the most comprehensive indoor smoking ban in the nation. In December, New York City, Chicago and Boston passed clean indoor air legislation that prohibits smoking in most restaurants, bars and other workplaces.

Preventing Secondhand Smoke During Pregnancy

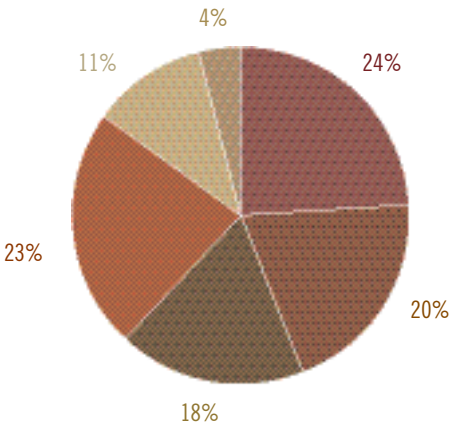
The Foundation made strides this year in its efforts to help pregnant smokers quit and stay smoke-free. Some 20 percent of pregnant women smoke, contributing to premature births, low-birthweight babies and infant breathing problems. The Foundation awarded a total of $5.8 million in 2002 for *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy*. The program supports a new National Partnership to Help Pregnant Smokers Quit, a coalition of more than 40 organizations joining forces in an education and communications initiative targeted at pregnant women and the health professionals who serve them. The initiative illustrates ways in which family members and friends can support and encourage pregnant smokers during their attempts to quit. It also promotes a new tool that health care providers now have at their disposal: a brief, easy-to-implement approach to counseling during prenatal care called the Five A's Approach (ask, advise, assess, assist, arrange follow-up). Studies find it doubles and in some cases triples quit rates among pregnant smokers, even among low-income women who are most likely to smoke during pregnancy.

Research and experience show that pregnancy is an ideal time to target women for smoking cessation. Women are more open to quitting than at any other time in their lives because they are worried about their baby's health, and they tend, during and immediately after pregnancy, to have regular contact with the health care system. ■

Distribution of 2002 Funds

During 2002, the Foundation awarded 1,150 grants and contracts totaling $556.02 million in support of programs and projects to improve health and health care in the United States. These grant funds, viewed in terms of the Foundation's principal objectives, were distributed as follows:

Distribution of Awards by Areas of Interest ($556.02 million)



24% $133.70 million for programs that assure that all Americans have access to basic health care at reasonable cost.*

20% $109.10 million for programs that improve care and support for people with chronic health conditions.*

18% $102.33 million for programs that promote healthy communities and lifestyles.

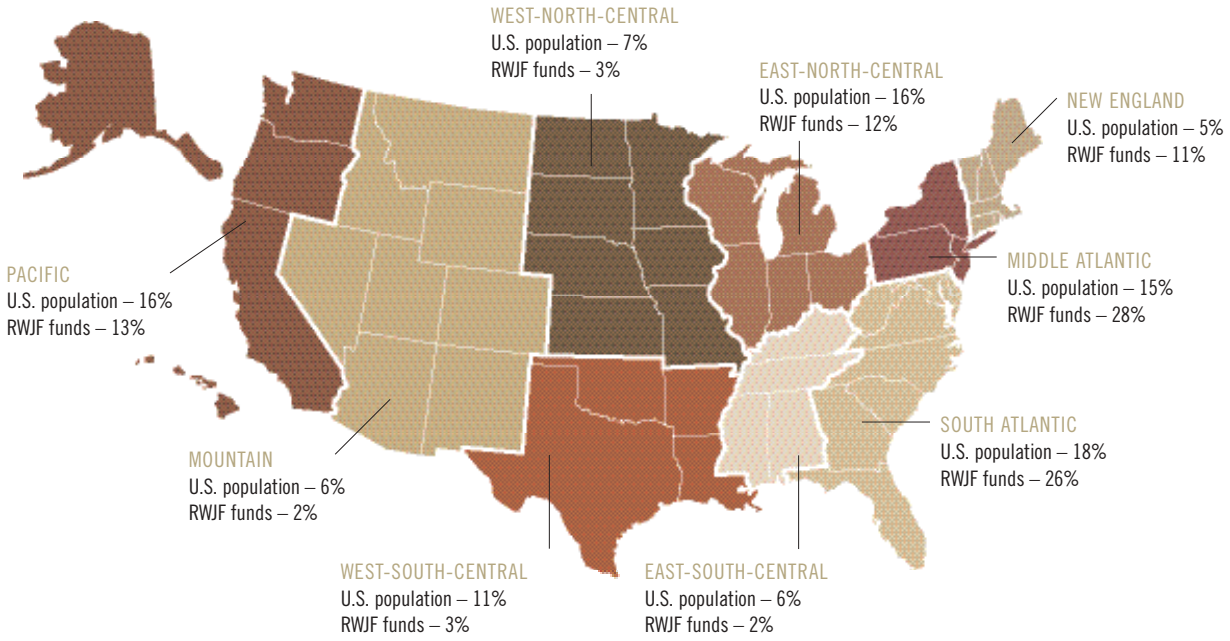
23% $128.49 million for programs that reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

11% $60.02 million for other health and health care programs, including our workforce training programs and grants that are consistent with our Program Management Teams.

4% $22.38 million for general philanthropy purposes, primarily to support health and health care in New Jersey where the Foundation originated.

* In January 2003, the Foundation revised our access and chronic health conditions goals to reflect our commitment to improving the *quality* of care available to all Americans. The two revised goal statements are: *to assure that all Americans have access to quality health care at reasonable cost* and *to improve the quality of care and support for people with chronic health conditions.*

Distribution of Awards by Geographical Region ($556.02 million)



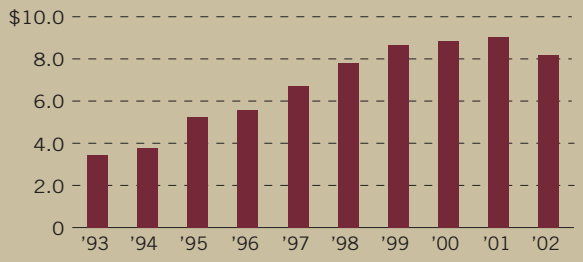
U.S. population taken from 2000 Census of Populations, U.S. Department of Commerce, Bureau of Census, March 2001.

The Year in Review

	January 1–December 31, 2002
Total Assets	$8.01 billion
Total Dollar Amount of Grants and Contracts Awarded	$556.02 million
Total Number of Proposals Received	7,060
Total Number of Grants and Contracts Awarded	1,150
Average Grant Size	$483,495

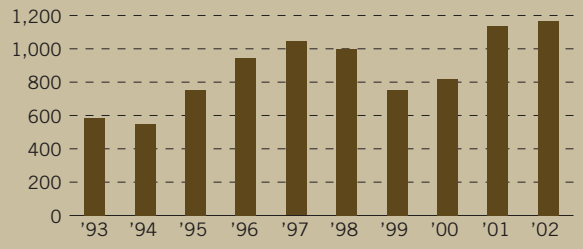
The Robert Wood Johnson Foundation Funding History

Assets of the Foundation 1993–2002 (in billions)

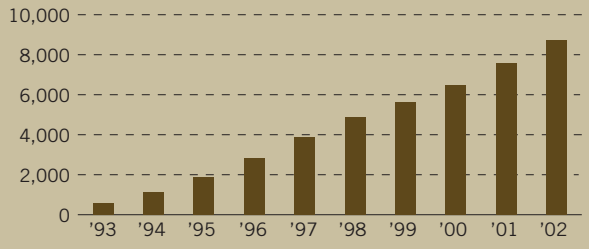


Number of Grants and Contracts Awarded 1993–2002

Individual Years

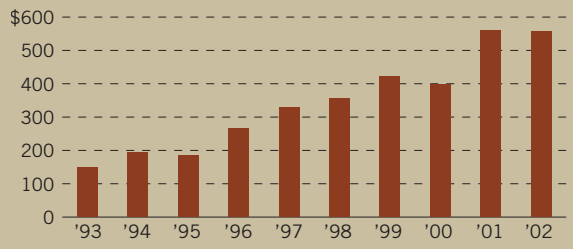


Cumulative

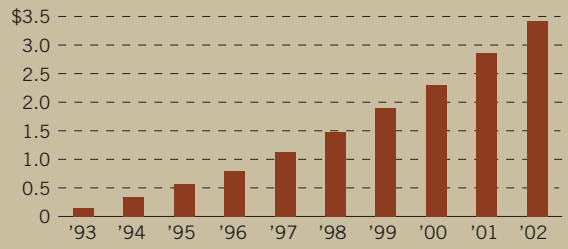


Dollar Amount of Grants and Contracts Awarded 1993–2002

Individual Years (in millions)



Cumulative (in billions)



Financial Statements

The annual financial statements for the Foundation for 2002 appear on pages 79 through 86. A listing of awards in 2002 begins on page 31.

In 2002 the net assets of the Foundation decreased 13.3 percent. Three factors contributed to this decline. First, the net return on the investment portfolio was negative 6.73 percent, primarily a reflection of the current economic conditions. Second, continuing a strategy of aggressive program development started last year, the Foundation awarded grants and contracts totaling $556 million. This is the second largest award year in the Foundation's history. Third, the Foundation spent 5.6 percent of its average asset value, exceeding the 5 percent payout requirement mandated by the tax law governing private foundations.

At the same time that we were ramping up our program development activities, we focused inward on our internal expenditures. As a result, program development, evaluation, and general administration for the year were $47.1 million or 8.5 percent of total awards. This represents a decrease of $132,000 compared to last year.

Investment expenses totaled $24.2 million, a decrease of $1.5 million compared to last year. This decrease is due to lower management fees as a result of a reduced asset base due to market conditions, coupled with some consolidation of investment managers. Federal and state taxes amounted to $6 million.

The Internal Revenue Code requires private foundations to make qualifying distributions of 5 percent of the fair market value of assets not used in carrying out the charitable purpose of the Foundation. These distributions are to be completed within twelve months of year-end. The Foundation has fulfilled its 2001 requirement of $406.3 million. The 2002 requirement is approximately $412 million.

Peter Goodwin
Vice President and Treasurer

Report of Independent Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

In our opinion, the accompanying statements of financial position and the related statements of activities and cash flows present fairly, in all material respects, the financial position of The Robert Wood Johnson Foundation ("the Foundation") at December 31, 2002 and 2001, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Foundation's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

New York, New York

February 10, 2003

Statements of Financial Position

At December 31, 2002 and 2001 (in thousands)	2002	2001
Assets:		
Cash and cash equivalents	$ 388,123	$ 359,413
Receivable on pending securities transactions	52,613	124,611
Interest and dividends receivable	11,576	13,358
Contributions receivable	14,069	14,364
Investments at fair value:		
Johnson & Johnson common stock	4,664,886	5,461,869
Other equity investments	2,071,722	2,233,721
Fixed income investments	730,733	760,126
Program related investments	11,468	12,860
Other assets	67,177	64,189
Total assets	$8,012,367	$9,044,511
Liabilities and Net Assets:		
Liabilities:		
Accounts payable and accrued expenses	$ 6,502	$ 8,720
Payable on pending securities transactions	160,006	179,586
Unpaid grants	671,874	580,531
Deferred federal excise tax	89,518	108,675
Accrued postretirement benefit obligation	12,331	10,050
Total liabilities	940,231	887,562
Net assets:		
Unrestricted	7,056,656	8,142,585
Temporarily restricted	15,480	14,364
Total net assets	7,072,136	8,156,949
Total liabilities and net assets	$8,012,367	$9,044,511

See notes to financial statements.

Statements of Activities

For the years ended December 31, 2002 and 2001 (in thousands)	2002	2001
Changes in unrestricted net assets		
Investment income:	$ 143,151	$ 148,356
Less: Federal and state tax	1,186	1,244
Investment expense	24,184	25,719
	117,781	121,393
Contributions	—	450
	117,781	121,843
Program costs and administrative expenses:		
Grants, net	443,000	487,692
Program contracts and related activities	56,044	54,771
Program development and evaluation	24,269	24,709
General administration	22,799	22,491
	546,112	589,663
Excess of program costs and expenses over income	(428,331)	(467,820)
Other changes to unrestricted net assets, net of related federal and state tax:		
Realized gains on sale of securities	284,683	345,279
Unrealized (depreciation) appreciation on investments	(942,281)	14,354
	(657,598)	359,633
Change in unrestricted net assets	(1,085,929)	(108,187)
Changes in temporarily restricted net assets		
Contributions	1,726	—
Change in value of charitable remainder trust	(610)	683
Change in temporarily restricted net assets	1,116	683
Change in net assets	(1,084,813)	(107,504)
Net assets at beginning of year	8,156,949	8,264,453
Net assets at end of year	$7,072,136	$8,156,949

See notes to financial statements.

Statements of Cash Flows

For the years ended December 31, 2002 and 2001 (in thousands)	2002	2001
Cash flows from operating activities:		
Change in net assets	$(1,084,813)	$ (107,504)
Adjustments to reconcile change in net assets		
to net cash used in operating activities:		
Depreciation	4,614	7,129
Net realized and unrealized (gains) losses on investments	657,598	(359,633)
Change in assets and liabilities:		
Decrease in interest and dividends receivable	1,782	1,345
Decrease in contributions receivable	295	1,317
Decrease in program related investments	1,392	951
Decrease in accounts payable and accrued expenses	(2,218)	(2,891)
Increase in unpaid grants	91,343	224,932
Increase in accrued postretirement benefit obligation	2,281	1,763
Increase in other assets	—	4,327
Net cash used in operating activities	(327,726)	(228,264)
Cash flows from investing activities:		
Proceeds from sales of investments	3,533,519	2,598,799
Cost of investments purchased	(3,169,481)	(2,251,249)
Acquisition of property and equipment	(7,602)	(33,791)
Net cash provided by investing activities	356,436	313,759
Net increase in cash and cash equivalents	28,710	85,495
Cash and cash equivalents at beginning of year	359,413	273,918
Cash and cash equivalents at end of year	$ 388,123	$ 359,413
Supplemental data:		
Federal and state taxes paid	$ 5,056	$ 8,574

See notes to financial statements.

Notes to Financial Statements

1. Organization:

The Foundation is an organization exempt from Federal income taxation under Section 501(c)(3), and is a private foundation as described in Section 509(a) of the Internal Revenue Code.

The Foundation's mission is to improve the health and health care of all Americans. The Foundation concentrates its grantmaking in four goal areas:*

- to assure that all Americans have access to basic health care at reasonable cost;
- to improve care and support for people with chronic health conditions;
- to promote healthy communities and lifestyles; and
- to reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

2. Summary of Significant Accounting Policies:

The accompanying financial statements are prepared on the accrual basis, which is in conformity with accounting principles generally accepted in the United States of America.

Cash and cash equivalents represent cash and short term investments purchased with an original maturity of three months or less. The carrying value approximates fair value.

Marketable securities are reported on the basis of quoted market value as reported on the last business day of the year on securities exchanges throughout the world. Realized gains and losses on investments in securities are calculated based on the first-in, first-out method.

Investments in limited partnership interests are stated at fair value based on financial statements and other information received from the partnerships. Fair value is the estimated net realizable value of holdings priced at quoted market value (where market quotations are available), historical cost or other estimates including appraisals. Because of the uncertainty of valuations for certain of the underlying investments which do not have quoted market values, the values for those investments could differ had a ready market existed. The realization of the Foundation's investment in these partnership interests is dependent upon the general partners' distributions during the life of each partnership.

Property and equipment are capitalized and carried at cost. Maintenance and repairs are charged to expense as incurred. Depreciation of $4,613,564 in 2002 and $7,129,001 in 2001 was calculated using the straight-line method over the estimated useful lives of the depreciable assets.

The Internal Revenue Service provides that each year the Foundation must distribute within 12 months of the end of such year, approximately 5 percent of the average fair value of its assets not used in carrying out the charitable purpose of the Foundation. The distribution requirement for 2001 has been met and the 2002 requirement is expected to be met during 2003.

Deferred federal excise taxes are the result of unrealized appreciation on investments being reported for financial statement purposes in different periods than for tax purposes.

* In January 2003, the Foundation revised our access and chronic health conditions goals to reflect our commitment to improving the *quality* of care available to all Americans. The two revised goal statements are: *to assure that all Americans have access to quality health care at reasonable cost* and *to improve the quality of care and support for people with chronic health conditions.*

Net Assets Accounting—The Foundation reports information regarding its financial position and activities according to the following two classes of net assets:

- Unrestricted net assets are not subject to donor-imposed stipulations or the restrictions have expired.
- Temporarily restricted net assets are subject to donor-imposed stipulations that can be fulfilled by actions of the Foundation or that expire by the passage of time. Temporarily restricted net assets include $13,754,429 and $14,364,453 at December 31, 2002 and 2001, respectively, related to a charitable remainder trust and $1,726,000 at December 31, 2002 related to a special program to be conducted in 2003.

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. The Foundation makes significant estimates regarding the value of limited partnership investments, discounts for contributions receivable and unpaid grants, and useful lives of property and equipment. Actual results could differ from these estimates.

The prior year financial statements have been reclassified to conform to the current year presentation. The principal reclassification was an increase in temporarily restricted net assets and a decrease in unrestricted net assets at December 31, 2001 relating to a contribution receivable in the amount of $14,364,453.

3. Federal Taxes:

The Internal Revenue Code imposes an excise tax on private foundations equal to 2 percent of net investment income (principally interest, dividends, and net realized capital gains, less expenses incurred in the production of investment income). This tax is reduced to 1 percent for foundations that meet certain distribution requirements. In 2002 and 2001, the Foundation satisfied these requirements and is, therefore, eligible for the reduced rate.

In 2002 and 2001, the Foundation was liable for federal and state unrelated business income tax in connection with its limited partnership interests. The amount paid in 2002 was $1,855,593 and 2001 was $4,173,771.

The provision for federal excise tax consists of a current provision on realized net investment income and a deferred provision on net unrealized appreciation of investments. The current provision for 2002 on net investment income at 1 percent was $4,037,118. The current provision for 2001 at 1 percent was $4,713,453. The change in unrealized appreciation reflected on the Statements of Activities includes a provision for deferred taxes based on net unrealized appreciation of investments at 2 percent. The decrease in unrealized appreciation in 2002 and increase in 2001 resulted in a change of the deferred federal excise tax liability of ($19,156,391) and $408,492, respectively.

4. Contributions Receivable:

Contributions receivable at December 31, 2002 and 2001 include $13,754,429 and $14,364,453 respectively, representing the present value of the estimated future benefit to be received as a beneficiary in a charitable remainder trust. The interest rates used to discount the trust receivable to present value range from 6.0 percent to 6.5 percent at December 31, 2002 and 5.5 percent to 6.5 percent at December 31, 2001.

5. Investments:

At December 31, 2002 and 2001, the cost and fair values of the investments are summarized as follows (in thousands):

	2002		2001	
	Cost	**Fair Value**	**Cost**	**Fair Value**
Johnson & Johnson Common Stock 86,853,208 and 92,417,408 shares in 2002 and 2001, respectively	$ 51,871	$4,664,886	$ 55,194	$5,461,869
Other equity investments:				
Domestic equities	486,918	497,692	569,490	676,011
International equities	385,348	339,801	427,654	407,630
Limited partnership interests	1,295,796	1,234,229	1,128,105	1,150,080
Fixed income investments	714,697	730,733	782,601	760,126
	$2,934,630	$7,467,341	$2,963,044	$8,455,716

Included in Domestic equities and International equities at December 31, 2002 and 2001 are approximately $8 million and $14 million, respectively, of securities on loan pursuant to a securities lending agreement.

Pursuant to its limited partnership agreements, as of December 31, 2002 and 2001, the Foundation had commitments of approximately $748 million and $814 million, respectively, which are expected to be funded over the next three to five years.

The Foundation purchases and sells forward foreign currency contracts whereby the Foundation agrees to exchange one currency for another on an agreed-upon date at an agreed-upon exchange rate to minimize the exposure of certain of its investments to adverse fluctuations in currency markets. At December 31, 2002 and 2001, the Foundation had open forward foreign currency contracts with notional amounts totaling $40.5 million and $79.6 million, respectively. Included in the Statement of Financial Position at fair value are pending receivables of $41,175,899 and pending payables of $41,740,617, resulting in an unrealized loss of $564,718 at December 31, 2002 and pending receivables of $79,519,547 and pending payables of $78,256,987, resulting in an unrealized gain of $1,262,560 at December 31, 2001. Such contracts involve, to varying degrees, the possible inability of counterparties to meet the terms of their contracts. Changes in the value of forward foreign currency contracts are recognized as unrealized gain or losses until such contracts are closed.

The net realized gains on sales of securities for 2002 and 2001 were as follows (in thousands):

	2002	2001
Johnson & Johnson Common Stock	$ 331,148	$ 441,712
Other securities, net	(41,696)	(88,755)
Less, Federal and state tax	(4,769)	(7,678)
	$ 284,683	$ 345,279

6. Property and Equipment:

At December 31, 2002 and 2001, property and equipment, a component of other assets, consisted of (in thousands):

	2002	2001	Depreciable Life in Yrs.
Land and land improvements	$ 2,677	$ 2,671	15
Buildings	49,810	48,062	40
Furniture and equipment	14,941	10,605	3–5
Total	67,428	61,338	
Less, Accumulated depreciation	(6,674)	(2,060)	
Property and equipment, net	$ 60,754	$ 59,278	

7. Unpaid Grants:

At December 31, 2002 the unpaid grant liability is expected to be paid in future years as follows (in thousands):

2003	$ 301,236
2004	246,614
2005	116,569
2006	52,110
2007 and thereafter	21,109
	737,638
Less, Discounted to present value	(65,764)
	$ 671,874

Generally accepted accounting principles require contributions made ("unpaid grants") to be recorded at the present value of estimated future cash flows. As of December 31, 2002, the Foundation has discounted the amount of unpaid grant liability by applying interest rate factors ranging from 5.0 percent to 6.5 percent and an estimated cancellation rate of 3 percent. At December 31, 2001, the unpaid grant liability was discounted to present value by $59,925,109.

8. Benefit Plans:

Retirement Plans

Substantially all employees of the Foundation are covered by two defined contribution retirement plans which provide for retirement benefits through a combination of the purchase of individually-owned annuities and cash payout. The Foundation's policy is to fund costs incurred. Pension expense amounted to $2,897,943 and $2,564,806 for 2002 and 2001, respectively, under these plans.

Postretirement Benefits

The Foundation provides postretirement medical and dental benefits to all employees who meet eligibility requirements. In addition, the Foundation has adopted supplemental benefit plans to provide additional benefits for certain key employees who meet certain requirements. The benefit obligation for 2002 and 2001 is summarized as follows (in thousands):

	2002	2001
Benefit obligation at December 31	$ 14,762	$ 11,760
Fair value of plan assets at December 31	—	—
Funded status	$ (14,762)	$ (11,760)
(Accrued) benefit cost recognized in the statement of financial position	$ (12,331)	$ (10,050)
Weighted-average assumptions as of December 31		
Discount rate:		
Medical and dental plans	6.50%	7.00%
Supplemental benefit plans	5.00%	5.50%
Expected return on plan assets	N/A	N/A

For measurement purposes, a 10.0 percent annual rate of increase in per capita cost of covered health care benefits was assumed for 2003. The rate was assumed to decrease gradually to 5.0 percent for 2010 and remain at that level thereafter. Benefit information for 2002 and 2001 is summarized as follows (in thousands):

	2002	2001
Benefit cost	$ 2,635	$ 3,650
Employer contributions	354	1,887
Plan participants' contributions	—	—
Benefits paid	354	1,887

The Secretary's Report

In July 2002, Risa J. Lavizzo-Mourey, M.D., M.B.A., was elected president and chief executive officer, as well as trustee, of the Foundation effective January 1, 2003. Lavizzo-Mourey had served as senior vice president and director of the Health Care Group at the Foundation since 2001. Prior to joining the Foundation, Lavizzo-Mourey was the Sylvan Eisman Professor of Medicine and Health Care Systems at the University of Pennsylvania School of Medicine. She also directed the University's Institute on Aging and was chief of the Medical School's Division of Geriatric Medicine. Lavizzo-Mourey is a former RWJ Clinical Scholar. She received her medical degree from Harvard Medical School and her M.B.A. in health care administration from the Wharton School of Business, University of Pennsylvania.

Lavizzo-Mourey succeeds Steven A. Schroeder, M.D., who retired from the Foundation on December 31, 2002, after 12-and-a-half years of service to the Foundation as president and chief executive officer. In January 2003, Schroeder was elected to the office of trustee emeritus and was cited by the Board for his leadership and distinguished service to the Foundation.

In April 2002, Ralph S. Larsen was elected to the Board of Trustees effective September 25, 2002. Larsen is former chairman of the board and chief executive officer of Johnson & Johnson.

In July 2002, Nancy-Ann DeParle was elected to the Board of Trustees. DeParle is an independent health policy consultant. She currently serves as an adjunct professor of health care systems at the Wharton School of the University of Pennsylvania, a senior advisor for J.P. Morgan Partners and a member of the Medicare Payment Advisory Commission.

In January 2003, Jack W. Owen, trustee of the Foundation, was elected to the office of trustee emeritus. Owen served as trustee since July 1985 and was cited by the Board for his many years of loyal and distinguished service to the Foundation.

Robert H. Myers died on May 11, 2002. Myers served on the Board from 1983 to 1992 and chaired the Board from 1986 to 1989. The Foundation is indebted to Myers for his leadership at the Foundation.

Staff Changes

In May 2002, Stephen Downs, S.M., joined the Foundation as senior program officer. Previously, Downs was director of the Technology Opportunities Program for the U.S. Department of Commerce, Washington. Downs received a master of science in technology and policy from the Massachusetts Institute of Technology.

In June 2002, Lori Melichar, Ph.D., joined the Foundation as program officer in the Research and Evaluation Unit. Prior to joining the Foundation, Melichar was social science analyst at the National Institutes of Health. Melichar earned a Ph.D. in economics from the University of Maryland at College Park.

In January 2003, Brian S. O'Neil joined the Foundation as chief investment officer. Prior to joining the Foundation, O'Neil spent over 20 years at Equitable Life/AXA Financial, where he most recently was executive vice president, head of the Funds Management Group, New York City. O'Neil received an A.B. in Sociology from Princeton University and an M.B.A. in finance from Columbia Graduate School of Business. O'Neil succeeds John D. Gilliam, who will retire at the end of 2003 after serving as chief investment officer since May 1995.

Since the date of the last Annual Report, Barbara Matacera-Barr was promoted to program officer; David C. Colby, Ph.D., has become deputy director, Health Care Group; Robert G. Hughes, Ph.D., has become coordinator of special projects for the president; and Robin E. Mockenhaupt, Ph.D., has become deputy director, Health Group.

Those departing the Foundation since the last Annual Report were the following: Paul S. Jellinek, Ph.D., vice president; Nancy J. Kaufman, R.N., M.S., vice president; Doriane C. Miller, M.D., vice president; and Judith Y. Whang, M.P.H., senior program officer.

Board Activities

The Board of Trustees met six times in 2002 to conduct business, review proposals and appropriate funds. In addition, the Nominating, Human Resources, Finance, Audit and Presidential Search committees met as required to consider and prepare recommendations to the Board.

J. Warren Wood, III, J.D.
Vice President, General Counsel and Secretary

This report covers the period through January 31, 2003.

This document, as well as many other
Foundation publications and resources,
is available on the Foundation's Web site:

www.rwjf.org

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Route 1 and College Road East
Post Office Box 2316
Princeton, NJ 08543-2316