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The Robert Wood Johnson Foundation Quarterly Newsletter

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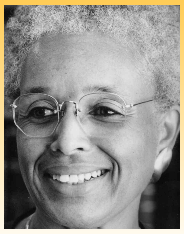


Substance Abuse Prevention: What Works and What Doesn't

Substance abuse is one of the nation's leading health problems — more people die, become ill, or are disabled from abuse of tobacco, alcohol, and illegal drugs than from any other preventable behavior. Given that, preventing substance abuse is a high priority — and a great challenge — for our society.

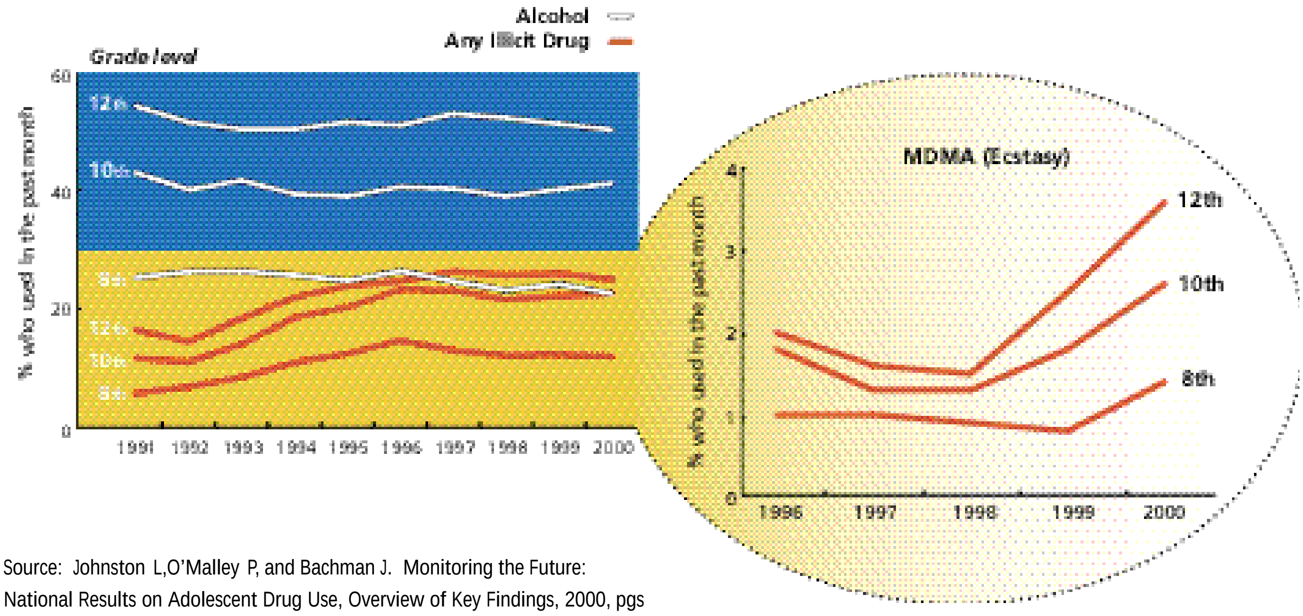
Over the years, various prevention and interdiction programs have been developed and implemented at a cost of billions of dollars. While there has been some progress, drug use among youth remains a persistent problem. According to the 2000 *Monitoring the Future* (MTF) survey, which tracks legal and illegal drug use by eighth, tenth, and twelfth graders, tobacco and illegal drug use increased among youth in the early 1990s and has generally leveled off or declined slightly in recent years. Alcohol use during the same period has been largely unchanged. However, adolescent use of the newly popular drug Ecstasy (MDMA) continues to rise sharply.

The good news is that after all these years of focusing on the problem prevention experts have a better sense of what works and what doesn't work, particularly with children and teens. With the support of The Robert Wood Johnson Foundation, researchers are pinpointing, with ever-increasing accuracy, what sort of approaches work best, narrowing their findings by each age group and specific substance.

"Based on reviews of 20 years of prevention program research, we now know that effective programs must have a solid, school-based component that incorporates active learning experiences," says Nancy Kaufman, MS,

See **Substance Abuse** — page 2

Trends in 30-Day Prevalence of Illegal Drug and Alcohol Use For Eighth, Tenth, and Twelfth Graders



Source: Johnston L,O'Malley P, and Bachman J. Monitoring the Future: National Results on Adolescent Drug Use, Overview of Key Findings, 2000, pgs 47-49.Bethesda,Md.:National Institute on Drug Abuse. Available online at <http://monitoringthefuture.org/pubs/overview2000.pdf.>

FEATURES

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From **Substance Abuse —** page 1

RWJF vice president. The list of positive learning experiences includes exercises such as practicing peer-refusal skills, working in student-directed teams to investigate what science says about the consequences of drug use, and studying marketing campaigns designed to sell alcohol and tobacco.

"Also important are parental involvement and community policies that discourage drug use, such as clean indoor air laws, media campaigns, and excise taxes on alcohol and tobacco," she continues. "Good prevention is complex."

Simpler approaches, such as one-shot lecture programs or school assemblies, simply don't work, Kaufman contends. "They probably do no harm, but they do waste valuable school time and taxpayer money."

Michael Roona,MS, MA, executive director of the Albany, N.Y.-based Social Capital Development Corporation, recently received RWJF funding to conduct a follow-up study of school-based interventions completed last year for an RWJF drug-prevention summit. Social Capital Development Corporation's initial study confirmed earlier research findings by Nancy Tobler, another RWJF-supported researcher, showing that interactive prevention programs were more effective than didactic ones. Roona and his colleagues also reported that programs teaching comprehensive life skills, such as assertiveness, decision-making, and goal-setting, had more effect than those that focused purely on social influences. Their follow-up study will look more closely at program effectiveness by age group and substance.

Beyond funding research, central to RWJF's mission is enabling research to have an impact. "It's clear to us in our prevention work that there are a number of effective programs out there,based on standards that meet scientific rigor," observes Kate Kraft,PhD, RWJF senior program officer. "Our challenge is to translate what we know into large-scale projects."

For example, RWJF is supporting a five-year, $13.7-million redesign of DARE (Drug Abuse Resistance Education),the widely distributed prevention program. Implemented in at least 75% of the nation's school districts, the program uses police officers to warn elementary school students about the dangers of drugs. Because of mounting evidence that any effect the program has in deterring drug use wears off by the time students become high school seniors or enter college,the Foundation stepped in with an offer of help. "If we can help redesign DARE to reflect what we know to be the best prevention science available, we can have a major impact," says Kraft.

Heading up the DARE redesign is Zili Sloboda,ScD, senior research associate, Institute for Health and Social Policy, University of Akron in Ohio. Because researchers have found that the biggest jump in drug use occurs between eighth and tenth grade, Sloboda says, the redesigned program will target seventh and ninth graders, rather than DARE's prior focus on fifth and sixth graders.

In contrast to the old program, which covered a huge range of topics in a lecture style, the new program will train DARE police officers to run more effective, engaging, interactive classes that encourage students to work out problems in small groups. The new DARE has three major goals: changing normative beliefs, building skills, and heightening perceptions of risk.

"When you talk to the students, they think everybody is using," says Sloboda, explaining the importance of normative beliefs. "The impact of what peers are doing is really great. So when they learn that 'I'm one of the majority, not the minority,' they feel less pressure to join the crowd [that uses]."

The program will focus on developing problem-solving skills and, in an effort to explain the risks of drug use, will offer straightforward information about how drugs and alcohol affect the functioning of the brain and body.

Looking ahead, how should future drug prevention programs be designed to maximize effectiveness? Leading prevention experts grappled with that question at the invitation of the Foundation during two days of presentations and discussions in St. Michaels, Md., last fall. Their findings can be synthesized into six key points:

- Coordinate school-based and community prevention efforts to forge an environmental change.
- Integrate prevention efforts with the academic curricula, stressing that prevention programs contribute to academic success.
- Maximize available resources by coordinating efforts across agencies and disciplines.
- Develop standard definitions and a common understanding of program goals, to avoid confusion.
- Employ new technologies to reach individuals with prevention messages, and disseminate science-based information about the most effective prevention efforts.
- Increase funding, training, and support for prevention researchers and practitioners.

As RWJF's Kaufman told researchers at the meeting, the Foundation sees its role as a facilitator to help start a new movement within the prevention field that will attract others and make new strides in implementing programs that have been shown to work in preventing substance abuse.

— LESLIE WHITAKER

Substance Abuse Report Charts Nation's Number One Health Problem

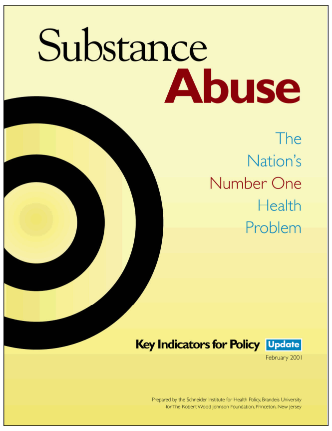
The Robert Wood Johnson Foundation has just released an updated version of *Substance Abuse: The Nation's Number One Health Problem: Key Indicators for Policy* prepared by the Schneider Institute for Health Policy at Brandeis University. The new resource tracks short- and long-term trends in tobacco, alcohol, and illicit drug use over the past three decades. This second edition of a report first released in 1993 concludes that substance abuse causes more deaths,illnesses,and disabilities than any other preventable health problem today.

"This report demonstrates that there is a gap between what we know about prevention and treatment, and what we actually do to prevent and treat this enormous problem," says J. Michael McGinnis, senior vice president and director of the health group at RWJF.

The new chartbook examines a number of factors that influence trends in substance abuse, including early use, media depictions of use and abuse, and prevalence and use of treatment services. It also discusses the economic implications of substance abuse; the relationship between substance abuse and education, income, and gender; and the role of regulatory strategies to reduce tobacco use and alcohol abuse.

"Our conclusion overall is that society continues to pay the price for a problem that is largely preventable and treatable," says Connie Horgan, ScD, professor and director of the Schneider Institute and principal investigator for the book.

To coincide with the release of *Substance Abuse: The Nation's Number One Health Problem*, RWJF has created an online Substance Abuse Resource Center, located at: <http://substanceabuse.rwjf.org>. The site consolidates a wealth of data and reports from RWJF National Program Offices, grantees, and other sources about the abuse of alcohol, tobacco, and illicit drugs and efforts to prevent harm from their use. From the site visitors can view an outline of chartbook topics and charts, and download or order a copy of the book.



Substance
Abuse
The
Nation's
Number One
Health
Problem
Key Indicators for Policy Update
February 2001
Prepared by the Schneider Institute for Health Policy, Brandeis University
for The Robert Wood Johnson Foundation, Princeton, New Jersey

To order a copy by mail, send a written request to The Robert Wood Johnson Foundation; Attn: Substance Abuse Chartbook; P.O. Box 2316; Princeton, N.J. 08543-2316.

— **MAUREEN COZINE**

New Building Now Occupied

On March 16, The Robert Wood Johnson Foundation moved into the first phase of its new building. Although the address remains the same, the new facility provides much-needed additional space and improved professional amenities.

The first change that visitors to the Foundation will notice is more prominent signage directing them toward the expanded visitor parking area, and new entrance and reception area. A large glass-enclosed atrium houses the Information Center, now centrally located and the focal point of the new layout. The larger working spaces, common areas, and conference rooms were designed and organized to offer greater opportunities for cooperation and collaboration among departments. A 102-seat auditorium combines state-of-the-art media presentation technology with an intimate setting that allows for increased interaction among meeting participants.

In keeping with RWJF's focus on health,the fitness center has been expanded and walking paths have been created to wind their way around the private wooded grounds. An enclosed parking garage accommodates 285 cars and provides connection to the new building via a covered walkway.

With the original part of the building now undergoing renovation and other improvements such as landscaping still under way, the Foundation continues to improve the working environment of the nation's largest philanthropy dedicated to health and health care.

— **HEDDA COLOSSI**

Front entrance and side of new headquarters.

New RWJF entrance.

MAKE A NOTE, many RWJF telephone numbers have been changed so that a common prefix — 627 — replaces 243, 951,and 720. So, for example, a phone number that was (609) 243-5919 is now (609) 627-5919. The one exception is the lobby reception phone number, which remains (609) 452-8701. The mailing address remains P.O. Box 2316, Princeton, N.J. 08543-2316 and the overnight delivery address is still Route One and College Road East,Princeton, N.J. 08543.

RUBY HEARN, PHD

PROFILE

For more than 25 years, Senior Vice President Ruby Hearn, PhD, has been a guiding force and inspiration at The Robert Wood Johnson Foundation. When she came to the Foundation in 1976, she focused her efforts on children's health — her lifelong passion. She was the leading developer of the Infant Health and Development Program, the first randomized clinical trial to look for interventions to improve outcomes for low-birthweight infants. Hearn also played a key role in formulating Foundation programs on AIDS, substance abuse, and minority medical education. Her interests and influence have helped inform the Foundation's approach to health. As she retires from RWJF, Ruby Hearn talks with *ADVANCES* about her vision for health philanthropy.

What is the role of philanthropy in society today?

HEARN — I view philanthropic resources as venture capital to test new approaches to solving problems. If we're doing our job well, we ought to get there before everybody else. One of the big advantages in philanthropy is that our work does not affect our bottom line. Philanthropy can afford to take risks in the public interest, to look for new ideas and to test them, to take the longer view. That's a role neither business nor government can play easily.

How has the role of philanthropy in health care changed during your tenure at the Foundation?

HEARN — I was fortunate enough to join RWJF in 1976, when we all had lunch at a single table. At that time, we were testing various ways of addressing problems,and assuming there would be a financing mechanism in place to support those more effective models. Basically, we assumed that if you built a better mousetrap, people would buy it. But over time, it became clear that having a better way was not enough. The real challenge is to develop the political will to transform that knowledge into public policy. Now I have a much greater appreciation of the political realities associated with trying to bring about change.

Why is there often so much resistance to new health programs on the local level?

HEARN — There's a tension between what people are willing to do for the benefit of themselves versus the benefit of their communities. We've seen a decline in people's sense of community. I have friends who live in suburban areas where the taxpayers won't support the schools. Their own children are grown, so they're not willing to invest in their neighbors' children. That's why we have been so interested in creating opportunities to link people in different groups and communities. Light bulbs go on when you bring people together. They start to realize that if you address the problems, it benefits everybody.

What has been RWJF's greatest success over the last 25 years?

HEARN — In philanthropy, it's very hard to hit a home run. We're trying to bring about change in some of the most vexing areas of health and health care, where our resources are quite small in relation to the problem. We're really about leverage and partnership. So rather than talking about success and failure, I can point to areas where the Foundation has made significant contributions. When the AIDS epidemic hit, we were the largest foundation to devote resources to improving care. Our work led to passage of the Ryan White bill, and dramatically changed out-of-hospital care for AIDS patients. We also have been one of the few foundations to take a leadership role on the problem of substance abuse. More recently, we've been a leader in working for the health and safety of children in urban areas.

What has been RWJF's biggest missed opportunity?

HEARN — Rather than focus on a specific issue, I would say that a missed opportunity overall was our inadequate recognition of the need to invest in leadership at the local level — not just physician leadership, but also in nursing, in public health, in lay leadership in distressed areas. We probably could have made more progress if we had given greater emphasis to building capacity on the community level.

In 1972, children's health programs accounted for 11% of RWJF's grants; in 1997, 35% went to support children's health. Why the move toward children, and what does that mean?

HEARN — For many health problems, the search for a solution leads you to focus on children. For example, we've been concerned about insurance coverage for a long time. In the aftermath of the health care reform debacle, we devised a program to expand coverage for children, and the Balanced Budget Act made money available in all 50 states. So the issue was coverage; the opportunity was children's coverage.

Over the last quarter century, RWJF has learned that often there is no single right approach to improving public health. Instead, programs need to be tailored to fit local needs. Given that, what can we do to improve our national health?

HEARN — The first thing we can do is understand and recognize the truth in that statement. All implementation plans are local, no matter where the money comes from. So a community has to have the will to do it, and then also have the capacity to do it. We need to invest in helping communities understand what their problems are, and what's known about effective approaches to addressing those problems. Then we need to help them devise strategies to get the support they need to implement those interventions. I think children's health insurance coverage is a good example. We've got federal funding that makes it possible to enroll children, but enrollment itself has to happen locally. If we don't have the capacity locally to find and enroll those children, then we can't capitalize on available funding.

What's your advice to RWJF for the next 25 years?

HEARN — Should foundations develop 25-year plans? It's hard to think in terms of a quarter century. But that's the great strength of foundations. While the rest of the world works in shorter time frames, we can take the longer view. So I think we should continue our long-term investments in people, such as the *Clinical Scholars Program* and the *Minority Medical Faculty Development Program*. I also think we should continue to capitalize on our size by making very substantial investments,along the lines of our $100-million commitment to the *Faith in Action* program. It would be interesting to see what would happen if you decided: "We're going to stay this course for the next 25 years." That might open up a different set of possibilities.

— INTERVIEW BY ELIZABETH AUSTIN

Indigent Primary Care Patients Have High Rates of Mental Illness; Want Mental Care Collaboration

In the general primary care population,the prevalence of mental illness and how it impacts function and health care use have been closely examined. But how do mental health disorders affect people in the primary care population who are living at the poverty level? These researchers studied 500 patients at a clinic in Colorado that served only the low-income uninsured. The investigators screened for mental disorders using a questionnaire that patients completed on the day of their clinic visit before seeing a physician, physician assistant, or nurse practitioner. The questionnaire identified threshold disorders (such as major depression) and subthreshold disorders (such as probable alcohol abuse). It also evaluated functional status and whether respondents preferred collaboration between mental and medical health care providers.

The investigators compared the rates of psychiatric disorders found in the indigent patients with those in 3,000 general primary care patients. They classified the indigent patients into three groups — no mental illness, subthreshold illness, and threshold illness — to test the hypothesis that more symptoms of mental illness would be associated with lower functional status and more disability, and thus increased use of health services.

About half (51%) of the indigent patients had at least one psychiatric disorder, which was almost twice the prevalence in the general primary care population (28%). In particular, indigent patients had more mood disorders (33% vs. 16%), anxiety disorders (36% vs. 11%), probable alcohol abuse (17% vs.7%), and eating disorders (10% vs. 7%) than were present in the general medical sector.

Poor, uninsured patients had a considerable number of disability days in the preceding 3 months, ranging from about 4 days on average for patients with no mental disorder to about 5 days for those with subthreshold illness and almost 19 days for those with threshold illness. In the preceding 3 months, only 16% of the patients with no mental illness had seen a physician 3 or more times, whereas 22% of those with subthreshold illness and 35% of those with threshold disorders had.

Overall, regardless of their degree of mental illness, the respondents were strongly in favor of collaboration between their primary care provider and mental health professionals, even if it meant they would have to go to a different location for health care. Some 90% of the indigent patients preferred inter-provider communication.

This preference was a significant finding from this study. The authors felt that, coupled with other research supporting collaborative health care, it represented a "compelling argument for system redesign." This finding prompted the clinic to seek funding for on-site counselors, case managers, group treatment, and training. In adopting this system for addressing psychosocial needs, the clinic may help reduce disability among indigent patients who cope not only with financial poverty, and high rates of medical illness and mental illness, but also with the consequences of poor mental health such as diminished self care and well-being, and a limited sense of control over their lives and future.

Mauksch LB et al. Mental Illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population. *The Journal of Family Practice* 50 (1): 41–47,2001.

End-of-Life Care: What's Important and What's Not

In the mid-1990s, the landmark SUPPORT study (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) revealed that terminally ill persons in this country often die in great physical and emotional pain. While patients, their families, and health care providers agree that end-of-life care can be improved, efforts to do so often are often haphazard because there is no clear understanding of what constitutes a "good death" and how that definition might vary from group to group.

To better understand what patients,families, physicians,and other health care providers consider important at the end of life,these researchers conducted a random national survey. Prior to the survey, the investigators held a series of focus groups to develop a list of important end-of-life factors. Then, over a 6-month period,340 terminally ill patients, 332 recently bereaved family members,361 physicians, and 429 other care providers (nurses, social workers, chaplains, and hospice volunteers) completed a questionnaire rating the importance of 44 attributes of quality at the end of life.

More than 70% of the respondents in each of the 4 groups (patients, family members, physicians, and other care providers) rated 26 of the 44 factors as very important at the end of life. (See table "Attributes with greater than 70% agreement.") The top 5 attributes that were rated as very important by the greatest number of respondents in each group were: to be kept clean; to be able to name a decision-maker; to have a nurse with whom one feels comfortable; to know what to expect about one's physical condition; and to have someone who will listen. Interestingly, more respondents ranked being comfortable with one's nurse as very important than being comfortable with one's physician.

Patients and physicians differed significantly in their ratings of the importance of 8 items: to be mentally aware; to be at peace with God; not to be a burden to family; to be able to help others; to pray; to have funeral arrangements planned; not to be a burden to society; and to feel one's life is complete. More than 70% of patients consider these factors important, but physicians were significantly less likely to rank them as important. For example, 92% of patients feel it is important to be mentally aware at the end of life while only 65% of physicians deem this important. In addition, 85% or more of patients say it is important to be at peace with God and pray while 65% or less of physicians consider these factors important.

All 4 respondent groups varied widely in their ranking of 10 items on the survey. (See table "End-of-life considerations with broad respondent variation.") Their views were most divergent in using all available treatments no matter what the chance of recovery. While 48% of patients and 38% of family members rank this factor important, just 7% of physicians and 5% of other care providers consider it important. Patients and family members with more education and income were less likely to rank this item important. In addition, more patients and family members than physicians or other care providers consider it important to know the timing of one's death.

Respondents also were asked to order a list of 9 factors frequently identified as important by focus group participants. The top 3 factors were freedom from pain, being at peace with God, and being in the presence of family.

The study's findings highlight a central challenge of providing quality end-of-life care: making physicians and health care providers aware of aspects of care that are critically important to patients and family members but may not intuitively be the focus of clinicians. "Quality care at the end of life is highly individual and should be achieved through a process of shared decision making and clear communication that acknowledges the values and preferences of patients and their families," the authors suggest.

Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L,and Tulsky JA. Factors Considered Important at the End of Life by Patients, Family, Physicians,and Other Care Providers. *The Journal of the American Medical Association* 284 (19): 2476–2482,2000.

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

Attributes with greater than 70% agreement

Attribute	Patient %	MD %	Other Care Providers %	Family %
Be kept clean	99	99	99	99
Name someone to make decisions	98	98	99	98
Have a nurse with whom one feels comfortable	97	91	98	98
Know what to expect about one's physical condition	96	88	94	93
Have someone who will listen	95	99	99	98
Maintain one's dignity	95	99	99	98
Trust one's doctor	94	99	97	97
Have financial affairs in order	94	91	90	94
Be free of pain	93	99	97	95
Maintain a sense of humor	93	79	85	87
Say good-bye to important people	90	95	99	92
Be free of shortness of breath	90	93	87	87
Be free of anxiety	90	90	90	91
Have a doctor with whom one can discuss personal fears	90	94	93	91
Have a doctor who knows one as a whole person	88	92	95	92
Resolve unfinished business with family or friends	86	87	97	85
Have physical touch	86	90	97	94
Know that one's doctor is comfortable talking about death and dying	86	93	97	85
Share time with close friends	85	91	96	91
Feel family is prepared for one's death	85	83	90	88
Feel prepared to die	84	79	87	81
Have the presence of family	81	95	96	95
Have treatment preferences in writing	81	73	90	85
Not die alone	75	84	88	93
Remember personal accomplishments	74	78	91	80
Receive care from personal doctor	73	82	82	77

End-of-life considerations with broad respondent variation

Attribute	Patient %			MD %			Other
	agree	neither	disagree	agree	neither	disagree	agree
Using all available treatments no matter what the chance of recovery	48	22	31	7	12	81	5
Not be connected to machines	64	20	16	50	41	9	61
Know the timing of one's death	39	39	22	26	46	29	35
Control the time and place of one's death	40	35	24	36	39	25	44
Discuss personal fears	61	28	11	88	11	1	94
Die at home	35	53	12	44	51	5	46
Be with one's pets	37	45	18	42	50	8	73
Meet with a clergy member	69	24	7	60	36	4	70
Have a chance to talk about the meaning of death	58	33	9	66	29	5	86
Discuss spiritual beliefs with one's doctor	50	37	13	49	41	10	51

Gateway Sequence of Drug Use Progression Seen As Social Artifact

Since the 1970s, a significant body of research has supported the theory that substance use and abuse among youth follows a distinct pattern: Young people begin using alcohol and/or tobacco, some then progress to marijuana use, and a proportion of the marijuana users subsequently use hard drugs such as cocaine, crack, or heroin. Based on this pattern of progression, alcohol, tobacco, and marijuana were labeled "gateway drugs."

This study looked at the observed gateway phenomenon by calculating the risk of progression at each stage and examining factors associated with increased

Care Providers %		Family %		
neither	disagree	agree	neither	disagree
12	83	38	18	44
30	10	63	20	17
47	18	49	35	16
30	25	38	40	22
5	1	80	16	4
52	2	30	54	16
24	2	47	44	10
30	1	83	17	1
12	1	72	26	3
42	7	54	39	7

risks. Researchers reexamined data for 1979 through 1997 from the National Household Survey on Drug Abuse (NHSDA), a survey conducted every 2 to 3 years beginning in 1971 and annually since 1990. They looked specifically at respondents' answers to the following question to infer if and how they progressed in their substance use: How old were you the first time you used alcohol, cigarettes, marijuana, or various hard drugs (cocaine, crack, or heroin)?

The investigators found that most of the NHSDA respondents followed the gateway sequence. About 85% moved from not using any kind of substance to use of alcohol and/or tobacco. Some 10% of the respondents never used any substances and 62% stopped at alcohol or tobacco use, never using any other substance. About 22% of the sample progressed from alcohol and/or tobacco use to marijuana, and about 8% progressed to hard drug use.

Alcohol and tobacco use were popular among adolescent respondents across all birth years. In fact, at least 80% of respondents born in 1915 or after report that they used alcohol or tobacco by age 25. In comparison, the likelihood of marijuana and hard drug use changed across birth year. Progression to marijuana and hard drugs only emerged with individuals born after World War II and peaked among individuals born around 1960. About 55% of alcohol/tobacco users born in 1958–59 progressed to marijuana and 39% of those born in 1962–63 progressed to hard drug use. Respondents born in the 1970s were less likely than their 1960s counterparts to use any kind of substance.

Like birth year, the age at which a person first used a substance was also associated with progressing to other substances. Respondents who used alcohol or tobacco before the age of 15 were significantly more likely to use marijuana or hard drugs than youth who didn't begin drinking or smoking until after age 17.

The authors emphasize that the gateway phenomenon was most characteristic of the late baby boomers' drug use experiences. They conclude: "The gateway phenomenon reflects norms prevailing among youths at a specific place and time. . . . Simply restricting youth's access to gateway drugs will not necessarily reduce subsequent hard drug abuse. A more effective strategy might be to try to understand and influence the prevailing norms,especially those affecting early initiators of alcohol, tobacco, and marijuana use."

Golub A and Johnson BD. Variation in Youthful Risks of Progression From Alcohol and Tobacco to Marijuana and Hard Drugs Across Generations. *American Journal of Public Health* 91 (2): 225–232,2001.

Childhood Sexual Abuse Increases Risk for Psychiatric Illness in Women

Childhood sexual abuse clearly increases the risk of psychiatric disorders in women later in their lives. But the issue raises complex questions about how directly the abuse can be linked with psychiatric illness, and the role that disturbed family relationships may play in the development of these disorders. To better understand the diagnostic significance of childhood sexual abuse for adult psychiatric illness and substance abuse, investigators studied 1,411 female twins who answered a mail-in questionnaire on the subject.

The twins, born between 1934 and 1974, were part of the Virginia Twin Registry, an ongoing study of

Do Patients Know Their End-of-Life Options?

For nearly a quarter century, US citizens have worked to ensure that terminally ill persons in this country can control how they die. Competent patients or their surrogate decision-makers are able to refuse or withdraw life-sustaining treatments. Individuals may draft advance directives stipulating what care measures may be used. In Oregon, "fully informed" terminally ill patients may request a lethal prescription from their physician.

These choices assume that patients and their decision-makers are well informed. But are they? Despite a spate of attention to death and dying in the popular press, a recent study suggests that many people don't understand their options in end-of-life care.

Using a short questionnaire that traced a series of medical events for a hypothetical patient, researchers tested the knowledge of more than 700 outpatients at 4 Oregon clinics about 4 end-of-life issues: refusal and withdrawal of life-saving treatments; physician-assisted suicide (when a physician prescribes a lethal substance to a patient but does not orchestrate the death); active euthanasia (when a physician is present at and helps orchestrate the death); and the doctrine of double effect (when a physician gives pain medicine to a patient even if it hastens death).

Although two-thirds of the respondents understood that competent patients could refuse life-saving or life-sustaining treatment in Oregon, less than half knew that it is legal to withdraw life-sustaining treatment. Only 23% of the participants identified physician-assisted suicide as a legal option in Oregon. About one-third of respondents correctly recognized euthanasia as illegal. In fact, many respondents did not differentiate between assisted suicide and euthanasia. Slightly more than 40% of respondents understood that the double effect doctrine is legal in Oregon.

Individuals who were white, married, 30 years of age or older, English-speaking, college-educated, and Jewish had higher knowledge scores on the end-of-life care questionnaire. In addition, respondents who had acted as a proxy decision-maker for a dying person were more likely to understand care options than were persons who had experienced a grave illness or the death or illness of a loved one, or had drafted an advance directive.

The authors conclude that "even extraordinary public discussion regarding end-of-life issues fails to educate typical outpatients." They recommend that physicians initiate end-of-life discussions with all patients and caution policymakers to be cognizant of this knowledge deficit as they draft end-of-life legislation.

Silveira MJ, DiPiero A, Gerrity MS, and Feudtner C. Patients' Knowledge of Options at the End of Life. *The Journal of the American Medical Association* 284 (19): 2483–2488, 2000.

Drs. Silveira and Feudtner were Robert Wood Johnson Clinical Scholars at the time of this research.

women twin pairs. Their psychiatric and substance abuse disorders had been previously documented. Data on major depression, generalized anxiety disorder, panic disorder, bulimia nervosa,and alcohol and drug dependence were analyzed for the present study.

The women answered questions about childhood sexual abuse in terms of their own experience and that of their twin. Investigators classified abuse according to three levels: no genital contact, genital contact, and intercourse. To determine the extent that family environment may contribute to psychiatric illness, the investigators contacted the parents and asked about their experiences with psychiatric and substance abuse disorders. Those interviews also assessed family disruption. About 90% of the parents participated.

Among the twins, 30% reported childhood sexual abuse of some form. The mean age of first abuse was at age 10. About a third of the incidents involved force or threat, and the perpetrators were most often a relative or a neighbor. In slightly more than a third of cases, the involved twin kept silent about the abuse. The other twin knew of the abuse only about half the time.

The investigators reported that psychiatric illnesses were significantly more likely to occur in the women who reported childhood sexual abuse than in those who did not. The risk of developing a disorder increased with the severity of abuse. Women who experienced nongenital abuse were significantly more likely to develop alcohol and drug dependence only, whereas genital abuse increased the risk for every disorder except panic disorder and bulimia. Abuse involving intercourse significantly raised the risk for all psychiatric disorders. Family discord and psychiatric illness in the parents was not strongly linked to the development of a psychiatric disorder in the twins.

By the unique design of their study using parent interviews, a twin as a genetic control,and examination of familial factors, these investigators provided new insight into the significance of childhood sexual abuse in adult psychiatric disorders.

Kendler KS et al. Childhood Sexual Abuse and Adult Psychiatric and Substance Use Disorders in Women. *Archives of General Psychiatry* 57 (October): 953–959,2000.

Social Capital on Campus Protects Against Binge Drinking

More than two-fifths of college students binge drink, consuming 5 or more drinks in one sitting. Recent efforts to curb excessive drinking have emphasized reshaping individual and environmental factors to protect against this behavior. Several studies on juvenile delinquency and violence have shown that neighborhoods with greater social capital — defined as civic engagement, trust, and mutual obligation among persons — have lower rates of crime. Could social capital also affect drinking patterns? Using data from the 1993 Harvard School of Public Health College Alcohol Study, this study examined rates of participation in volunteer activities on college campuses — a proxy for social capital — and their relationship to binge drinking.

Between 20 to 25% of students reported that they had participated in volunteer activity within the previous month. On average, students devoted 22 minutes per day to volunteer work; however, this time commitment ranged from 0 minutes to 8 hours per day. At a campus-wide level, the time commitment to volunteerism ranged from about 7 minutes to 70 minutes per day.

While individual volunteerism had only a minimal impact on binge drinking, reducing it by about 5%, campus-level volunteer activity had a significant effect on binge drinking. Students at campuses with high levels of volunteerism were 26% less likely to binge drink than students at campuses with lower levels of volunteerism.

The researchers had predicted that high levels of social capital would protect against excessive drinking but not lower-risk, light drinking. They found this to be the case. Students at campuses with high levels of volunteer activity were 32% more likely to consume 1 or 2 drinks when drinking than they were to have 3 or more drinks.

"The protective effect of social capital might reflect the effect of norms and social controls on curtailing deviant and dangerous consumption in communities where individuals are more bonded to each other and the group," the investigators suggest. Therefore,they conclude, "The findings encourage us to include as prevention programs initiatives aiming to change the social fabric of a college community."

Weitzman ER and Kawachi I. Giving Means Receiving: The Protective Effect of Social Capital on Binge Drinking on College Campuses. *American Journal of Public Health* 90 (12):1936–1939,2000.

Physician Visits Are Longer, Not Shorter

Despite the widespread belief that managed care has caused doctors to spend less time with patients, a new study shows that physician visits may, in fact, have gotten slightly longer.

Using data from the National Ambulatory Medical Care Survey (NAMCS), conducted by the National Center for Health Statistics, and the Socioeconomic Monitoring System (SMS), by the American Medical Association, investigators analyzed office visits to physicians between 1989 and 1998, when managed care had its greatest impact on medical practice.

From the NAMCS, investigators evaluated tens of thousands of randomly chosen office visits with primary care physicians and specialists. They examined the reason for the visit, its duration, and whether it was prepaid by an HMO or a capitated insurance plan. The investigators also considered whether the severity of patients' diagnoses affected the length of visits.

From the more general SMS data, duration of a visit was calculated from the total number of hours a physician reported spending with patients each week, divided by the number of patients.

Both sets of data showed that the length of visits to physicians' offices increased by 1 to 2 minutes between 1989 and 1998. The NAMCS also showed a decrease of 1 minute between 1995 and 1998, but the change was not significant.

Twice as many visits were prepaid in 1998 as in 1989, and the length of those visits increased by 2.5 minutes.

Visits to primary care physicians and specialists became longer, with the exception of psychiatrists. However, non-prepaid visits to specialists declined by nearly 3 minutes between 1995 and 1998. The patient's diagnosis did not change these general trends.

The authors might have been skeptical of their findings had similar patterns not emerged from 2 rather different data sources. They offer several explanations for the results: the increased competition for patients among health plans and physicians; more awareness and questions among patients with increased availability of health information and direct pharmaceutical advertising; and increased expectations of physicians to do more.

Mechanic D et al. Are Patients' Office Visits with Physicians Getting Shorter? *New England Journal of Medicine* 344 (3): 198–204,2001.

Dr. Mechanic's work was supported by the Investigator Awards in Health Policy Research Program.

Faith in Action Expands Grant Program For Community Volunteers

Watering a garden, playing cards, shopping for groceries, talking, just being a friend. They are simple tasks, but tasks that enrich the lives of elderly, disabled, and chronically ill people all across America.

Since its beginnings in 1983 (as the *Interfaith Volunteer Caregivers Program*), The Robert Wood Johnson Foundation's *Faith in Action* program has inspired volunteers of faith congregations to help elderly and chronically ill people in their homes. The program has grown to include 1,100 interfaith coalitions and many thousands of volunteers. And now that effort is expanding.

In a rollout ceremony held in March at the National Cathedral in Washington, D.C., RWJF announced a $100-million commitment, its largest ever, over the next seven years to build 2,000 more coalitions around the country.

"*Faith in Action* is about providing informal care and support to people who live at home with long-term health problems or disability," says Paul Jellinek, PhD, RWJF vice president. "It's about the simple things you'd do for a neighbor, like picking up groceries or shoveling the front walk when it snows, or just visiting and spending time. For a lot of these folks, the only company they have is the TV set. *Faith in Action* has successfully drawn Americans from all walks of life and faiths to help their neighbors. It now has the potential to reach even more people — and at a time when the need is clearly growing."

He cautioned, however, that even with the addition of 2,000 more coalitions, *Faith in Action* can only meet a part of the need for chronic care nationwide.

"Families, government, and the private sector all have a major role to play," Jellinek says. "*Faith in Action* provides each of us, as individuals, an opportunity to help out by helping our neighbors in need."

Indeed, Americans throughout the country seem receptive to the idea.

A survey of 663 chronically ill and 320 caregivers conducted between March and November 2000, the results of which were released at the recent press conference, reveals that three out of four respondents (77%) said they would be willing to help a non-relative or non-friend with a chronic condition. Some 93% of those interested in volunteering said they would be more likely (21%) or equally likely (72%) to help someone with a chronic condition if a religious institution organized the care. And 78% agreed that it is difficult for people with chronic illnesses to get help from their family to manage their basic care at home.

Rabbi Mark Gellman (seated left) and Monsignor Thomas J. Hartman (seated right) listen to Faith in Action recipient Lea Lazar and Faith in Action volunteer Mikey Aiken give testimonials for the program.

Katherine Wertheim (standing center) of Emmaus Senior Services, Washington, D.C.,and other attendees at the national rollout ceremony enjoy the gospel sounds of the Mighty Clouds of Joy.

"Forty years ago, older people would live with their daughters and sons, and were taken care of in that way," says Leroy Grube, who volunteers twice a week as a driver for the *Faith in Action* meals-on-wheels coalition in Sioux Falls, S.D. "But today, it's all different. The children and grandchildren move away, or the husband and wife both work and don't have time to care for the older people. The people who get these meals — you can't imagine how happy they are when I walk up to their doors. This program connects people, where families sometimes can't."

According to Jellinek, seed grants of $35,000, together with technical assistance and outreach, will help launch the new coalitions, and special attention will be paid to inner-city and remote rural areas that were somewhat under-represented in the first phase.

"Our hope is to make *Faith in Action* a household name — one of America's great volunteer programs," says Burton Reifler, MD, national program director. "Historically, if people were motivated to help neighbors who'd been affected by disasters, they could volunteer for the Red Cross. If they wanted to help build homes for the poor, they could volunteer for Habitat for Humanity. But if they wanted to provide help for neighbors with chronic illness or disability, it really wasn't clear where to turn. Our hope is they'll now say, 'My search is over. I can call the *Faith in Action* site in my community and see who needs someone with a big heart who is willing to invest a little time to help them.' "

— Shari Mycek

Nursing Educators Respond Enthusiastically To End-of-Life Care Training

When nurse educators at the American Association of Colleges of Nursing (AACN) and the City of Hope Cancer Center in Los Angeles sent out a notice for a new faculty training program in end-of-life care last year, they weren't certain they would fill the 100 available slots. To their surprise, 426 undergraduate nursing faculty immediately signed up for the End of Life Nursing Education Consortium (ELNEC) training project.

"A lot of educators and practicing health professionals want to do better in this area," says Rosemary Gibson,senior program officer at The Robert Wood Johnson Foundation. "They are grateful for anything that can help them improve care for people at this point in their lives."

Training program organizers had already received a $2.24-million grant from RWJF in February 2000, but needed more funding to accommodate everyone who had an interest. For that reason, the Foundation awarded an additional $847,000 grant in January, to increase the total number of participants from 500 to 875 people between now and 2003.

"Our goal is to make this an integral part of education and training in all US nursing schools," Gibson says.

Nurses are in a unique position to care for the dying and to help them communicate with their loved ones about what they are going through. But very few nursing schools address end-of-life care in their curricula. Further, only 2% of 950 nursing textbooks included material on this topic, according to a survey by Betty Ferrell,RN, PhD, City of Hope Cancer Center research scientist, published in the June/July 1999 issue of *Oncology Nursing Forum*. "Education mirrors society," says Ferrell. "As a society, and as a medical community, we have all been so busy avoiding death and thinking we can cure people."

End-of-life care also has received less attention because nursing instructors simply have too much material to cover in too little time,says Ferrell, who is principal investigator for ELNEC at City of Hope Cancer Center. Many nursing schools offer electives in palliative care, but it is not a required course. Instead, ELNEC organizers want to encourage educators to weave end-of-life care into their daily instruction. Educators who attend the upcoming ELNEC training sessions will receive sample lectures, slides, classroom exercises, and free textbooks. "We want to put all of the resources in their hands so they are ready to go when they return to campus," Ferrell says. The training sessions will cover such topics as pain management, communication strategies, and cultural considerations. For details, visit the Web site <www.aacn.nche.edu>.

As part of another RWJF grant, Ferrell also helped to improve end-of-life content on national certification exams for registered nurses. If students are going to be tested on end-of-life care, instructors are going to make sure they learn it, Ferrell says.

After the training sessions, ELNEC will track the project's effectiveness through evaluation forms and online discussion groups. ELNEC instructors have already received positive feedback from participants in the first two sessions,says Geraldine Bednash, RN,PhD, AACN executive director and principal investigator for ELNEC at AACN.

ELNEC will focus on undergraduate and continuing education instructors first, but eventually would like to work with other groups as well. "The next challenge will be to move on to the next level, to offer this program to the graduate-prepared nurses," says Bednash.

As newly trained faculty bring ELNEC into classrooms across the country, team members believe it has the potential to help transform care of the dying in America. They believe patients will have less pain and more support as they say good-bye to their families. And relatives will have more help as they face the loss of a loved one.

"The end of life is something we will all experience, so we want to be sure we have sensitive, competent providers caring for us at that point," Bednash says. "We're glad to be shining a spotlight on this important issue and helping make sure every provider has the same level of concern."

—MELISSA KNOPPER

The 2000 Annual Report of The Robert Wood Johnson Foundation is now available. The 2000 report, "The Challenge of Substance Abuse: Ten Years of Grantmaking," tracks the history of the Foundation's efforts to reduce substance abuse, and discusses our approaches, what we've learned, and what challenges lie ahead.

Though our mission has been to improve the health and health care of all Americans since becoming a national foundation in 1972, it was only in the late 1980s that RWJF began to discover substance abuse as a target for our philanthropic efforts. Since then, however, we have made significant investments designed to combat substance abuse — about $775 million by the end of 2000.

The report talks about our initial efforts in the field, and describes how we came to formalize combating substance abuse as a goal of the Foundation in 1991. It then discusses the strategies we have pursued since then. These include:

- Providing long-term support for innovative institutions to bring the best resources to bear on the problem.
- Building public interest and support.
- Establishing community-based service and demonstration projects to combat the sense of hopelessness and complacency in communities beleaguered by substance abuse.
- Creating and communicating new knowledge, particularly about prevention and treatment.
- Working to integrate the most effective prevention and treatment strategies into the legal and medical systems.
- Career development, to bring new people into the fight.

Together, these six strategies are intended to build an infrastructure of institutions and individuals that work at the national level, the community level, and across the two. They also work to provide evidence, examples, and a platform from which to highlight the problems of substance abuse and to bring prevention and treatment into the mainstream.

Finally, the report outlines the challenges to continued progress and offers examples of important successes that hold hope for the future. To view the 2000 annual report or request a copy, please visit the RWJF home page at <www.rwjf.org>.

2ND QUARTER

SELECTED GRANTS

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

- For building a national college alcohol prevention movement, $5.1 million to Education Development Center, Newton, Mass.
- For evaluating *A Matter of Degree: Reducing High-Risk Drinking Among College Students — Phase III,* $2.4 million to Harvard University School of Public Health, Boston.
- For evaluating the *Urban Health Initiative: Working to Ensure the Health and Safety of Children*, $7.5 million to New York University, Robert F. Wagner Graduate School of Public Service, New York, N.Y.
- For a national support center for community substance abuse coalitions, $2.8 million to Community Anti-Drug Coalitions of America, Alexandria, Va.
- For incorporating substance abuse treatment into welfare reform programs, $4.4 million to the National Center on Addiction and Substance Abuse at Columbia University, New York, N.Y.
- For evaluating the Kids Act to Control Tobacco program, $946,370 to George Washington University, Washington, D.C.
- For developing a guide to treatment programs for adolescent substance abusers, $451,107 to Drug Strategies, Washington, D.C.
- For developing a five-state consortium to implement tobacco-cessation guidelines, $399,489 to Oregon Health Sciences University, Portland, Ore.
- For improving practice and policy for people with co-occurring mental and addictive disorders, $749,993 to RAND Corporation, Santa Monica, Calif.
- For coordinating youth tobacco cessation partnerships, a renewal award of $225,196 to Center for the Advancement of Health, Washington, D.C.
- For disseminating findings from Phase IV of the College Alcohol Study, a renewal award of $574,657 to Harvard University School of Public Health.
- For building US support for the Framework Convention on Tobacco Control, a renewal award of $745,187 to National Center for Tobacco-Free Kids, Washington, D.C.
- For assessing the effectiveness of school-based drug education programs, a renewal award of $249,712 to Social Capital Development Corporation, Albany, N.Y.
- *Partners with Tobacco Use Research Centers: Advancing Transdisciplinary Science and Policy Studies.* Awards to three sites, totaling $2.5 million.
- *SmokeLess States®: National Tobacco Policy Initiative.* Awards to 16 sites, totaling $15.7 million.
- *Substance Abuse Policy Research Program.* Awards to five sites, totaling $1.1 million.

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

- For researching market-based models to reduce the number of uninsured, $200,594 to National Institute for Health Care Management Research and Educational Foundation, Washington. D.C.
- For the Health Insurance Reform Project, a renewal award of $747,895 to George Washington University.
- *Communities in Charge: Financing and Delivering Health Care to the Uninsured*. Renewal awards to three sites, totaling $2 million.
- *Research Initiative on Health Insurance.* Award of $9.1 million to University of Michigan School of Public Health, Ann Arbor.
- *Southern Rural Access Program* Revolving Loan Fund, $610,850 to Enterprise Corporation of the Delta, Jackson, Miss.

Projects to Improve the Way Services Are Organized and Provided to People with Chronic Health Conditions

- For training physicians in end-of-life care, $2.1 million to Northwestern University, Evanston, Ill.
- For promoting patient safety through health care purchasing tools, $391,074 to Academy for Health Services Research and Health Policy, Washington, D.C.
- For developing a media guide on health care quality, $254,300 to Association of Health Care Journalists, Minneapolis.
- For evaluating the Chronic Care Networks for Alzheimer's Disease project, $746,489 to Benjamin Rose Institute, Cleveland.
- For evaluating the effectiveness of telephone counseling in managing depression associated with chronic medical illness, $749,999 to Harvard Pilgrim Health Care, Boston.
- *Coming Home: Affordable Assisted Living.* Awards to eight sites, totaling $2.2 million.
- *Improving Chronic Illness Care.* Awards to 12 sites, totaling $3 million.
- *Targeted End-of-Life Projects Initiative.* Awards of three grants, totaling $1 million.
- For helping primary care practitioners assess genetic vulnerability to common chronic diseases, a renewal award of $540,402 to University of Virginia Health Sciences Center, Charlottesville.

Other Programs and Those That Cut Across Foundation Goals

- For developing physical activity programs for older adults, $351,039 to University of California, San Francisco.
- For training to help primary care providers to incorporate health behavior counseling into routine medical care, $399,500 to Church Health Center of Memphis, Tenn.
- To expand a statewide walking/health education program for older adults, $165,000 to Massachusetts Governor's Committee on Physical Fitness and Sports, Boston.
- For a conference to train member hospitals in injury prevention, $534,547 to National Association of Children's Hospitals and Related Institutions, Alexandria, Va.
- For developing an integrated online resource on health, financial, and employment services for low-income families, $305,338 to One Economy Corp., Washington, D.C.
- For studying the feasibility of developing health impact statements, $607,626 to Partnership for Prevention, Washington, D.C.
- For creating a program on human values in aging, $401,191 to Research Foundation of the City University of New York.
- For improving social connections in Shreveport communities, $400,000 to Shreveport Community Renewal, Shreveport, La.
- For promoting active living through tribal youth councils, $436,000 to United National Indian Tribal Youth, Oklahoma City.
- For developing a media-based community physical activity campaign, $354,757 to West Virginia University Research Corporation, Morgantown.
- For a clearinghouse and resource center on increasing physically active communities, a renewal award of $427,005 to The Bicycle Federation, Washington, D.C.
- For examining integration strategies in hospital systems, $292,990 to Boston University.
- For researching public opinion on RWJF priorities, $411,234 to Harvard University School of Public Health.
- *Health Tracking.* For a national survey of physician organizations and the management of chronic illness, a supplemental renewal award of $296,555 to University of California, Berkeley, School of Public Health.
- *Investigator Awards in Health Policy Research.* Awards to four sites, totaling $1 million.
- *Changes in Health Care Financing and Organization.* Awards to three sites, totaling $1.3 million.
- For establishing a postdoctoral fellowship program in health program evaluation, $297,092 to University of Pennsylvania, Philadelphia.
- For data collection and analysis of the foundation field, $250,000 to Foundation Center, New York, N.Y.
- For providing case management and mental health services to victims of Hurricane Floyd, $163,799 to We Will Rebuild, Bound Brook, N.J.
- For a citywide program to strengthen human services and resources, a renewal award of $350,000 to New Brunswick Tomorrow, New Brunswick, N.J.
- For a neighborhood family support services program, a renewal award of $454,118 to Renaissance Community Development Corporation, Somerset, N.J.
- Support for 2000–2001 campaign, an award of $205,000 to United Way of Greater Mercer County, Lawrenceville, N.J.

New Grant Results Reports Posted on RWJF Web Site

In January 2000,49 new and 3 updated Grant Results Reports were posted on the RWJF Web Site, <www.rwjf.org>. Reports on closed grants are organized by topic area. A search engine allows a full-text search. Among newly posted reports are these on projects with products available:

- **Support for the National Inhalant Prevention Coalition (NIPC)**. NIPC annually leads a week-long national grassroots inhalant education and awareness campaign, National Inhalants and Poison Awareness Week (NIPAW). Available free of charge: "Educate: Creating Inhalant Abuse Awareness Together" (video); *ViewPoint* (quarterly newsletter); and "A Parent's Guide to Preventing Inhalant Abuse" (brochure). NIPAW Coordinator's Kit is $35 plus $5 postage. Call (800) 269-4237, or visit the NIPC Web site, <www.inhalants.org>.
- **Implementation of the Kassebaum-Kennedy Legislation (Health Insurance Portability and Accountability Act [HIPAA] of 1996)**. The Institute for Health Care Research and Policy, Georgetown University Medical Center catalogued every state's implementation of HIPAA, legislation meant to protect people when they buy, keep, or switch health insurance, even if they have serious health conditions. Researchers found that HIPAA added protections for people covered by group health plans. Consumer guides to finding, getting, and keeping health insurance are available for every state and the District of Columbia at <www.healthinsuranceinfo.net>.
- **The Community Tool Box: A Computer Information Database and Exchange Network.** The University of Kansas Institute for Life Span Studies expanded and refined the Community Tool Box, an online source of downloadable information on community health (substance abuse,AIDS prevention, teen pregnancy, youth violence, rural health, and other topics), with links to many online resources. See <http://ctb.lsi.ukans.edu/>.
- ***The New Cancer Survivor: Living with Grace, Fighting with Spirit*.** The late Natalie Davis Spingarn, a 25-year cancer survivor and medical journalist, prepared a revised edition of the 1982 book *Hanging in There: Living Well on Borrowed Time.* The updated book describes how people with serious, long-term illness can achieve greater control over the quality of their lives. Available in bookstores, $45 hardcover, $16.95 paperback.

Editor's Note: The Issue 4, 2000, item on Volunteers in Medicine Institute, Hilton Head Island, S.C., listed an incorrect phone number to contact Jack McConnell, MD. He can be reached at (843) 342-5700.

— MOLLY MCKAUGHAN

PEOPLE

WELCOME

RISA LAVIZZO-MOUREY, MD, MBA, joined the Foundation in April as senior vice president and director, health care group. Lavizzo-Mourey previously was at the University of Pennsylvania School of Medicine where she was the Sylvan Eisman Professor of Medicine and Health Care Systems, director of the Institute on Aging, and chief of the division of geriatric medicine. Lavizzo-Mourey received her MD from Harvard Medical School and her MBA from The Wharton School at the University of Pennsylvania.

MARY ANN SCHEIRER, PHD, joined RWJF in March after working as an independent consultant evaluating health promotion programs, educational and human services programs, and development of performance measures. Scheirer was an adjunct faculty member of George Washington University, Department of Public Administration, Washington, D.C. She earned her doctorate in sociology from Cornell University.

CONGRATULATIONS

CALVIN BLAND, MS, was appointed special adviser to the president of RWJF in April. Previously he was a senior program adviser in the Executive Office and interim director of the health care group.

NANCY FISHMAN, MPH, was promoted from program associate to evaluation officer in the Research and Evaluation Unit.

FAREWELL

SETH EMONT, PHD, senior program officer in the Research and Evaluation Unit, left the Foundation in March to establish an independent consulting business.

LAURA LOWENTHAL, MSW, program associate, left the Foundation in April to become the deputy director for RWJF's new National Program, *Community Partnerships for Older Adults*, at the Muskie School of Public Service, University of Southern Maine.

CAROLINE ROAN, MPA, program associate, left RWJF in April to join Pfizer Pharmaceuticals Corporate Philanthropy in New York City as manager of philanthropy programs for the United States.

MERRY WOOD, program associate, bade farewell to the Foundation in April to become the outreach coordinator for the California Healthcare Foundation's Quality Initiative in Oakland, Calif.