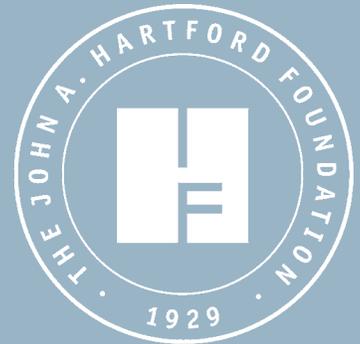


ANNUAL REPORT 2007

The John A. Hartford Foundation

**Dedicated to Improving
Health Care for Older
Americans**



Mission Statement

Founded in 1929, the John A. Hartford Foundation is a committed champion of health care training, research and service system innovations that will ensure the well-being and vitality of older adults. Its overall goal is to increase the nation's capacity to provide effective, affordable care to its rapidly increasing older population. Today, the Foundation is America's leading philanthropy with a sustained interest in aging and health.

Through its grantmaking, the John A. Hartford Foundation seeks to:

- Enhance and expand the training of doctors, nurses, social workers and other health professionals who care for elders, and
- Promote innovations in the integration and delivery of services for older people.

Recognizing that its commitment alone is not sufficient to realize the improvements it seeks, the John A. Hartford Foundation invites and encourages innovative partnerships with other funders, as well as public, non-profit and private groups dedicated to improving the health of older adults.

“It is necessary to carve from the whole vast spectrum of human needs one small band that the heart and mind together tell you is the area in which you can make your best contribution.”

THIS HAS BEEN THE GUIDING PHILOSOPHY of the Hartford Foundation since its establishment in 1929. With funds from the bequests of its founders, John A. Hartford and his brother George L. Hartford, both former chief executives of the Great Atlantic and Pacific Tea Company, the Hartford Foundation seeks to make its best contribution by supporting efforts to improve health care for older Americans.





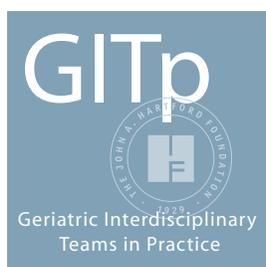
The John A. Hartford Foundation

CONTENTS

Report of the Chairman	4
Trustees and Staff	6

The John A. Hartford Foundation Program Initiative: Geriatric Interdisciplinary Teams in Practice	7
Introduction	8
Improving Care of the Chronically Ill	10
History of Commitment to Team Care	14
Team Care Models	17
Care Transitions Model	18
Improving Transitions Across Sites of Geriatric Care	20
Care Management Plus Model	29
Using Technology to Improve Outpatient Care for Older Adults	30
Senior Health and Wellness Clinic	41
Managing Care of Older Patients in the Clinic by Fostering Team Care	42
Virtual Integrated Practice Model	50
Implementing Team Care Across Practices and Virtually	52
Senior Resource Team	60
Important Role Foundations Play in Taking Risk and Learning from Failure	60
Looking Toward the Future of Team Care	62

2007 Aging and Health Grants	64
Financial Reports	67
Financial Summary	68
Independent Auditors' Report	69
Summary of Active Grants	78
Application Procedures	88



Report of the Chairman



Norman H. Volk
CHAIRMAN

IT IS ONCE AGAIN MY PLEASURE TO INTRODUCE the annual report of the John A. Hartford Foundation. This publication features the exciting work of the Geriatric Interdisciplinary Teams in Practice initiative. Launched in 2000, this nearly \$11 million investment recognizes and begins to redress the essential mismatch between our current care system, which focuses on responding to sudden illness, and the actual needs of older patients, nearly two-thirds of whom cope with two or more chronic illnesses at a time.

As research and practice has amply demonstrated, good care for these older patients is ultimately team care, utilizing and coordinating the skills not only of doctors and nurses but also social workers, rehab professionals, dieticians, and others. The Geriatric Interdisciplinary Teams in Practice project supported the creation and careful testing of five such team care models in a variety of settings around the country. The four most promising received continued funding through a \$1.1 million dissemination project at the University of Colorado. This initiative supports these model programs' efforts to create toolkits and business plans and conduct the outreach necessary for broad adoption. Spreading these kinds of innovations through the current health care system is not easy, but we believe it is critically important to ensuring that older patients receive care in ways that respond to their unique needs.

During 2007, along with our continued support for team care, the Foundation's Trustees approved 32 new grants worth \$47 million. These represent our ongoing commitment to enhancing and expanding the training of doctors, nurses, social workers, and other health professionals who care for elders; and to promoting innovations in the integration and delivery of services for all older people.

This year in the practice arena, the Foundation expanded its interest in improving home, community-based, and primary care services with two significant grants. The first will provide \$2.4 million to the Oregon Health & Science University to promote the diffusion of Care Management Plus, one of the models initially supported by the Teams in Practice initiative. This innovative primary care model combines the "high tech" of a state-of-the-art electronic health record system with the "high touch" of a specially trained care manager. The second grant approved by the Trustees, \$500,000 to the AARP Foundation, seeks to build the knowledge of professional caregivers in order to better support the 33 million family caregivers of older adults. This will fund a rigorous review of what nurses and social workers should do to support family caregiving.

The Trustees built on previous investments in both medicine and nursing to create additional academic centers of geriatric excellence. In particular, we made grants to establish three new centers of excellence in geriatric medicine to train and recruit

more geriatrics faculty. This grant expands the number of centers nationwide to 27—part of a \$38 million initiative since 1997. Similarly, the Foundation provided \$4 million to fund four new centers of geriatric nursing excellence, an effort that now includes nine centers in schools across the country. We also continued to build the geriatric capacity of the social work field. Notably, the Trustees approved a \$4.7 million renewal of the GeroEd Center at the Council of Social Work Education to enable more than 130 schools of social work to increase the geriatrics content in their curricula. We also extended our support for the Hartford Partnership Program for Aging Education, with a \$4.6 million grant to create aging-rich field experiences for Masters-level social work students at 25 additional schools nationwide.

The Foundation's assets totaled \$683.8 million at the end of 2007, representing an increase of \$42.3 million during the year, before spending for grants and expenses. In a year that saw a sharp increase in market volatility caused by the bursting of the housing bubble, we are gratified that the 6.8 percent return of the portfolio allowed for modest growth in the assets after spending. Although we did not achieve our objective of adding to the value of the endowment after spending and inflation in 2007, history has shown that through prudent diversification this goal can be met over the longer term. Accordingly, in 2007 the Foundation increased its international equity exposure and invested strategically in absolute return, private equity and real estate funds within the boundaries of acceptable levels of risk.

The composition of our Board of Trustees remained the same in 2007, but we are pleased to report an important addition to our staff. Formerly a program executive on the U.S. Ageing Team at The Atlantic Philanthropies, Christopher Langston, PhD, has taken on the newly established position of program director. A familiar face here at the Foundation, Chris served as a program officer and then senior program officer from 1997 to 2005. In his new role, he will focus on supporting program staff, shaping grantmaking strategy, and, along with Corinne Rieder, our executive director, expanding the Foundation's relationships and influence with other funders and decision makers.

Finally, I would like to recognize the extraordinary and ongoing efforts of our Board of Trustees, staff, and grantees. I am proud to be a member of such a dynamic and superbly professional group of people. It is an honor and a pleasure to serve with them to further the Foundation's critically needed work and ensure that the growing number of older adults receive the health care they, and indeed we all, deserve.



Norman H. Volk

Trustees

NORMAN H. VOLK

CHAIRMAN

KATHRYN D. WRISTON

PRESIDENT

WILLIAM T. COMFORT, JR.

SECRETARY

JOHN H. ALLEN

ANSON MCC. BEARD, JR.

JOHN J. CURLEY

LILE R. GIBBONS

JAMES G. KENAN III

CHRISTOPHER T. H. PELL

BARBARA PAUL ROBINSON

MARGARET L. WOLFF

Staff

CORINNE H. RIEDER

EXECUTIVE DIRECTOR AND TREASURER

SAMUEL R. GISCHE

FINANCE DIRECTOR AND CONTROLLER

CHRISTOPHER A. LANGSTON

PROGRAM DIRECTOR

STEVE ABRAMOVICH, JR.

INFORMATION TECHNOLOGY OFFICER

AMY J. BERMAN

PROGRAM OFFICER

MARCIA E. BROWN

EXECUTIVE ASSISTANT

EVA Y. CHENG

ASSISTANT CONTROLLER

BENITA B. COX

ADMINISTRATIVE OFFICER

MANUELA CRUZ-GALAN

RECEPTIONIST

FRANCISCO J. DOLL

GRANTS MANAGER

JAMES G. GALLAGHER

GRANTS MANAGEMENT ASSOCIATE

MARCUS R. ESCOBEDO

PROGRAM ASSOCIATE

GAVIN W. HOUGHAM

SENIOR PROGRAM OFFICER

JULIANNE N. MCLEAN

PROGRAM SECRETARY

JAMES F. O'SULLIVAN

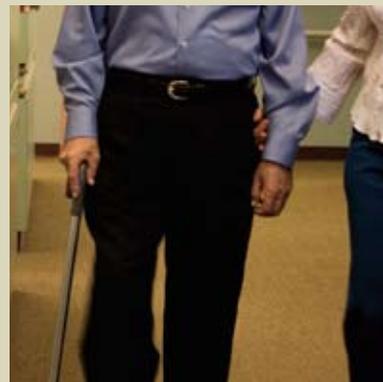
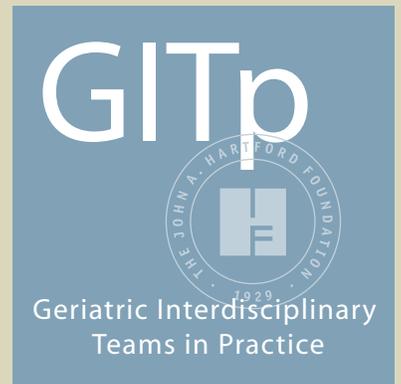
SENIOR PROGRAM OFFICER

RACHAEL A. WATMAN

PROGRAM OFFICER

THE JOHN A. HARTFORD FOUNDATION PROGRAM INITIATIVE

Geriatric Interdisciplinary Teams in Practice



Introduction

For thirty years, experts have warned that the United States' health care system, which is focused primarily on acute care, is unprepared to provide adequate chronic care for the aging "baby boom" generation. Despite these admonitions, America's health care policies and providers have not focused on chronic care. Its hospitals, nursing homes, outpatient clinics, and home care agencies still operate as uncoordinated silos and the quality and efficiency of chronic care in America remain far from optimal.

The cost of fragmented, inefficient chronic care is high. Medicare beneficiaries with four or more chronic conditions account for 80 percent of Medicare spending,¹ which totaled \$402 billion in 2006.² American medicine stands at a worrisome crossroads as the first baby boomers near retirement age. Without prompt transformation, chronic care in America will soon become unsustainably expensive. Re-designing primary care to provide high-quality chronic care requires new and realistic strategies.

1- Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med* 2002;162:2269-76.

2- Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Fund. Paulson, H. M., Chao E., Leavitt M. O. et al (online). Available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf>. Accessed January 22, 2008.

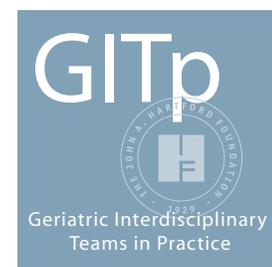
To help bridge the gap between the growing need for high-quality chronic care and the present fragmented, acute care-oriented delivery system, the John A. Hartford Foundation has made a long-term commitment to fund the creation and dissemination of new conceptual models of chronic care for the nation's older adult population.

At the heart of an effective geriatric chronic care system is a strong interdisciplinary team. Studies have shown that innovations in interdisciplinary team care, enhanced decision support, improved clinical information systems, support for self-management, and better access to community resources can improve clinical and/or financial outcomes in outpatient settings,³ in the home, and during transitions between sites of care.⁴

Over the past two decades, concepts of interdisciplinary team care have been woven into many of the Foundation's grants in the areas of medicine, nursing, and social work. These concepts have been directly addressed in a series of initiatives starting in 1992 with the Generalist Physician initiative and culminating in current efforts to disseminate models of team care developed under the Geriatric Interdisciplinary Teams in Practice (GIT-P) grants. Four strong models of team care—the Care Transitions Intervention, Care Management Plus, Senior Health and Wellness Clinic, and Virtual Integrated Practice—have shown improvements in health care quality and cost, and are being actively promoted to achieve widespread adoption.

Bringing change to health care delivery is a difficult undertaking. The Hartford Foundation employs three core strategies in its efforts to transform the health care system to improve care: prove and promote innovations in health care delivery, articulate the financial impact and benefits to make the case for adoption, and shape the system to demand innovation.

The Hartford Foundation's commitment to improving the health of our nation's elders has led to significant shifts and broad dissemination of innovations across care settings. Through these efforts, the Foundation has a direct and major impact on the care of older adults across the country.



3- Counsell SR, Callahan CM, Clark DO et al. Geriatric care management for low-income Seniors: A randomized controlled trial. JAMA 2007;98(22):2623-33.

4- Coleman EA, Min S, Chomiak A, Kramer AM. Post-hospital care transitions: patterns, complications, and risk identification. Health Serv Res. 2004;39:1449-1465.

Improving Care for the Chronically Ill

CHRONIC ILLNESS DISPROPORTIONATELY AFFECTS OLDER ADULTS.

Most Medicare beneficiaries (82 percent) have at least one chronic condition. Two-thirds of these older adults have several chronic conditions, with 24 percent coping with four or more.⁵ These older adults can suffer from the fragmented nature of the health care delivery system in numerous ways. For example, medical errors, which are often caused by faulty systems, injure a million or more people each year and are the cause of about 100,000 deaths, according to a widely publicized report by the Institute of Medicine in 2000.⁶



Older adults with chronic illnesses are particularly vulnerable. Even with no chronic health conditions, older adults typically fill about 10 prescriptions each year for various health problems. For a person with five chronic illnesses, the number of prescriptions jumps to 57. Drug interactions and mistakes in administration by both patients and providers can have serious health consequences. More than a million patients are injured annually from medication errors, according to the U.S. Food and Drug Administration. Nearly 50 percent of deaths caused by medication errors occur in older adults.

In the current disease-focused system, patients see different physicians for treatment of each ailment: a cardiologist for heart disease, an endocrinologist for diabetes, an ophthalmologist for glaucoma, and so on. The high quality care delivered by each provider can easily suffer when physicians do not communicate with one another and fail to coordinate care.

The following scenario demonstrates how the health care system can fail the most vulnerable patients:

At age 80, Mrs. Jones, a widow who lives by herself, takes medications for arthritis, high blood pressure, high cholesterol, glaucoma, and osteoporosis. At a family get together, she faints and is rushed to the hospital where it is discovered that her blood sugar levels are high. She is diagnosed with type 2 diabetes. The doctor in the hospital gives her a new prescription and some brief instructions about diet and exercise. He also tells her to make an appointment with her primary care doctor and a nutritionist.

Mrs. Jones, upset about being in the hospital and rattled by the new diagnosis, does not remember all of the instructions. She does not know a nutritionist to call and does not change her diet. She starts to take the new medication, but it doesn't make her feel any better. Because of her difficulty walking, she decides to put off seeing her doctor until she is feeling stronger.

5- Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med* 2002;162:2269-76.

6- Leape L, Member, Quality of Health Care in America Committee, Institute of Medicine, and Adjunct Professor, Harvard School of Public Health. Concerning Patient Safety and Medical Errors. Statement before the United States Senate Subcommittee on Labor, Health and Human Services, and Education. January 25, 2000.

Mrs. Jones gets weaker and more fatigued. Her vision becomes blurry and she experiences a tingling sensation in her hands and feet. When Mrs. Jones's daughter comes to check on her mother, she discovers her mother in distress and calls for an ambulance. Mrs. Jones is readmitted to the hospital. Her diabetes is not under control, and now she is unable to walk as a result of deconditioning. She is now having difficulty managing for herself at home.

Older adults coping with multiple chronic medical conditions require the most intense management of conditions and coordination of care, yet they are the very patients who often slip through the cracks and wind up in jeopardy as a result of the system that is supposed to serve them. Patients who present the greatest challenges often have multiple chronic illnesses coupled with cognitive impairment, depression, or physical limitations.

In an ideal health care system, care for these vulnerable older patients would be provided through interdisciplinary teams. Communication among physicians, nurses, social workers, pharmacists, dieticians, physical therapists, and others, would utilize well-designed information technology systems. Patients and family caregivers would be treated as integral members of the team, rather than as passive recipients of medical procedures and advice. Well-informed patients would become motivated to actively take part in their own healing and wellness.

When Mrs. Jones receives health care from a well-coordinated interdisciplinary team the result is very different:

Mrs. Jones has a primary care physician and also sees specialists for her chronic conditions. Her care is coordinated with an efficient information technology system that facilitates communication among all of her health care providers. After fainting at the family party, Mrs. Jones goes to the hospital and receives the diagnosis of diabetes. Her primary care doctor is alerted to the hospitalization and a receptionist calls Mrs. Jones to schedule a follow-up appointment. The doctor, who has limited time to educate Mrs. Jones about the management of diabetes, engages other members of the health care team. A nutritionist is consulted and takes time to educate Mrs. Jones about the dietary requirements for a person with diabetes. A pharmacist reviews all of the medications Mrs. Jones is taking and makes suggestions to the physician for combinations of drugs that will not adversely interact with one another. The pharmacist also reviews all of the instructions for each of the medications with Mrs. Jones. Because



In 1996, the multi-site Geriatric Interdisciplinary Team Training initiative demonstrated the feasibility of bringing medicine, nursing, social work, and other health professions students together to learn team skills and interdisciplinary practice in order to provide better care to older adults with multiple health conditions.

Mrs. Jones has difficulty walking, making it hard to get to the clinic, a social worker connects her with a local senior center that offers van rides to older adults.

Mrs. Jones's health improves. The deterioration in her ability to walk was partly due to fatigue brought on by her diabetes, and now she feels well enough to attend an exercise program at the senior center. Not only does Mrs. Jones stay out of the hospital—she feels stronger and more confident. She is able to join her daughter and grandchildren on an outing to her favorite botanical garden.

Team Care Recognizes and Embraces Complexity

The project development teams of the five Geriatric Interdisciplinary Teams in Practice (GIT-P) models recognized that care of patients with complex care needs can be both rewarding and cost efficient, contrary to what many health care professionals believe. At the core of good geriatric care are these elements: prevention, patient self-management, involvement of family caregivers, efficient use of information technology, and a strong interdisciplinary team.

Ideal team care involves consultation with the right provider at the right time and effective communication among providers to prevent avoidable complications, catch medication problems and other types of errors, and ensure patient safety.

Well-coordinated team care emphasizes team building and use of information technology to share information, coordinate care, and ensure efficient use of evidence-based guidelines. Team building activities help health professionals to work together more efficiently and information technology systems serve as a valuable aid to patient care. Ultimately, interdisciplinary team care can be very rewarding for health care professionals, who gain a sense of accomplishment when chronically ill patients improve.

Because patients with complex needs tend to see numerous health care providers in different settings, effective team care must extend to multiple care settings, including the hospital, hospital clinic, skilled nursing facility, physician's office, and other sites of care. Currently, 33 percent of care plans are not transferred between health care settings. Making matters worse, patients released from the hospital, and their caregivers, may be unprepared for their self-management role.

“Team care is not an endpoint; team care is one of the essential ways to improve care of the chronically ill,” says Eric Coleman, MD, Professor

of Medicine, Divisions of Health Care Policy and Research and Geriatric Medicine, University of Colorado Health Sciences Center.

Team Care is Cost-Effective Care

Interdisciplinary team care clearly benefits patients and providers, but it also has the potential to produce significant cost savings to the health care system. Health care for older adults with chronic illnesses is expensive. In the United States, 125 million people are living with chronic illnesses;⁷ they account for approximately three-fourths of total healthcare spending,⁸ and costs are rising.

Older adults are particularly hard hit; the 65 percent of Medicare recipients who have two or more chronic illnesses account for 95 percent of all Medicare spending.⁹ Despite these high expenditures, the Institute of Medicine reports that over half of patients with various chronic diseases, including diabetes, high blood pressure, congestive heart failure, and depression, are managed inadequately.¹⁰

These facts make widespread implementation of the GIT-P team care models essential, especially if they can deliver on the promise of producing cost savings for the health care system.

Making Team Care the Standard of Care

Organizations such as the Institute of Medicine (IOM) and the Joint Commission strongly advocate change. In its 2001 report “Crossing the Quality Chasm,” the IOM defined a vision for improving the quality of the nation’s health care. The report distilled the elements of change into six guiding principles.¹¹ Health care should be:

- Safe
- Effective
- Efficient
- Patient-centered
- Timely
- Equitable

Even though influential organizations and health policy experts have strongly advocated interdisciplinary team care, it has not yet become the standard of care. Therefore, the Foundation encouraged grantees of the initiative to develop models practical for implementation in “real world” scenarios. Initial conversations with the ultimate adopters have eased the way for implementation in many settings. In addition, health policy must be shaped to create demand for new models of care. Medicare has an acute-care approach to reimbursement. Consequently, innovative cost-effective models to promote prevention and wellness are not well-supported.

7- Adams K, Corrigan JM (Eds). Priority areas for national action: Transforming health care quality. Washington, DC: National Academies Press. 2003

8- Hoffman C, Rice D, Sung HY. Persons with chronic conditions: their prevalence and costs. JAMA. 1996;276(18):1473-1479.

9- Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. Arch Intern Med. 2002;162(20):2269-2276.

10- Institute of Medicine. The chasm in quality: Select indicators from recent reports. Crossing the Quality Chasm: The IOM Health Care Quality Initiative. <http://www.iom.edu/?id=14991>

11- Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001.

Hartford's Commitment to Team Care

EFFECTIVE INTERDISCIPLINARY TEAMWORK has been shown to enhance quality of care, improve patient safety, and reduce medication errors, while making the duties of health care professionals more personally rewarding and efficient. Yet evidence alone does not bring about change in the large, well-entrenched health care system. Translating study findings into clinical practice requires visionary leadership to create and fund innovative, cost-effective models of care that become widely accepted and adopted across the health care system.



For over two decades, the Foundation has funded initiatives aimed at improving care of older adults by incorporating interdisciplinary team care into professional education and clinical practice. The current team care initiatives build on past successful work that utilized an interdisciplinary team care approach.

The Acute Care for Elders (ACE) model, which was created by C. Seth Landefeld, MD, and colleagues, first funded in 1989, integrates geriatric assessment into the medical and nursing care of hospitalized older patients using interdisciplinary teams. ACE units are specialized units in the hospital that incorporate home-like features and encourage patients to be active and involved in their care.



Project IMPACT (Improving Mood-Promoting Access to Collaborative Treatment), launched in 1999, is an \$11.1 million ground-breaking team model for late-life depression treatment in primary care. IMPACT demonstrated that team management of depression in primary care can improve the quality of life of elders in ways that are both practical and cost-effective.

The Generalist Physician initiative, which was funded in 1992, sought to improve primary care office practice by bringing health professionals such as nurses, social workers, and physician assistants into traditional physician care. From this initiative, the Foundation realized that improved academic training models were needed to prepare future professionals for interdisciplinary practice.

Education programs for health care professionals tend to follow strict disciplinary lines, leaving students unprepared for the work of facilitating and implementing patient care plans in an interdisciplinary setting. The Foundation's Geriatric Interdisciplinary Team Training (GITT) program, begun in 1995, focused on educating future health professionals (physicians, nurses, and social workers) to provide interdisciplinary care. GITT succeeded in demonstrating the

(Above) Students and faculty at the Houston Geriatric Interdisciplinary Team Training [GITT] initiative meet to learn how to bring the combined expertise of many health disciplines to support effective team care.

(Below) A Houston GITT team poses with their patient.

feasibility of introducing formal education and training on geriatric teams into the education of health care professionals. GITT showed that even experienced professionals can improve their teamwork skills.

From the GITT initiative it became clear that training future professionals in team care was essential, but change must also take place at the system level. Most health care systems do not deliver care to older patients effectively or efficiently, in part because they do not make appropriate use of interdisciplinary teams. A 1999 report by Chad Boulton, MD, MPH, MBA, and colleagues noted that the use of teams in innovative health care models “reflects the growing sense that chronically ill older people need additional expertise and structure in their health care,” but that relatively few health systems provide such care. They conclude that, “conditions are ripe to reward informed innovation in the care of chronically ill older people.”

The Geriatric Interdisciplinary Teams in Practice (GIT-P) initiative was first funded in June 2000 to support the creation and careful testing of innovative models of interdisciplinary team care. The overarching goals of this initiative were to (1) demonstrate the effectiveness of new models of interdisciplinary team care; (2) create exportable models, toolkits, and business plans that are compelling to the primary audiences of end adopters (namely payers, health care systems, and providers); and (3) promote wide-scale adoption of successful models.

Five sites were selected to conduct demonstration projects evaluating the clinical and financial impact of geriatric team care for five team models: 1) Care Transitions Intervention (University of Colorado Health Sciences Center); 2) Care Management Plus model (Intermountain Health Care and Oregon Health & Science University); 3) Senior Health and Wellness Clinic model (PeaceHealth Oregon Region); 4) Virtual Integrated Practice model (Rush University Medical Center); and 5) Senior Resource Team model (Group Health Cooperative). The findings from four of these projects were compelling and warrant a broad-based transfer of these models into new health care settings. The Senior Resource Team model was not successful, and therefore a case could not be made to move forward to a dissemination phase.

To facilitate the dissemination of the four models, in 2005 the Foundation awarded a three-year grant of \$1,128,206 to the University of Colorado Health Sciences Center to lead the effort to promote the adoption of the models into practice nationwide. Rather than award



Project IMPACT established the utility of an interdisciplinary model incorporating medicine and nursing or social work to provide targeted management of depression in older adults in the primary care setting.



Case conferences at which medical professionals model team skills are an integral part of Geriatric Interdisciplinary Team Training. Here, at New York's Mount Sinai School of Medicine, the clinical team attends a daily morning meeting at which care plans for patients with complex health conditions are reviewed.

individual dissemination grants to each site, the Foundation chose to structure the effort under one grant. The dissemination project is led by Eric Coleman, MD, MPH, Professor of Medicine, Divisions of Health Care Policy and Research and Geriatric Medicine, University of Colorado Health Sciences Center (UCHSC). Dr. Coleman is also the chief architect of one of the team care models—the Care Transitions Intervention.

The coordinating center at UCHSC collaborates with project leaders to develop an overall plan for promoting adoption of the models. By bringing the models together under the umbrella of one dissemination effort, the grantees can share results, learn from each other, take advantage of economies of scale, and spread the word about each other's projects. Key steps for ensuring successful adoption include engaging senior management and clinical leadership, effective presentation of process and outcome data, identifying an existing infrastructure that can support adoption, and articulating how the innovation responds to immediate and significant pressure in the practice environment.

Grant funding is used for four activities:

- Prepare marketing and training materials
- Refine the business case for the models and help project staff to present them effectively to health care leaders
- Develop a common brand identity
- Cross-train investigators to serve as spokespersons for all models

All of the models continue to be strongly supported within their own environments and have stimulated adoption in other settings. In 2005, when the grant was awarded, the Foundation anticipated 20 early adoptions by the end of three years. This goal was met in just one year and by 2007 had been far exceeded.

Team Care Models

The advantages of interdisciplinary team care for improving the lives of older adult patients with chronic illness have been clearly demonstrated. The challenge remains to reshape the health care system in ways that transfer the knowledge gained from early studies and programs of team care into everyday clinical practice. With support and guidance from the Hartford Foundation, the five grantees of the GIT-P initiative developed innovative models of team care. The Foundation encouraged each of the grantees to keep the end user in mind as they developed these models.

Five sites were chosen that represent different approaches to interdisciplinary team care for treatment of older patients with chronic illnesses. These grants recognized the diversity of settings in which older adults receive health care services.

- The **Care Transitions** model addresses the challenge of coordinating care when patients must move among health care settings (for example, going to a rehabilitation facility or home after a stay in the hospital).
- In the **Care Management Plus** model, the care manager is augmented by information technology systems to facilitate care coordination.
- The **Senior Health and Wellness Clinic** model is an out-patient, primary care clinic that teaches and reinforces team care among its multi-disciplinary practitioners to deliver ambulatory primary care to frail, vulnerable elders living in the community.
- Because many primary care physicians work in solo or small practices, the **Virtual Integrated Practice** model was developed to allow for the creation of interdisciplinary teams of practitioners working in different settings.
- In the **Senior Resource Team** model, an interdisciplinary consulting team (composed of a geriatrician, gerontological nurse practitioner, and pharmacist) is embedded in a primary care practice.

The developers of these interdisciplinary, coordinated team care models are leading the way toward a revolution in the care of the nation's older adult population. Four of these models (described below) produced compelling evidence for improved, cost-effective geriatric care and are being vigorously promoted and disseminated with support from the Foundation's Dissemination of GIT initiative. The fifth model, while not being actively disseminated, offered important lessons.



Care Transitions Model

Starting when a patient is scheduled to be discharged from the hospital, the Care Transitions Model helps older patients at high risk for complications or rehospitalization. The Transition Coach, a specially trained nurse, visits with the patient and their caregivers over four weeks—both in the hospital and at home—and helps patients learn to manage multiple prescriptions, follow post-hospital recommendations, and present their other health care providers with the information they need to be effective. Over 100 hospitals and health care systems had adopted the model by 2007.





Improving Transitions Across Sites of Geriatric Care

TO ADDRESS THE PROBLEMS of uncoordinated and fragmented care around the period of hospitalization, the Foundation awarded the University of Colorado Health Sciences Center, Denver, Colorado, a five-year grant of \$1,207,404 in 2000 to develop the Care Transitions Intervention. Dr. Eric Coleman served as principal investigator of this project. Dr. Coleman is a Robert Wood Johnson Clinical Scholar and a Beeson Scholar. He has served on the American Geriatrics Society health care systems committee and has worked with federal policy makers through convenings such as those of the National Health Policy Forum.



Eric Coleman, MD, MPH
Principal Investigator,
Care Transitions
University of Colorado

Older patients with serious or multiple chronic illnesses are at risk for suffering new health problems or worsening of their existing conditions following a hospital stay. For example, a patient with diabetes who has received confusing or possibly conflicting information about a change in his medication regimen while in the hospital may wind up with uncontrolled blood sugar levels.

Older patients with complicated health problems often see numerous health care providers, a number that increases if treatment in a hospital becomes necessary. The patient may be treated by a primary care physician and various specialists in their medical offices, a hospitalist physician and nursing team in the hospital, a different physician and nursing team during a stay in a skilled nursing facility, and a visiting nurse in the home. Care can become fragmented when these providers work independently of one another or, worse, at cross purposes. Even when each health care provider delivers high quality care, the result can be substandard care if their efforts are not coordinated.

Shorter hospital stays and inefficient systems for transferring medical information from one health care site to another often place a burden on patients and their families to navigate the complex health care system. Yet patients and their families rarely receive adequate information and preparation to manage and coordinate care after a hospital stay.

Lack of coordination on the part of health care providers and inadequate preparation of patients increases the risk for medication errors and health complications. This leads to avoidable readmissions to the hospital, leading to greater health care costs. National 30-day readmission rates among older Medicare beneficiaries range from 15 to 25 percent.^{12,13}

12- Coleman EA, Min S, Chomiak A, Kramer AM. Post-hospital care transitions: patterns, complications, and risk identification. *Health Serv Res.* 2004;39:1449-1465.

13- Centers for Medicare and Medicaid Services. Medicare Quality Monitoring System. 2006. http://www.cms.hhs.gov/QualityInitiatives/GenInfo/15_MQMS.asp.

Medication errors are of particular concern. A study by Dr. Eric Coleman and colleagues found that 14 percent of elderly patients admitted to the hospital experienced one or more discrepancies between their prehospital medication regimen, posthospital medication regimen, and what the patient reported actually taking.¹⁴ Factors involving patients, such as misunderstandings and other reasons for not complying with the regimen, contributed to about half of the medication errors. The other half of the errors were attributable to prescribers or the broader health care system. Medication discrepancies led to a greater number of hospital readmissions within 30 days.

Dr. Eric Coleman and his colleagues at the University of Colorado Health Sciences Center developed the Care Transitions Intervention team care model (www.caretransitions.org) to address these problems. The Care Transitions Intervention focuses on providing support and education for the patient and family caregiver. Interdisciplinary team care generally does not extend beyond the walls of a given institution. The only common thread moving across all sites of care is the patient and the caregiver, who become de facto care coordinators.

“We need to fix the broken health care system where providers don’t talk to each other,” says Dr. Coleman. “But in the meantime, we need to support patients and families in their self-management role.” Placing the older adult patient (and caregiver) at the center of the interdisciplinary team in no way abdicates the responsibilities of the health care professionals. This arrangement encourages greater accountability for ensuring that the essential steps that need to take place before and after transfer are executed.

The Four Pillars of Care Transitions

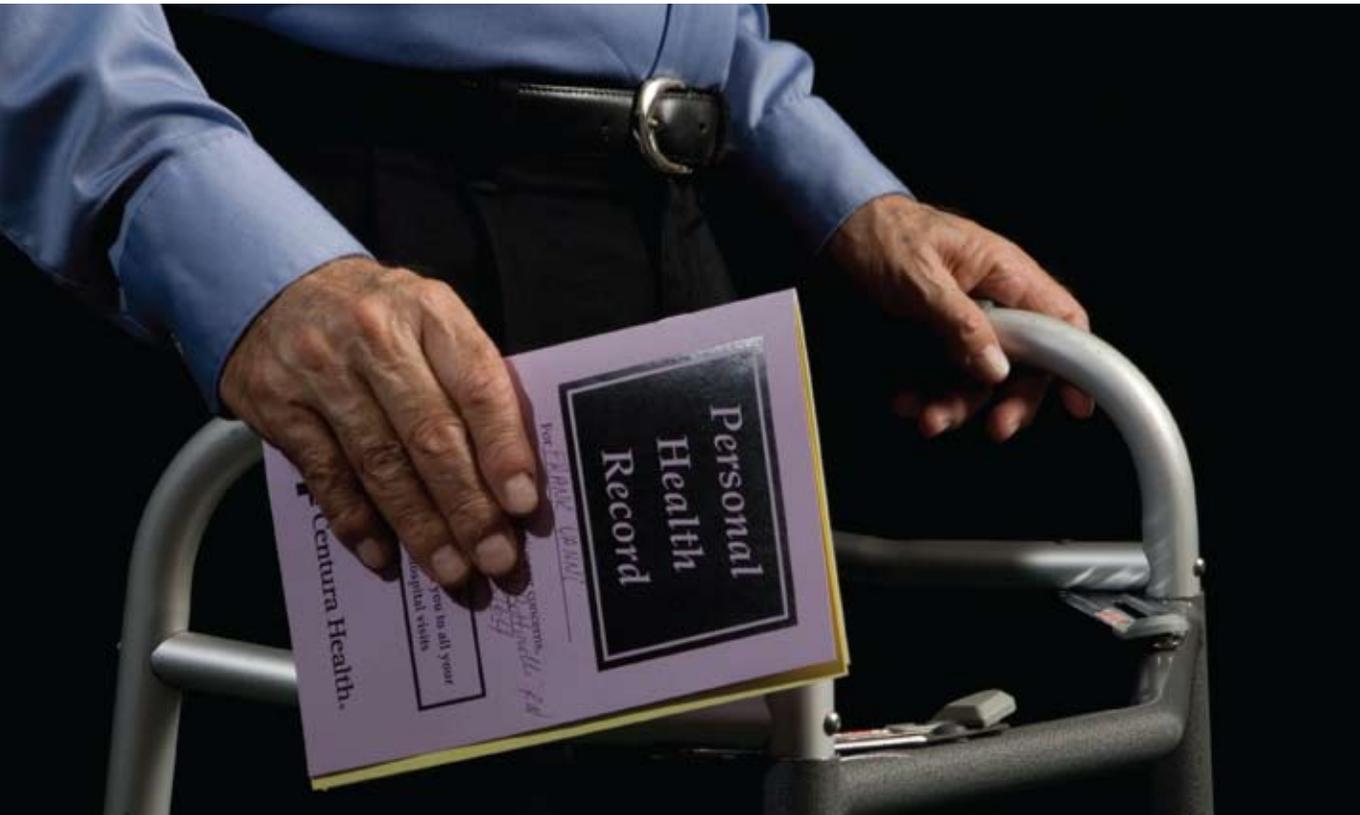
During the four-week Care Transitions program, patients with complex care needs and family caregivers work with a “Transition Coach” and learn self-management skills that will ease their transition from hospital to home. The coach is an advanced practice nurse or a registered nurse who has received training in the Care Transitions Intervention program. This intervention is centered on four pillars:

1. Medication self-management
2. The Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

*“If you’re selling umbrellas,
you have to figure out
how to make it rain.
We make it rain by
reshaping the health care
environment to embrace
these team care models.”*

*Eric Coleman, MD, MPH
Principal Investigator,
Care Transitions*

14- Coleman EA, Smith JD, Raha D, Min S. Posthospital medication discrepancies. Arch Intern Med. 2005;165:1842-1847.



A low-tech but highly effective tool developed by the Care Transitions team—the Personal Health Record—helps patients track prescriptions and instructions from their different doctors and other health care providers. By bringing the record to each visit, patients can keep their different doctors informed and reduce the risk of rehospitalization or medication errors.

The transition coach visits the patient for the first time just prior to discharge from the hospital and then makes a home visit a few days later. During this home visit, the coach reviews all of the medications the patient is taking. If errors are detected or if the regimen is confusing or impractical, the coach helps the patient and family caregiver to communicate their questions and concerns to the relevant health care provider.

The coach also educates the patient about warning signs (red flags) that the patient's condition may be worsening and helps him or her to understand when to call the physician or other health care provider. If patients have particular questions or concerns about their care, if they've received conflicting instructions from different care providers, or if they simply need clarification about something, the coach supports them in communicating with their care providers.

The coach also instructs the patient in the use of the Personal Health Record, in which the patient records medicines and administration schedules, allergies, instructions from health care providers, red flags for his or her disease, and questions and concerns to discuss at future health care visits.



PATIENT LEAVING THE HOSPITAL



The Care Transitions Model

focuses on patients at high risk for complications or rehospitalization.

Prior to discharge from the hospital, a specially trained nurse (the coach) visits the patient to begin the process of a successful transition to self management at home.



The Transition Coach

For patients released to a skilled nursing facility, the coach makes a second visit prior to discharge home.

At the home visit, the coach:

- Reviews medication orders
- Educates about warning signs (“red flags”) of a worsening condition
- Reviews the Personal Health Record
- Provides support in communicating with care providers

Three follow-up phone calls are made by the coach: two days later, a week after that, and then two weeks later.

“We recognized that even smart, innovative models can wind up with no takers if they turn out to be impractical from the standpoint of the delivery system.”

*Eric Coleman, MD, MPH
Principal Investigator,
Care Transitions*

Structured visits and phone calls by the coach promote safe transitions during the critical first month at home following a hospitalization. The patient is encouraged to call the coach at any time with questions.

For patients discharged from the hospital to a skilled nursing facility, once weekly the coach visits the skilled nursing facility until the patient returns home.

“Patients really have a chance to regain their independence through this program,” says Kathryn Botinelli, Transitions Coach, Centura Home Health, Denver, Colorado. She has witnessed the change in patients from being confused and overwhelmed to feeling confident and being active participants in their own healing. “The program, and particularly the Personal Health Record, helps them to feel that they can talk to the doctor instead of just being talked at by the doctor,” she says.

While the Care Transitions program lasts for just one month, the impact has been shown to be more long-lasting. The patients who participate in the program have complex chronic illnesses and therefore are at high risk for repeat hospitalizations. They use the self-management skills learned during the program in subsequent episodes of care transitions.

Measuring the Success of Care Transitions

With the Care Transitions Intervention model patient health and well-being are improved and the health care system derives cost savings from reduced readmission to the hospital. Both patients and health care providers report satisfaction with the program.

These results were demonstrated in studies conducted by Dr. Coleman and his colleagues. In one study, performed in 2004, hospitalized patients who received the Care Transitions Intervention were approximately half as likely to return to the hospital as those who did not receive the intervention.¹⁵ In a study from 2006, which was funded by the Hartford Foundation, patients receiving the Care Transitions Intervention also had lower rehospitalization rates.¹⁶ This study also found that hospital costs were lower for patients with care transition coaches. The investigators estimated that the hospital, health plan, or clinic which employs the coach can realize annual net cost savings of \$295,594 across 350 patients.

Dr. Coleman’s team has also shown that patients who were assisted by care transitions coaches had greater knowledge and skills regarding

15- Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer A. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. *J Am Geriatr Soc.* 2004;52:1817-1825.

16- Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med.* 2006;166:1822-1828.

their illness.¹⁷ They understood how to manage their medications and they confidently knew what was required of them during the transition period. The continuity of the coaching relationship fostered a sense of caring, safety, and predictability about the transition, which contributed to greater patient investment in the program.

Moving the Model from Two Sites to 100

The Care Transitions model was initially tested in two health systems: Kaiser Permanente of Denver and Centura Health. Even after the demonstration project was completed, these institutions continue to utilize the Care Transitions Intervention. Efforts to disseminate the model to other institutions have resulted in 100 organizations adopting the model by the end of 2007.

Of the four team care models in the dissemination of GIT-P grant, the Care Transitions model is the most widely disseminated. One surprise for Dr. Coleman and his team has been the diversity of health care delivery systems that have adopted the model. In developing the model, the team felt that it was a natural fit for Medicare Advantage (Medicare Managed Care Plans). They have also partnered with hospitals and home care agencies.

One key to the Colorado team's success in disseminating their model lies in the groundwork laid from the beginning. "Early on we were encouraged to think about what the end adopters would need," says Dr. Coleman. As part of the initial grant, the Hartford Foundation had asked them to write a business plan, which proved to be pivotal to the success of the program. He and his team put together a panel of experts (the key decision makers from health plans, hospitals, nursing homes, and home care agencies), presented the model, and sought input from the outset. They received concrete suggestions, which were used to alter the model. These recommendations, combined with input from patients and families, allowed Dr. Coleman and his colleagues to create a model that was likely to be implemented.

Dr. Coleman also emphasizes that widespread dissemination depends on influencing the health care environment to build demand for this and other models of team care. Traditionally, a new model of care is developed and tested and then marketed to the end user or adopter. Dr. Coleman advocates a different approach. He works to influence the delivery system to make effective team care, including improved transitions across sites of care, a requirement. For example, Dr. Coleman and his colleagues partnered with the consumer

"The Care Transitions program is attractive because it is a relatively low cost and relatively simple intervention that has the potential to produce a very good return on the investment, both in terms of clinical outcomes and financially."

Alan Lazaroff, MD
Director of Geriatric Medicine,
Centura Senior Life Center
Denver, Colorado
Adopter of Care Transitions
Intervention



In Denver, CO, Frank Yanni meets with his primary care physician, Alan Lazaroff, MD, at Centura Senior Life Center several weeks after being discharged from the hospital.

17- Parry C, Kramer H, Coleman EA. A qualitative exploration of a patient-centered coaching intervention to improve care transitions in chronically ill older adults. *Home Health Serv Q.* 2006;25(3-4):39-53.

A Transition Coach Makes Recovery from Surgery Faster, Easier

When Frank Yannì, 69, a participant in the Care Transitions Intervention program, noticed that the pain he was experiencing weeks after surgery for a staph infection of the spinal cord was not only not getting better but was getting worse, he knew to insist that it be looked into. A magnetic resonance

Colorado, has witnessed the devastating consequences when older adult patients fail to recognize early warning signs of an exacerbation of their illness and wind up critically ill. Now working as a Transitions Coach, Ms. Bottinelli is particularly interested in educating patients just discharged from the hospital about warning signs of complications that require early attention before a crisis occurs.

Ms. Bottinelli began working with Frank and his wife Beatrice in August 2007. She first met the Yannìs in the hospital when Frank was preparing to go home. The first surgery for the

infection had left Frank in pain, for which he needed potent medications. Ms. Bottinelli focused much of her work with the Yannìs on pain control issues. Frank relied heavily on his wife to keep track of his medication schedule. "Our little purple book [the Personal Health Record] has been a great help to us," says Beatrice. "I can keep track of all his medications." Because Frank's medications were changed frequently, Ms. Bottinelli worked closely with the couple on medication reconciliation.

Ms. Bottinelli also helped Frank with goal setting. He set as his goals being free from pain and being able to walk unaided. After the second surgery, Frank began to feel markedly better. The pain was diminishing and he was able to start physical therapy, including water aerobics, to regain mobility. He is steadily getting better and is optimistic that he will achieve his goals.

Having the opportunity to work with a Transitions Coach meant a lot to the Yannìs. "Kathryn has been a great help to us," says Beatrice. "Working with her was very rewarding for me," adds Frank.

Ms. Bottinelli also derives great satisfaction from working with the Yannìs and other patients and family caregivers as their coach. She sees patients who are able to maintain their independence largely because they have access to the tools provided by the program, such as the Personal Health Record where they can read about red flags for their condition, write down the content of conversations with their coach and health care providers, and keep track of medications. This can be especially helpful for patients experiencing memory difficulties.

"With the Personal Health Record, patients feel more intelligent talking to the doctor," says Ms. Bottinelli. And it helps the physician, especially for patients seeing multiple health care providers at different sites. "The patient feels more like a member of the team and the doctor talks to the patient with more respect, which motivates the patient to be more active in his or her own health care," she adds, "and the patients heal quicker."



imaging test revealed a postoperative infection that required a second surgery. "Had he let that go for even another week, he could have ended up in the ICU, septic and horribly sick," says Kathryn Bottinelli, Frank's transition coach.

As a former ICU nurse, Kathryn Bottinelli, RN, Transitions Coach, Centura Home Health, Denver,

(Above) After coming home from spinal cord surgery, Frank Yannì and Transition Coach Kathryn Bottinelli, RN, review Mr. Yannì's upcoming appointments.

(Right) The Personal Health Record provides Mr. Yannì and his wife Beatrice with an easy reference for medications information, post-hospital care needs, and space to log questions for the next time they visit the doctor.



representatives to the Joint Commission, a national accrediting body for hospitals and other health settings. This ultimately led to changes in the requirements of the Joint Commission regarding how patients are moved across the health care system. A Joint Commission Resources publication, titled “Improving Hand-Off Communication,” features the Care Transitions Intervention model.

“This is how we create an environment that identifies a need for innovation and then we present our model as the logical solution,” says Dr. Coleman.

Other changes in health care policy also work to the advantage of dissemination of the Care Transitions Intervention model. For example, hospitals are now required to publicly report 30-day readmission rates. A program such as the Care Transitions Intervention, which has proven to reduce readmission rates, becomes even more desirable.

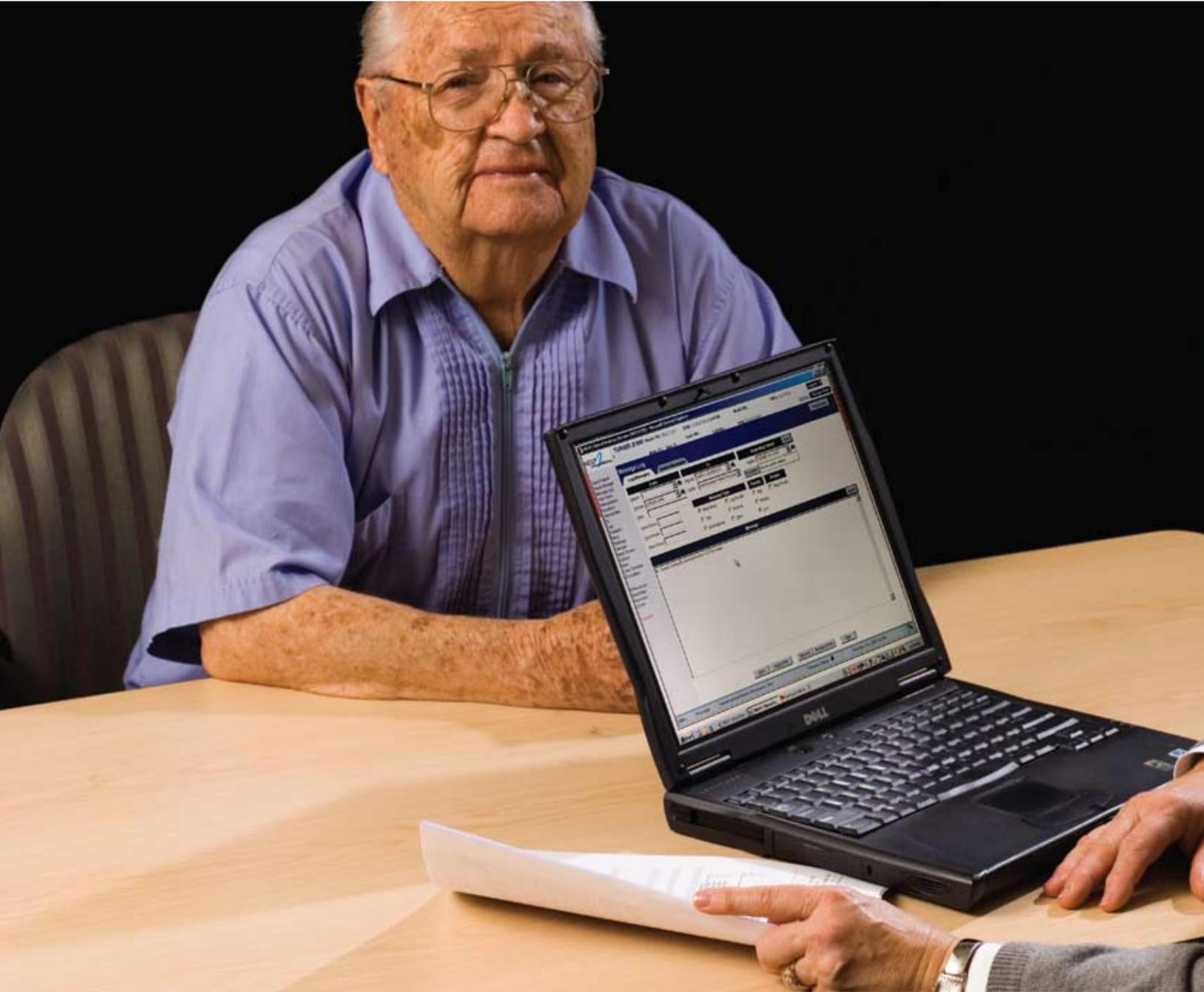
Dr. Coleman continues to foster awareness of the poor quality of many care transitions, their adverse consequences for elderly patients and the need for reform. He does this through specially convened meetings of national and regional health care leaders, briefings with federal officials and other regulatory bodies, publications, speeches, and the Care Transitions Program Web site (www.caretransitions.org). His efforts have paid off as there is now much more system-wide recognition of the importance of this problem and a willingness to address it.

The long-standing commitment of the Hartford Foundation to the creation and dissemination of the Care Transitions Intervention model has allowed the University of Colorado Health Sciences Center to raise over \$2.5 million in support of the model from additional funders. Sources of funding have come from the following:

- CMS (in partnership with the Colorado QIO)
- Community Health Foundation of Western and Central NY
- California Health Care Foundation
- Robert Wood Johnson Foundation
- Christus Health Care
- National Institutes of Health
- Aetna Foundation

“Creating the Care Transitions Intervention model required creativity and innovation; developing the avenues for dissemination and widespread adoption necessitates a different skill set, but just as much innovation.”

*Eric Coleman, MD, MPH
Principal Investigator,
Care Transitions*



Care Management Plus Model

In primary care clinics, Care Management Plus provides information technology systems to facilitate the work of a care manager and the interdisciplinary team to ensure care coordination for older patients with multiple health needs. Drawing from computerized records, a summary worksheet allows the care manager and patient to access the patient's medical history and medications for use in ongoing assessment and adjustments to the care plan when needed. For one common chronic health condition, diabetes, older patients served by Care Management Plus experienced a 24% reduction in hospitalization rates, saving hundreds of thousands of dollars, avoiding likely complications, and sparing their caregivers the stress of having a loved one in the hospital.



Using Technology to Improve Outpatient Care for Older Adults

INTERMOUNTAIN HEALTH CARE in Salt Lake City, Utah, has a national reputation for chronic disease care, quality improvement, and innovations in electronic medical records. Building on the pioneering work to integrate technology with care management led by Paul Clayton, PhD, Chief Medical Informatics Officer; Laurie Burns, PT, MS; and Adam Wilcox, PhD, Senior Medical Informaticist, the Foundation awarded Intermountain a 63-month grant of \$1,248,373 in 2001 to develop the Care Management Plus model.

In a smooth leadership transition, Cherie P. Brunker, MD, Chief of Geriatrics for LDS Hospital and David Dorr, MD, MS, then assistant professor of medicine at the University of Utah, took over direction of the demonstration and brought it to a successful conclusion.



David Dorr, MD, MS
Principal Investigator,
Care Management Plus
Oregon Health & Science University

When patients receive care from several physicians and other health care providers, those clinicians may not communicate effectively with one another and often do not put together comprehensive care plans. Important tests and procedures may not get done and patients may become confused about their medication and treatment regimens. This can result in worse health problems and unnecessary hospitalizations.

To illustrate the problem, Dr. Dorr describes the following typical older patient: Maria Viera is a 75-year old woman with diabetes, high blood pressure, mild congestive heart failure, arthritis, and recently diagnosed dementia. She comes with her husband to see Dr. Smith, her primary care physician (she also sees five other physicians sporadically for her various illnesses), to discuss hip and knee pain, questions about her medicines, dizziness, low blood sugar, and a recent fall. In a typical primary care physician's office, the ability to track these multiple concerns is limited. Likely, Dr. Smith, a busy practitioner, has limited time to address all of Mrs. Viera's complaints or to communicate with her other doctors. Dr. Smith may make recommendations that conflict with instructions by Mrs. Viera's other doctors or she may prescribe medications that interact with drugs she is not aware that Mrs. Viera is taking.

Without a coordinated care plan and follow through, Mrs. Viera's diseases are likely to lead to frequent hospitalizations and emergency visits.

The Care Management Plus model was developed to improve care for patients like Mrs. Viera who have complex illnesses. The model

redesigns care in practices of ambulatory care physicians through a team-care approach. It has two main components: the introduction of a care manager (a nurse or social worker) and effective use of an electronic information technology system.

Based on the demonstration's strong results in improved quality of care and financial benefits, the Foundation made a dissemination award of \$2,477,509 to Oregon Health & Science University, where Dr. Dorr had relocated as assistant professor of Medical Informatics and Clinical Epidemiology. Colleagues at Utah continue to contribute to the project and Dr. Brunner serves as co-principal investigator for the effort.

With the support of the dissemination grant from the Foundation, interest in and adoption of the Care Management Plus model has exceeded expectations. From the original seven sites, the project expanded to reach 30 sites serving over 8,000 older adult patients in 2007. The developers of the model actively promote Care Management Plus and they continue to receive enthusiastic responses and requests for training in use of the model.

Description of the Model: Care Management Plus

In the Care Management Plus model, physicians in a primary care practice identify patients with complex care needs and refer them to a care manager. These patients with long-term chronic diseases require more education or more time to understand their medications or other aspects of their care. For example, they may need to learn about controlling their diabetes, they may be frail, or they may be at high risk for complications.

The care manager—in consultation with the patient, family, physicians, and other health care providers—assesses the patient's needs, creates a care plan, and acts as a catalyst to make sure the care plan occurs. Care managers help patients and caregivers to self-manage their disease and navigate the health care system. They provide links to community resources and ensure that patients receive the highest quality care. The care manager also can identify possible coexisting conditions, such as depression, or other barriers that may be preventing the patient from effectively managing their illness.

“My job is to do all the things that a care manager does—screen, assess, plan, coordinate, and monitor,” says Ann Larsen, RN, CDE, Care Manager, Intermountain Healthcare Medical Group, Roy, Utah.

“But I also treat the whole patient. For example, a patient might be referred to me for diabetes, but the patient is depressed. We can't work

“Health care providers tend to struggle with complex chronic illness care; but it can be very rewarding with the right tools in the right environment.”

*David Dorr, MD, MS
Principal Investigator,
Care Management Plus*



The InterMountain Healthcare (Salt Lake City) Care Management Plus Team: Cherie Brunker, MD (front right), and her Primary Care Team (clockwise): Liz Garcia-Leavitt, LCSW (Care Manager), Vikie Durrant (Receptionist), Kip DeWeese, APRN, GNP (Nurse Practitioner), Mary Carpenter, LPN (Licensed Practical Nurse). The Team applies the Information Technology tools and works together with their patients and caregivers to provide efficient, high quality health care.

on the diabetes until the depression is addressed. My job is to find out what's causing the patient to have a difficult time managing his or her illness. Most patients want to be well. They just may not know how."

An electronic information system facilitates the work of the interdisciplinary team by incorporating protocols and reminders for optimal care of patients. For example, the Care Management Tracking database keeps track of tasks, such as following up with other clinicians, calling patients to check in with them, and assuring tests are ordered. It also keeps track of patient outcomes. A Patient Summary sheet contains pertinent health information. Electronic messaging systems help providers gain access to care plans, remind them about the best health care practices for the patient's condition, and facilitate communication among the health care team. The system also creates reports for ongoing assessment and administration of a care management program.

"Having these tools helps the clinic to be more efficient," says Cherie Brunker, MD, co-principal investigator, Care Management Plus. "Before I see a patient, the system has identified lab work, such as liver function tests or other routine tests for a specific patient, and the office staff puts that in the queue to be ordered. It's done automatically."



IDENTIFIES PATIENT AT RISK IN PRIMARY CARE PRACTICE



Care Management Plus patients at risk for complications and worsening of their health are referred to a care manager. The care manager—in consultation with the patient, family, physicians, and other health care providers—assesses the patient’s needs, creates a care plan, and acts as a catalyst to make sure the care plan occurs. Care managers help patients and caregivers to self-manage their

disease and navigate the health care system.

Information technology (IT) systems complement the role of the care manager. IT tools include a tracking database, patient summary sheet, and electronic messaging systems. Reports are generated for ongoing assessment and administration of a care management program.



The Care Manager



Dr. Cherie Bruncker meets with patient John Walton and his wife Ruth. Care Management Plus's information systems have allowed the three of them to work together to control John's diabetes through a combination of exercise, changes in diet, and insulin regimen.

These freely available information technology tools were developed by Drs. Clayton and Wilcox at Intermountain Healthcare as part of the project supported by the Foundation. Care managers can use these tools to access disease-specific recommendations and reminders. This technology is specifically created for and by care managers and care teams that are responsible for the care of older adults.

Measuring the Success of Care Management Plus

This straightforward approach of integrating care managers into the primary care team and using information technology tools improves health and decreases complications for older adults. In initial research and testing of the model, people with diabetes had better control of their blood sugar levels and were more likely to be tested, which corresponded to 15 to 25 percent fewer long-term complications. This translates into significant cost savings and allows patients to live independently far longer. Seniors with diabetes had a 20 percent reduction in death and a 24 percent reduction in hospitalizations, saving Medicare up to \$274,000 per clinic.^{18,19,20}

Benefits to practices are derived in several ways. For example, through the use of information technology systems, physicians can create a

18- Dorr DA, Wilcox A, Donnelly SM, Burns L, Clayton PD. Impact of generalist care managers on patients with diabetes. *Health Serv Res.* 2005;40(5 Pt 1):1400-1421.

19- Dorr D, Bruncker C, Wilcox A, Burns L. Implementing protocols is not enough: the need for flexible, broad based care management in primary care. TRIPP conference; 2006 July 10-12; Washington, DC: AHRQ;2006.

20- Dorr DA, Wilcox A, Burns L, Bruncker CP, Narus SP, Clayton PD. Implementing a multidisease chronic care model in primary care using people and technology. *Dis Manag.* 2006;9(1):1-15.

more efficient medical practice and can see more patients. A study by Dr. Dorr and colleagues demonstrated an 8 to 12 percent improvement in productivity of health care providers who actively send patients to a care manager versus those who do not.²¹ This translates to over \$99,000 per clinic in additional revenue. With the increase in productivity and the right clinic environment, care manager services can be cost effective, even in Medicare fee-for-service.

The benefits extend to the larger society as well, both in terms of health and dollars. For example, implementing the program in 60 clinics is estimated to prevent 259 hospitalizations per year and to eliminate 253 unnecessary deaths per year.²² Medicare will save approximately \$9.1 million on reduced costs of the seniors treated.

The National Search for Quality Health Care Finds Care Management Plus

The positive results of the Care Management Plus model have caused many primary care clinics, health care plans, health systems, and Medicare to take notice. Through the diligent work of Dr. Dorr,



Dr. Cherie Bruncker uses the Patient Worksheet, an information technology tool, to provide goal-directed evidence-based medical care for her patients.

Dr. Brunker, and their colleagues, with support and funding from the Hartford Foundation's dissemination of GIT-P initiative, the Care Management Plus model has been implemented in over 30 health care sites across the country and the number is growing.

The first step in moving innovation to practice requires identifying like-minded people who are looking for ways to transform health care to improve quality and increase efficiency. Dr. Dorr makes presentations at local and national conferences to generate interest and several organizations have been led to the model through the Web site (www.caremanagementplus.org).

"We need to pay attention to preventing medical problems and preventing complications that can be avoided. The Care Management Plus program can help older adults, including healthy older adults, to maintain their health by focusing on prevention."

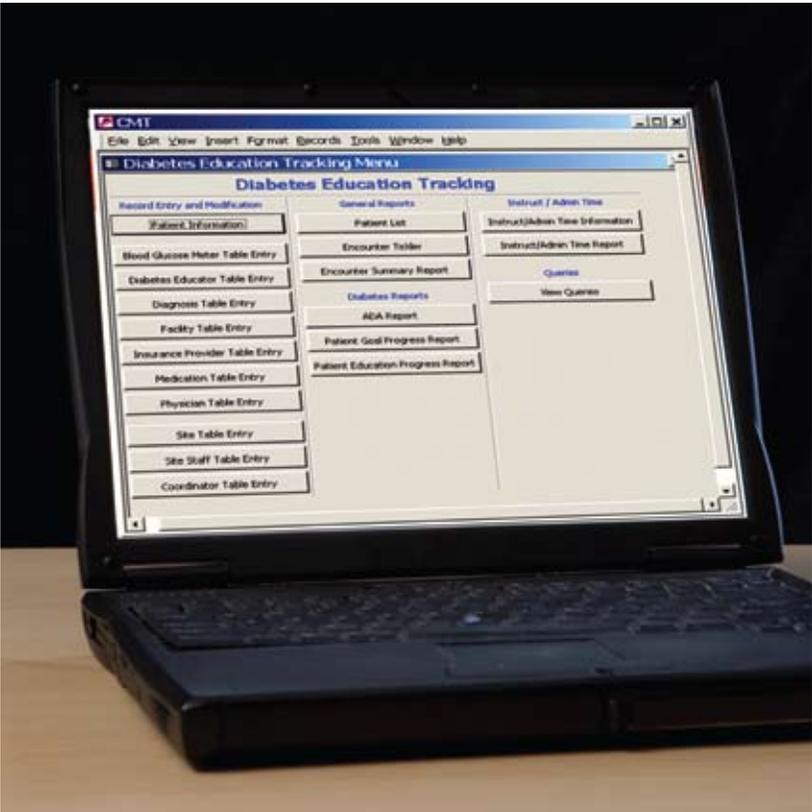
*Cherie Brunker, MD
Co-Principal Investigator,
Care Management Plus
Intermountain Healthcare
LDS Hospital Division of Geriatrics*

21- Dorr DA, Wilcox A, McConnell KJ, Burns L, Brunker CP. Productivity enhancement for primary care providers using multicondition care management. *Am J Manag Care.* 2007;13(1):22-28.

22- Dorr DA, Donnelly SM, Wilcox AB, Brunker CB, Burns L. Incorporating multidisease care management into primary care using people and technology. *Academy Health,* June 25-28, 2006, Seattle, WA.



Care Management Plus provides a variety of printed and virtual tools to assist both doctors and older patients in managing complex health conditions.



An early relationship with one of Medicare's quality improvement organizations (QIOs) gave the model important recognition and an early boost in dissemination.

At the time the Care Management Plus model was under development, the team at Intermountain Healthcare was working with a Medicare initiative called Doctor's Office Quality – Information Technology (DOQ-IT) to obtain Medicare data for analysis. Through the DOQ-IT project, Medicare supports the effective use of information technology by physicians' offices to improve quality and safety for Medicare beneficiaries. It soon became evident that there was a natural fit between the missions of the DOQ-IT and the Care Management Plus team care model.

To facilitate adoption of the Care Management Plus model, Dr. Dorr and his associates developed a training program. They also disseminate the information technology components (for example, the Care Management Tracking database) and provide expertise to help clinics successfully adopt these components. For the first training in September 2006, the DOQ-IT recruited six clinics from around the state of Utah to participate. This was soon followed by a presentation of the Care Management Plus model at the national conference of Quality Improvement Organizations (QIO). A subsequent article about the Care Management Plus model published in *Quality Insight*, the official journal of the QIOs, propelled the model to national attention. As a result, several clinics contacted Dr. Dorr's group to receive training in implementation of the model.

Adoption of Care Management Plus requires primary care clinics to make a substantial investment: hiring and training care managers, upgrading or acquiring information technology, and devoting the time and resources of other staff members to training and protocol implementation. Each clinic's investment is about \$100,000 over the first year of the program, which should be recouped in increased productivity.

Given the need for this investment, an essential element of dissemination involves creating an environment for reimbursement and health policy that facilitates acceptance of the team care programs as cost-efficient. Toward this end, Dr. Dorr testified before the United States Senate Special Committee on Aging on May 9, 2007. Dr. Dorr stressed that care management programs can produce cost savings and also emphasized the need for reimbursement for the services

"Care Management Plus has brought us together as a practice and provided the structure for caring for the most challenging patients."

*Albert DiPiero, MD
Assistant Professor of Medicine,
Oregon Health & Science University
Adopter of the Care Management
Plus model*

Tracking Care Over Time Helps Avoid Serious Disability



When a visit to his physician at Intermountain Healthcare’s Herefordshire Clinic revealed that B. Ward Turner had high blood sugar levels and a hemoglobin A1C of 10.9 (a test to assess diabetes control—the usual goal is a level less than 7), his physician wasted no time in referring him to Ann Larsen, a registered nurse care manager. Ward, who is now 84 years old, was at high risk for complications of diabetes due to a previous heart attack and multiple chronic health conditions, including congestive heart failure, arthritis, thyroid problems, and high cholesterol. Identifying and treating diabetes is critical, especially since close to 21 percent of Americans age 60 and over have diabetes, many of whom are not diagnosed.

Preventing diabetes complications such as kidney damage, loss of vision, and heart disease would require aggressive management of Ward’s disease and the physician simply did not have time to properly educate him. This was almost ten years ago. Ann evaluated Ward for conditions such as fall risk, memory, and mood—all key factors that can impact his health and quality of life. She also invited him to attend a

wellness clinic where she teaches the standards of diabetes care. Ward learned about the importance of cholesterol control and yearly foot and eye exams to check for changes. His health care team followed his progress with tools of Care Management Plus: the patient worksheet and the care manager tracking database.

With appropriate lifestyle changes, including water aerobics, meal planning, monitoring his blood sugar, and taking medication, Ward met his goal of controlling his diabetes. Over time, however, his blood sugar levels began to rise and Ward and his doctor decided to begin insulin therapy. Ann provided the training and coaching to help Ward learn how to administer insulin injections and she continues to monitor his progress, dealing also with his other conditions.

“Ann is a great partner,” says Ward. “I feel good and I’m happy with where I am.” For Ann, having the opportunity to help patients like Ward is the best job she’s ever had. “My goal is to find out what the patient needs and get it in place,” says Ann.

(Above) In Salt Lake City, B. Ward Turner does water aerobics regularly as part of a comprehensive care plan to keep his diabetes under control.

(Right) Mr. Turner with his Care Manager Ann Larsen, RN, Certified Diabetes Educator. Ms. Larsen’s participation in the interdisciplinary team allows her to provide regular updates on Mr. Turner to his health care providers while helping Mr. Turner adjust to recommended changes in his treatment regimens.



offered by a care manager. U.S. Senator Blanche Lincoln and others, acknowledging the pressing need for change in the way the growing elderly population is cared for, had organized the session in support of a new bill that would pay for programs like Care Management Plus.

The Care Management Plus team also has a strong relationship with those working on the Donald W. Reynolds Foundation grant “Comprehensive Program to Strengthen Physicians Training in Geriatrics,” awarded to the University of Utah with a subcontract to Intermountain Healthcare for \$340,000 over four years. Dr. Dorr is also heavily involved in the Willamette Valley, Oregon, two-year, \$600,000 Aligning Forces for Quality grant as a technical expert and primary care redesign expert.

Care Management Plus continues to successfully leverage the funding from the Hartford Foundation to help transform health care, pursue new areas of innovation, and develop partnerships to sustain these efforts. The 24 clinics that are fully implemented and the 18 more in process of implementation have committed millions of dollars toward the redesign of primary care for older adults. As further endorsement of the Hartford-funded effort, in 2007 the Agency for Healthcare Research and Quality (AHRQ) awarded \$250,000 over two years for the Care Management Plus team to partner with the Oregon Rural Practice-based Research Network (ORPRN). Through this effort, six rural clinics will adopt the program and AHRQ will evaluate the business case and improvements in clinical outcomes.

“Care managers augment what the doctor does. Physicians feel better about the medicine that they practice and patients feel better about the care they have received. Overall, the outcome is better health.”

*Linda Leckman, MD
Chief Executive Officer,
Intermountain Medical Group*





Senior Health and Wellness Clinic Model

As a central element of the Senior Health and Wellness Clinic model, the interdisciplinary team meets weekly to discuss high-risk, complex patients. At PeaceHealth in Eugene, OR, staff members contribute valuable information that enable the clinic's most frail and vulnerable to continue living in the community. Senior Health and Wellness Center patients had lower average Medicare charges than comparison groups—even though participants were older, more vulnerable and higher risk—driven by same or reduced utilization of outpatient, hospital, and emergency department services.



Managing Care of Older Patients in the Clinic by Fostering Team Care

ONE APPROACH TO INTERDISCIPLINARY TEAM CARE for older patients with chronic illness involves providing comprehensive specialized geriatric primary care services all in one setting. The PeaceHealth Oregon Region Center for Senior Health set up such a clinic. The Senior Health and Wellness Clinic came to the attention of the Foundation through their work in the Institute for Healthcare Improvement (IHI) Breakthrough Collaborative on Improving Care for People with Chronic Conditions. Their work was subsequently presented at an IHI Congress conference in October 1998. The Foundation was impressed with the Senior Health Wellness Clinic model and in 2000 awarded PeaceHealth a 63-month grant of \$1,407,390 to measure the impact of their interdisciplinary team care approach. The project is led by Ronald D. Stock, Executive Medical Director, the Gerontology Institute, PeaceHealth Oregon Region, Center for Senior Health, Eugene, Oregon.



Ronald D. Stock, MD, MA
Principal Investigator,
Senior Health and Wellness Clinic
PeaceHealth, Eugene, Oregon

“An interdisciplinary, interdependent team provides the best health outcomes, especially for older patients with complex care needs,” says Dr. Stock. However, simply placing a group of health professionals from different disciplines in the same room does not mean that they will function well as a team. Most medical professionals are not trained in team skills. Formalized training and ongoing support of team behaviors is required, as demonstrated by the work of the Hartford Foundation’s Geriatric Interdisciplinary Team Training (GITT) initiative.

Because interdisciplinary team care is not routinely practiced, the team care model developed at PeaceHealth focuses on team development. The model was designed to be most applicable for large, multispecialty group practices. It was developed and tested at the PeaceHealth Senior Health and Wellness Center (SHWC).²³ The SHWC is an outpatient fee-for-service clinic affiliated with Sacred Heart Medical Center, PeaceHealth in Eugene, Oregon. The SHWC is staffed by geriatricians, nurse practitioners, a social worker, a dietician, a pharmacist, and other health professionals.

The methods created by the SHWC project team improve health outcomes by fostering productive interactions between a prepared, proactive health care team and informed, activated patients and/or caregivers. To ensure the ongoing benefits of team care, the SHWC developed a tool to continuously measure team development.

23- Stock RD, Reece D, Cesario L. Developing a comprehensive interdisciplinary senior healthcare practice. *J Am Ger Soc.* 2004;52:2128-2133.

Senior Health and Wellness Center: Total Care Under One Roof

The SHWC interdisciplinary team is defined more broadly than many health care teams. It includes physicians, nurse practitioners, a social worker, nurses, receptionists, a pharmacist, and a dietician. Ad hoc members include a chaplain, physical therapists, a home health nurse, a behavioral health professional, and a patient information librarian.

Each patient's health status is assessed at the first visit using standardized tools that measure mental status, risk for falls, depression, nutrition, and other health conditions. Medical practice guidelines for chronic pain, falls, diabetes, urinary incontinence, dementia, and osteoarthritis are used.

An electronic medical record houses all of a patient's medical records (from hospitalizations and visits to the clinic) on the same platform. Extension of the electronic medical record into nursing homes and home health/hospice has allowed for improved communication of vital information across care settings. Reports identify patients who go to the emergency room, hospital, or outpatient surgery.

A central element of the SHWC team care approach is hour-long weekly care conferences. The interdisciplinary team, which includes every staff person in the clinic, meets to discuss high-risk, complex patients. "Everybody has their own perspective," says Kathleen Chinn, Nurse Practitioner, Senior Health and Wellness Center, PeaceHealth Medical Group. "The people in the front office know the patients differently than the nurses and the nurses know the patients differently than the physicians. Everyone brings something valuable to the table."

Team Care Approach at SHWC

An elderly patient made recurring visits to the emergency room at Sacred Heart Medical Center with minor complaints or questions about his medications. The SHWC was notified through the electronic medical record and the patient was asked to come to the clinic for an appointment with the lead physician, Jeffrey Larkin, MD, to reconcile his medications. Every time the patient came in he either had different medications or forgot to bring his medications. It was apparent to Dr. Larkin that the patient was having memory problems, and tests confirmed the diagnosis of Alzheimer's disease. Dr. Larkin asked the patient's wife to accompany him to the next appointment and then asked her to help manage his medications. "I wanted to make sure I knew what the patient was taking before starting him on medications for Alzheimer's," said Dr. Larkin.

"An interdisciplinary, interdependent team provides the best health outcomes, especially for older patients with complex care needs."

*Ronald D. Stock, MD, MA
Principal Investigator,
Senior Health and Wellness Clinic*



PeaceHealth team with Christa St. George, patient and volunteer. (Left to right) Alison Gregory, RMA, Sandy Sanders, LCSW, Danny Stobaugh, PT, Jeff Larkin, MD, Kari Cox, RD, Ericka Carter, Receptionist, Brad Johnson, RPh, CGP, (Center) Christa St. George

The medications continued to be taken incorrectly. The patient's wife was a patient at the clinic, but she was not Dr. Larkin's patient. Dr. Larkin decided to discuss this case at the weekly care conference. In consultation with the team, which included the wife's physician, it became evident that the patient's wife was also exhibiting memory problems. Because of the care conference, the wife was brought in for testing and was diagnosed with dementia. The social worker was able to work with family members to arrange for proper care of the couple. The pharmacist got involved with a medication review to ensure the patient was on the proper regimen for his multiple health conditions and that it was being followed. "With a team approach, we were able to come up with a solution for this patient that I wasn't able to achieve alone," said Dr. Larkin. "This is a common scenario," he said.

Measuring the Success of Senior Health and Wellness Clinic

The SHWC model improves quality of care and reduces the number of medications that older patients take. Supported by the Foundation's grant, Dr. Stock and his colleagues conducted a study in which patients of the SHWC were compared to patients receiving care from primary care providers supported by a care manager and patients cared for in practices without a care manager. And the practice grew with implementation of the model.



PATIENT CARE IS COORDINATED WITHIN THE SENIOR CLINIC



COMMUNICATION AMONG TEAM MEMBERS

Senior Health and Wellness Clinic Model

The interdisciplinary team consists of every staff member who interacts with patients, including physicians, nurse practitioners, social workers, nurses, receptionists, pharmacists, dieticians, physical therapists, home health nurses, chaplains, and librarians.

The entire team meets for hour-long weekly care conferences to discuss high-risk, complex patients.

For all patients seen in the SHWC, health status is assessed using standardized tools for health data such as mental status, risk for falls, depression, nutrition, and others.

Medical practice guidelines for pain, falls, diabetes, urinary incontinence, dementia, and osteoarthritis are used. An electronic medical record houses patient’s medical records from hospitalizations and visits to the clinic. Weekly reports identify patients who go to the emergency room, hospital, or outpatient surgery.

“The Senior Health and Wellness Clinic is always pushing the envelope to make patient care better. I absolutely look forward to coming to work every day.”

Bradley T. Johnson, RPh,
CGP, CDM, FASCP
Clinical Geriatric Pharmacist,
PeaceHealth, Eugene, OR

Patients treated at the SHWC were more likely to receive vaccinations. They were prescribed fewer medications (thus lowering the risk for dangerous interactions among drugs). Rates of falls were less in the SHWC model compared to the other models, especially for older female patients. Scores on tests for depression improved with the SHWC model, whereas scores worsened in the comparison groups. Physical function declined for more than 80 percent of participants in all the groups given aging over two years. However, the health-related quality of life (HRQL) remained unchanged for those in the SHWC model, while the participants in the other groups experienced a decline in HRQL that paralleled the decline in physical function.²⁴

Of note, average Medicare charges per participant were less in the SHWC group than the other two groups for all services. Despite evidence that the patients treated at the SHWC were older, more vulnerable, and at higher health risk than patients in the comparison groups, utilization of outpatient, hospital, and emergency department services were the same or less. Also, while caring for this population, the practice grew, adding staff and patients.

Customizing Team Care to Work Locally

A team approach to geriatric care must be adapted to the needs and culture at each institution. Dr. Stock and his colleagues invite those who are interested in the SHWC model, or aspects of the model, to a site visit. They provide detailed written materials and often visit the site where the model will be implemented to discuss how it can be efficiently incorporated within the existing structure and to provide technical assistance for implementation. This one-on-one assistance can be particularly helpful for convincing sometimes reluctant administrators of the benefits, both clinical and financial, of the model.

Rosemary Laird, MD, Health First Aging Institute, Cocoa Beach, Florida, found this individualized assistance particularly useful. She had to surmount some common hurdles. Dr. Laird is a geriatrician in a small, community-based, not-for-profit health system, and several years ago she was looking for ideas to improve care for her patients. She met Dr. Stock at a meeting of the American Geriatrics Society and became aware of his work on team care in a geriatric clinic. With advice and counsel from Dr. Stock, she began to implement some of the concepts of the SHWC model in her clinic, and was pleased with the results. When a new administrator was hired, all of these concepts were scrapped. Undaunted, Dr. Laird began calculating the lost revenue resulting from having shut down the SHWC initiatives.

24- Stock RD, Mahoney E, Reece D, Cesario L. Developing a senior healthcare practice using the chronic care model: effect on physical function and health related quality of life. J Am Ger Soc. 2008. Accepted for publication.

A year later, armed with the data she had collected and an article Dr. Stock and his colleagues had published in the *Journal of the American Geriatrics Society*, Dr. Laird convinced the leadership at the Health First Aging Institute to engage in a formal relationship with the group at PeaceHealth and to reinstate aspects of the model. For example, they broadened their pool of providers, increased revenue-generating clinical services (such as adding a foot care clinic), and have regular team meetings in one of their two clinics.

“Administrators assume that you can’t take care of older people cost effectively,” said Dr. Laird. “The group at PeaceHealth were really effective in helping me to communicate with administrators and convince them that it is possible.” Individualized assistance from Lorelei Cesario, Director of Senior Business Development, The Gerontology Institute, PeaceHealth Oregon Region, on the financial aspects of the model was instrumental in persuading administrators that it made good business sense.

“If you can’t convince an administrator and make the business case, everything just stops,” says Dr. Laird.

The PeaceHealth SHWC model has found converts in a variety of health care systems. For example, when Karol Attaway, Vice President of Operations, Healthcare Partners Medical Group, in Southern California, was designing a home care program for older patients with chronic illness who were not able to travel to the clinic, she looked for models of interdisciplinary team approaches. A site visit to the PeaceHealth SHWC provided valuable insights on managing chronically ill patients. Ms. Attaway was especially impressed with the care collaboration meetings that include everyone in the clinic, including the front office staff, and she has incorporated this into the home care program. She was also interested in the written materials the SHWC had created for patients, which include photographs and bios of the physician. “We’re going out to patients’ homes, so we thought it was a great idea to mail these materials, with the physician’s photograph, ahead of the visit,” says Ms. Attaway.

Interest in the SHWC model is generated from a variety of sources, including professional networks and visibility at relevant meetings. Dr. Stock and the group at PeaceHealth have been invited to give 25 presentations over the past five years to approximately 1,000 clinicians in venues such as the American Geriatrics Society, National Patient Safety Forum, Institute for Healthcare Improvement, American Medical Association, National Council on Aging-American Society on Aging, Gerontological Society of America, Agency for Healthcare



Senior Health and Wellness Clinic team members meet with patient Christa St. George. Patients treated at the SWHC were more likely to receive vaccinations, were prescribed fewer medications, and were less likely to fall.

From Clinic Volunteer to Clinic Patient, But Always a Member of the Team

Every new patient treated at the Senior Health and Wellness Clinic (SHWC) begins with an orientation given by volunteer Christa St. George. Christa explains the team concept to patients, informs them about the different types of health providers available at the clinic and what each one does, and gives them a tour of the facility. "I tell them what we have, what we can do for them, and what we expect from them," says Christa.

The patients are attentive and extremely grateful for the information. "People tell me this has never happened anywhere else they've been to for health care," says Christa, who has a friendly, welcoming personality and thoroughly enjoys her work.

clinic's lead physician, Dr. Jeffrey Larkin. Dr. Larkin discovered numbness in both hands and some neck pain. An MRI of the neck showed a cancerous tumor in Christa's upper spinal column.

"Two days later, I was in surgery for seven hours, followed by four days in the intensive care unit and more than a month in an inpatient rehabilitation facility," says Christa. With the help and support of different members of the interdisciplinary team, of which Christa, now as a patient, is a vital member, she has gotten through her ordeal, although she remains impaired.

Dr. Larkin credits, in part, the longer appointment times given to clinic patients for his ability to quickly get Christa the treatment she needed. "Spending more time with patients leads to more accurate diagnoses," he says. "Christa's case could easily have been written off as carpal tunnel syndrome, but I had the time to spend with her and get it right."

Even though Christa continues to have difficulty with walking and with hand coordination she has come back to the clinic as a volunteer to give patient orientations, now with a new perspective on the resources of the clinic to share with incoming patients.



When Christa, who is 75, began to feel some tingling in her fingertips, she shrugged it off and continued giving patient orientations. But the morning she wasn't able to button her blouse, she decided to consult with the

(Above) Christa St. George provides a tour of the clinic to Darold Alexander. Having successfully recovered from spinal surgery, Ms. George tells every new patient on orientation what team care did for her, and what it can do for them.

(Right) St. George with Senior Health and Wellness Clinic physician, Jeffrey K. Larkin, MD.



Research and Quality, National Institute for Case Management Clinical Case Management Conference, and Society for Social Work Leadership in Health Care. PeaceHealth has consulted with or hosted site visits for 35 health care organizations from the United States and Canada.

In addition to written materials that aid in the implementation of the SHWC team care concepts, the SHWC team also developed an assessment tool called the Team Development Measure (TDM). The TDM (available on the SHWC Web site www.teammeasure.org) measures the degree to which a team has in place the components needed for highly effective teamwork and how firmly these components are in place.

“This survey tool can be used as a measure of quality and it can also be used to provide feedback in order to improve ‘teamness,’ so it can be a quality improvement measure,” says Dr. Stock.

Dr. Stock and the group at the SHWC also developed the “Team Bundle.” This is a description of the four components that must be in place for successful implementation of the model. These are:

- Healthcare leadership must make a commitment to the team care approach.
- Team development measures should be used to provide feedback to the team about “teamness” and areas for improvement.
- There needs to be a focus on training clinic staff to communicate better amongst themselves.
- All teams need to practice team skills, which is one of the roles of the weekly patient care conference.

To encourage even wider dissemination of the model, SHWC is developing a business model based on demonstrating that the SHWC team care model provides higher quality cost efficient care, and that it can realistically be implemented in a community health system outside of an academic setting. The successful implementation of this model has allowed the group at PeaceHealth to leverage the Hartford Foundation support and receive additional funding from several sources. These include the following:

- Robert Wood Johnson Foundation
- Agency for Healthcare Research and Quality
- Sacred Heart Medical Center Foundation
- Collins Foundation
- Northwest Health Foundation
- Spirit Mountain Community Fund
- Lane County United Way 100% Access Coalition

“Working as a team is the only way to take care of a geriatric population.”

*Kathleen Chinn, FNP
Senior Health and Wellness Center
PeaceHealth Medical Group*

Virtual Integrated Practice Model

Virtual Integrated Practice (VIP) team care meeting at Rush Medical Center, Chicago, IL. In an early morning meeting via teleconference, members of the primary care team across Chicago discuss patient care issues. Patients in a Virtual Integrated Practice demonstrated a greater understanding of their medications and how to manage their disease.





Implementing Team Care Across Practices and Virtually

AS AN OUTSTANDING EDUCATIONAL SITE within the Foundation's Geriatric Interdisciplinary Team Training program, Rush University Medical Center successfully integrated concepts of interdisciplinary team training into the curricula of the disciplines involved in geriatric care, including medicine, nursing, and social work. In 2000, the Foundation awarded Rush a five-year grant of \$1,833,284 to extend its work on interdisciplinary team care into the realm of clinical practice with the Virtual Integrated Practice team care model. The project is led by Steven K. Rothschild, MD, Associate Professor of Family Medicine and Director of the Section of Community Medicine, Department of Preventive Medicine, Rush University Medical Center, Chicago, Illinois.



Steven K. Rothschild, MD
Principal Investigator,
Virtual Integrated Practice
Rush University

In the United States, the majority of primary care offices are solo fee-for-service practices of four or fewer physicians.²⁵ Unlike larger practices and clinics, these small practices rarely have the capability to offer the kind of multidisciplinary team care that has been shown to improve outcomes for older adult patients with complex care needs. Ideally, interdisciplinary teams include social workers, nurse practitioners, pharmacists, physical and occupational therapists, clinical nutritionists, and others to provide critically needed and well coordinated patient care services. Small practices often lack the financial resources and space to support and accommodate these additional clinicians. Practices in rural settings have particular difficulty offering interdisciplinary team care.

“We developed a team care model that brings primary care physicians together with providers in other disciplines at other sites to a virtual table to interact around the care of patients with chronic diseases and disability,” says Dr. Rothschild, Principal Investigator. The model, called Virtual Integrated Practice (VIP), utilizes redesign of office systems, structured communications tools, and relationship building to coordinate patient care among team members who do not share office facilities.

The VIP model was developed by an interdisciplinary team of researchers and clinicians. David Lindeman, MSW, PhD, an internationally recognized gerontologist, was Co-Principal Investigator. Dr. Lindeman, then Director of the Mather Institute on Aging, Evanston, IL, brought insight from two decades of work on the care of persons with Alzheimer's disease. Lois A. Halsted, PhD, RN,

25- Wassenaar JD, Thran SL. Physician socioeconomic statistics. Chicago, AMA Press, Center for Health Policy Research. 2003.

then the Associate Dean of the Rush College of Nursing and currently Vice-Provost and Vice President for University Affairs at Rush, provided nursing input into the project.

Drs. Lindeman and Halstead continue to work on the VIP team, along with a dietician (Kathy Keim, PhD, RD), a social worker/gerontologist (Robyn Golden, LCSW), and two additional nurse-researchers (Ann Minnick, PhD, RN and Cathy Catrambone PhD, RN). A gerontologist, Stan Lapidos, has served as Project Manager for VIP and Rush's prior GITT initiative.

Rush was an outstanding educational site in the Hartford Foundation's previous Geriatric Interdisciplinary Team Training (GITT) initiative. It has developed its capacity to train future health professionals to work together and deliver care to older people using an interdisciplinary approach.

Virtual Integrated Practice: The Community Response

Rather than hiring additional staff, the VIP concept calls for primary care physicians to identify practitioners in nearby health care settings or community organizations and develop working relationships among them. Teams are built among providers in the community who are seeing the same patients and addressing the same issues around aging and chronic disease management, but who don't otherwise interact with one another. Communication among these team members occurs primarily through e-mail, voicemail, and Internet-based medical informatics systems to facilitate efficient teamwork.

The VIP process begins with convening and training the virtual team members. The team members discuss clinical issues that they can work on together. For example, the physician may identify diabetes education as an area that he or she lacks the resources to comprehensively provide.

The pharmacist may offer to give medication instruction and a dietician may offer to provide nutrition education. The team also develops population-based goals for patients with target conditions. For example, a team may decide to increase the number of diabetic patients with controlled blood pressure or reduce the number of patients who are nonadherent with their medication.

The team can also utilize a toolkit of activities that were devised by the Rush team to facilitate the team process. The toolkits provide guidance on four improvement strategies: planned communications, process

"Each member of our research team brings stellar academic credentials and practical bedside experience in their respective clinical disciplines. The result is a robust care model that is informed by theory and clinical practice."

*Steven K. Rothschild, MD
Principal Investigator,
Virtual Integrated Practice*



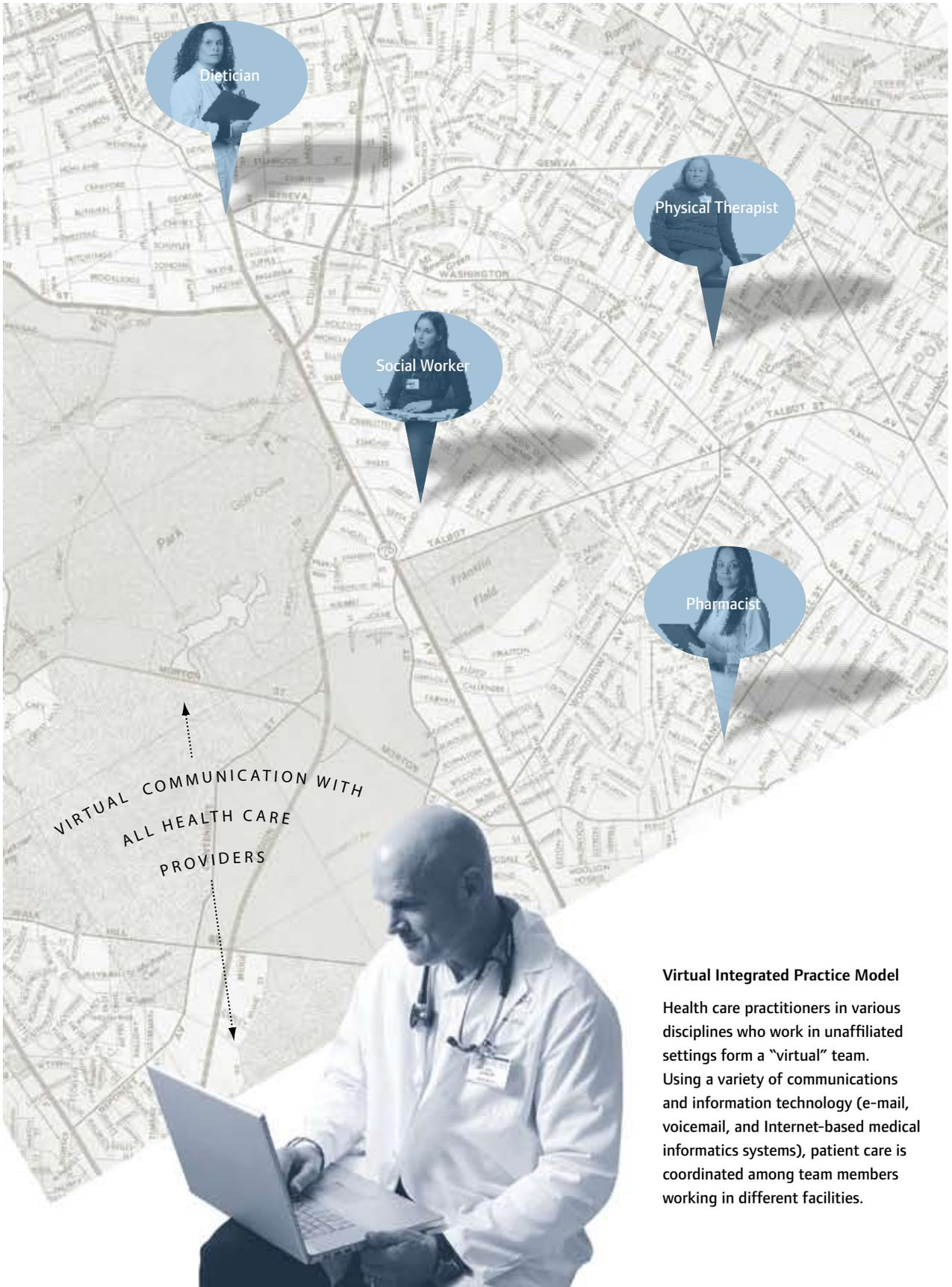
Jack Olsen, MD, examines patient Carmen ZuZula in SeniorCare at Rush University Medical Center. Technology allows Dr. Olsen to communicate his findings with members of the health care team.

standardization, patient self-management, and group activities. Planned communication involves team members being explicit with each other in advance about what information they want and how they want to receive it. Process standardization means that the team determines each provider's role and responsibility in delivering care that adheres to evidence-based practice guidelines. Patients themselves are integral members of the team and must be armed with knowledge about their illness and empowered to alter their own behavior to improve outcomes. Group activities involve bringing together small groups of patients with a common diagnosis or health problem to receive direct care or education at the same time.

While the members of the virtual team—nutritionist, social worker, pharmacist, physician, and others—are not employed in the same location, for the patient the experience is one of coordinated team care.

Measuring the Success of Virtual Integrated Practice

Having implemented the VIP model, Dr. Rothschild and the team at Rush sought to measure how well primary care practices that use VIP can modify their approach to chronic disease care. They collected data



VIRTUAL COMMUNICATION WITH
ALL HEALTH CARE
PROVIDERS

Virtual Integrated Practice Model

Health care practitioners in various disciplines who work in unaffiliated settings form a "virtual" team. Using a variety of communications and information technology (e-mail, voicemail, and Internet-based medical informatics systems), patient care is coordinated among team members working in different facilities.



When the health care team communicates well with each other and with the patient, together better health outcomes are achieved. Primary care physician Dr. Rothschild reviews medications with the Carreto family.

from four practices using the VIP model and compared them to practices engaged in usual care. The study focused on care of patients with type 2 diabetes, chronic obstructive pulmonary disease, or urinary incontinence. In the practices using the VIP model, patients reported more satisfaction with their care. Patients also had greater understanding about their medications and how to manage their disease. More patients in the VIP practices reported that they knew how to get help if they had a problem.

Among patients with poor physical functioning (about 13 percent of all patients), those who were not treated in the VIP practices were far more likely to use the emergency room; their usage of the ER was twice that of those in the VIP practices. Reducing use of the emergency room has huge potential to reduce health care costs.

The VIP approach targets a reduction in crisis intervention and acute care management for frail elders. Moreover, as each member of the team already bills for the care they provide, the Virtual Integrated Practice is cost-neutral for providers while supporting improved health outcomes.

Building Community Capacity

Dr. Rothschild and the group at Rush are using funds from the dissemination of GIT-P grant to develop materials to aid in the dissemination of the model to primary care practices. They have developed a VIP handbook and a Web site (www.rush.edu/professionals/vip/). They are also creating a train the trainer program. While discussions are underway with several health organizations and health insurance plans about adoption of the model, some organizations have already incorporated aspects of the model in their own team care projects.

As he began developing a pilot program in San Diego County for a coordinated, low-cost team approach to chronic illness care, Mark Meiners, PhD, George Mason University professor of health policy, learned of the VIP model and contacted Dr. Rothschild. When he first wrote the grant for the program, called “Team San Diego,” Dr. Meiners used the term “virtual teaming,” not knowing at the time that the idea of virtual teams was already being applied to the care of chronically ill patients.



(Above) Primary care physician Dr. Rothschild referring his patients to dietician Kristin A. R. Gustashaw virtually.

Dr. Rothschild shared the VIP materials with Dr. Meiners, which he is now using to help develop the training, delivery, and evaluation methods for the Team San Diego project. “Virtual team care introduces formality to things that are happening but in a haphazard way,” says Dr. Meiners. “By formalizing it the chances of improving care are increased significantly.”

Dr. Rothschild and the group at Rush are also overseeing curriculum development as part of a broad initiative to expand the availability of Programs of All-Inclusive Care for the Elderly (PACE) across the United States. PACE, which has been supported

“The word ‘virtual’ might be misleading, because it isn’t virtual to the patient. We see the patient in an office, just not the same office as the physician. What is virtual is the well coordinated communication systems in place among the various care providers.”

*Kristin A. R. Gustashaw, MS, RD, CSG
Rush Nutrition and Wellness Center
Department of Food and Nutrition Services*

VIP: A Seamless System of Resources



Maria Guadalupe (Lupe) Carreto and her husband Fernando, who both have diabetes and hypertension, were advised over ten years ago by their doctor to exercise as part of a

comprehensive health plan. Lupe, who was working as a volunteer in the clinic of her physician at the time, realized that she and her husband were not the only seniors who needed a regular exercise program. Working with another volunteer and her doctor they set up a two day a week exercise program at a field house in a local park, originally for five to ten older adult clinic patients. Eventually, the director of the park noticed the group and incorporated them into a group called Seniors of Dvorak Park. The Chicago Park District now runs the exercise program with an exercise instructor sent by the Department on Aging, and the group has grown to over 20 people aged 70 to 85.

Without realizing it, Lupe, whose physician is Dr. Steven Rothschild, created an important community resource that has become part of Virtual Integrated Practice (VIP). “The theme of VIP is community partnership, using resources outside of the formal health system,” says Dr. Rothschild, Principal Investigator of the VIP team care model.

Fernando and Lupe, now in their 70s, have been patients of Dr. Rothschild for over 20 years. As they developed chronic health conditions, their need for services beyond what the doctor is capable of providing grew. In addition to advising increased exercise, Dr. Rothschild also referred them to a community-based dietician. The dietician was particularly helpful to Lupe, teaching her what foods the couple should be eating and what to avoid. Lupe and Fernando also participated in group visits with other diabetes patients and were encouraged in the self-management of their health conditions.

The Carretos continue to get the word out about the exercise program to seniors in their community. For seniors with diabetes and other infirmities, this type of program is invaluable for maintaining and improving physical functioning.

“VIP is about building a seamless system of resources that allows us to get patients the services that we can’t provide in the office,” says Dr. Rothschild. “It’s about building an extension into the community or into other providers and putting them on a team.”



(Above) Lupe and Fernando Carreto, both in their 70s, exercise twice a week as part of a comprehensive health plan.

(Below) The Carretos attend exercise class in the Dvorak Park Field House located on the south side of Chicago.

by the Foundation since its earliest days, makes it possible for older adults to avoid nursing home placement and receive coordinated medical and social services, enabling them to age in their communities. It is a comprehensive, integrated health care plus financing model. The VIP team will build an on-line curriculum for Rural PACE. The National PACE Association has expressed interest in using the curriculum for urban settings as well.

Other organizations that have consulted with the VIP team include Blue Cross of Illinois, Chicago Department on Aging (CDC Hispanic Elders Initiative), Chicago Department of Public Health, and the Illinois Department on Aging.

Validation from the Hartford effort was very important for co-investigators Robyn Golden and Stan Lapidos in their successful application to the Retirement Research Foundation. Awarded \$203,234 over three years in 2006, project BRIGHTEN expands on the virtual team model to improve the identification and treatment of depression in primary care settings. Equally important has been the role of the Foundation in opening doors. The Hartford “imprimatur” is recognized for its high standards in quality care of older adults.



(Above) Social worker, Robyn L. Golden, LCSW, with patient.



(Below) Catherine Catrambone, PhD, RN, explaining peak flow monitoring for asthma management.

As the team at Rush talks to physicians, hospitals, and professional societies, the John A. Hartford Foundation has been an important door opener.

“Virtual team care introduces formality to things that are happening but in a haphazard and unsystematic way. By formalizing the team, chances of improving care are increased significantly.”

*Mark Meiners, PhD
Professor of Health Policy
George Mason University
Fairfax, Virginia and
National Program Director
Medicare/Medicaid Integration
Program, sponsored by the Robert
Wood Johnson Foundation*

Senior Resource Team

EDWARD H. WAGNER, MD, MPH, DIRECTOR, The W.A. MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, Seattle, Washington, is recognized internationally for his development of the Chronic Care Model, which encourages high-quality chronic disease management. Recognizing Dr. Wagner's work on developing and evaluating interventions for people with chronic illnesses, the Foundation awarded Group Health Cooperative of Puget Sound a five-year grant of \$1,523,571 to develop the Senior Resource Team model of team care.



26- Warshaw GA, Bragg EJ. The training of geriatricians in the United States: three decades of progress. *J Am Geriatr Soc.* 2003;51:S338-345.

27- Warshaw GA, Bragg EJ, Shaull RW, et al. Geriatric medicine fellowship programs: a national study from the Association of Directors of Geriatric Academic Programs' Longitudinal Study of Training and Practice in Geriatric Medicine. *J Am Geriatr Soc.* 2003;51:1023-1030.

Foundations can offer funding to test creative solutions with the understanding that not all projects will produce viable interventions. In the case of the Senior Resource Team, when the intervention was tested it did not result in better patient outcomes than the control group. Therefore, this model was not included in the dissemination of the GIT-P grant.

Important Role Foundations Play in Taking Risk and Learning from Failure

Most older adults receive health care from primary care physicians who are not specialists in geriatrics. In the United States, there are on average 5.5 geriatricians per 10,000 persons aged 75²⁶ and the fill rate for the first year of geriatric medicine fellowship training programs is only about 70 percent.²⁷ This means that generalists working in primary care settings provide health care for large numbers of older patients, yet they often lack adequate training in the care of this population of patients. The result is the potential for suboptimal quality of care for older adults, who are at greatest risk for complex health problems and functional decline.

Edward H. Wagner, MD, MPH, and his colleagues at Group Health Cooperative of Puget Sound sought to address this issue by creating the Senior Resource Team model, in which an interdisciplinary geriatric consulting team is embedded in a primary care practice. In this model, the geriatric team consisted of a geriatrician, a gerontological nurse practitioner, and a pharmacist with specialized geriatric training (offsite but connected electronically). Dr. Wagner and his team reasoned that the close proximity of clinicians with geriatric expertise would encourage formal referrals as well as informal consultation, which would improve quality of care.

The Senior Resource Team provided ongoing geriatric education and support and focused on assessment and management of older adult outpatients (age 75 and older) at risk for disability, geriatric syndromes, and control of chronic diseases. The developers of the model hypothesized that this team approach would result in less functional decline and fewer hospitalizations for older patients.

To test this hypothesis, the team at Group Health Cooperative conducted a study involving two clinics and a total of 31 primary care providers. Patients aged 75 and older were randomly selected to receive care either with or without the Senior Resource Team model. After two years of the study, Dr. Wagner and his colleagues were not able to demonstrate a measurable benefit with the model. Overall, the primary care physicians viewed the intervention favorably and felt that their patients benefited from the direct care of the geriatric team and from the team's indirect influence on the primary care physician. However, referrals to the geriatric team were limited and there was no improvement in patients' functional ability, which was the main objective of the study.

“Even though the geriatric team was just down the hall, the kind of formal consultation that we had in mind didn't happen very often,” says Dr. Wagner. There was a subset of patients who were referred to the geriatric team, but these patients did no better than the control group. As a possible explanation, Dr. Wagner suggests that the geriatric teams in the Senior Resource Team model took a less intensive approach than a geriatric evaluation and management (GEM) unit, which has been shown to benefit patients. In a GEM unit, the geriatric team takes over care of the patient for a period of time. “Our teams didn't take over the care of patients,” says Dr. Wagner. “They complemented the primary care of patients and they tried to influence the primary care.”

Because the Senior Resource Team model was not able to demonstrate improvement in care of older adult patients, it has not been included in the GIT-P dissemination initiative. From the outset, the Foundation did not anticipate the success of all of the models. An important role of foundations is to take risks on untested interventions with the goal of learning from experience and thereby enhancing delivery of care to older adults. Even though the Senior Resource Team model did not produce the hoped for measurable improvements in patient outcomes, it did provide these important lessons.

“We're contributing to the growing body of evidence that if you really want to improve important health measures in older patients you have to have a team with geriatric expertise actually manage the patients for a period of time, similar to the GEM units.”

*Edward H. Wagner, MD, MPH
Director, The W.A. MacColl Institute
for Healthcare Innovation,
Group Health Cooperative of
Puget Sound, Seattle, WA*

Looking Toward the Future of Team Care

Overcoming the deficiencies of a health care system in which care for older patients with chronic illness is not well-coordinated among interdisciplinary teams of providers requires nothing short of a transformation of the health care system. Such a transformation may be on the horizon as the Centers for Medicare and Medicaid Services (CMS) confronts the reality of a growing number of Medicare beneficiaries—the leading edge of the baby boom generation is about to turn 65. Driven by an imperative to rein in costs, proposals that promise to improve care while lowering costs are receiving greater reception. These proposals include increased use of health information technology systems and programs to more efficiently manage the care of people with multiple chronic conditions.

To support quality improvement in the care of Medicare beneficiaries, the CMS is developing and implementing many quality improvement initiatives. These include pay-for-performance and the medical home, amplifying twenty years of Hartford Foundation efforts and accomplishments. Pay-for-performance means that payment is aligned with quality rather than the number of tests and procedures performed. Recognizing that many opportunities for quality improvement are patient-centered and cut across settings of care, CMS is also pursuing the medical home concept to provide improved care coordination for patients with chronic illnesses. Pay-for-performance and medical home are in the early stages of development, and the CMS is still determining the best methods of approaching a comprehensive program. This represents an opportunity for the team care models funded by the Foundation to play an important role.

CMS also promotes quality care through the Quality Improvement Organization (QIO) Program, which consists of a national network of 53 QIOs. According to the CMS, “QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time...” Echoing the six guiding principles set forth by the IOM, the QIO Program assists providers in transforming health care to make it safe, effective, patient-centered, timely, efficient, and equitable.

In its proposed 9th scope of work, the QIO Program has identified coordination of care across settings as a priority. This draft document has not yet been finalized, but it appears that the program is at least considering quality indicators that go beyond individual settings (hospital, physician practice, nursing home, etc.) and instead focusing on indicators of quality that cross health care settings.

In the view of the Foundation, the four team care models developed with Foundation funding are poised to meet the growing demand for improved, cost-efficient care of Medicare beneficiaries with chronic illnesses.

The Foundation is proud of the role it has played in advancing improved care for older adults. It remains committed to working at the practice level to ensure that older adults receive the best care possible.



2007 Aging and Health Grants

In 2007, the John A. Hartford Foundation awarded 32 new grants under its Aging and Health program totaling \$47,385,062. Authorizations for new programs or large renewal grants are described here.

ACADEMIC GERIATRICS AND TRAINING

American Geriatrics Society
New York, NY
Geriatrics for Specialty Residents Program Expansion
Ronnie Rosenthal, MD
\$5,082,481, 54 Months

This project will competitively award 75 grants over three years to surgical and specialty resident programs across the country to create and implement training courses that effectively teach future specialists how to work with older patients. Each project will be led by a specialty medicine professor partnered with a faculty member from geriatric medicine, receive technical support from former grantees and American Geriatrics Society staff, and be brought together for opportunities to share learning.

Centers of Excellence in Geriatric Medicine and Training Grants
\$5,100,000, Three to Five Years

The Foundation awarded grants for three new Centers of Excellence in Geriatric Medicine and Training and renewed five existing centers to continue their efforts to increase the number of physician faculty dedicated to geriatrics. Funding is used variously for direct salary support, pilot research, tuition or training expenses, or hiring research support personnel. At least 130 advanced fellows and junior faculty members will be supported through these grants for careers in aging research and teaching geriatric medicine.

Brown University/Rhode Island Hospital
Providence, RI
Richard W. Besdine, MD
\$450,000, Three Years

University of Wisconsin
Madison, WI
Sanjay Asthana, MD
\$450,000, Three Years

Wake Forest University
Winston-Salem, NC
Jeff D. Williamson, MD, MHS
\$450,000, Three Years

Johns Hopkins University
Baltimore, MD
Samuel C. Durso, MD, MBA
\$750,000, Five Years

University of Hawaii
Honolulu, HI
Patricia L. Blanchette, MD, MPH
\$750,000, Five Years

University of Pittsburgh
Pittsburgh, PA
Neil M. Resnick, MD
\$750,000, Five Years

University of Rochester
Rochester, NY
William J. Hall, MD
\$750,000, Five Years

Yale University
New Haven, CT
Mary E. Tinetti, MD
\$750,000, Five Years

Gerontological Society of America
Washington, DC
Hartford Doctoral Fellows in Geriatric Social Work Program Renewal
James Lubben, DSW, MPH, and
Linda Harootyan, MSW
\$5,000,000, Five Years

The Doctoral Fellows program will support the dissertation research and career development of 39 doctoral students committed to geriatric research topics with fellowship stipends, research training, and mentorship. An additional 60 doctoral students will receive a pre-dissertation travel award to attend scientific meetings and participate in workshops on dissertation proposal and grant writing.

Council on Social Work Education
Alexandria, VA
National Center for Gerontological Social Work Education
Nancy Hooyman, PhD, and
Julia M. Watkins, PhD
\$4,739,983, Five Years

Renewal support to the Council on Social Work Education will expand the National Center for Gerontological Social Work Education to enable at least 130 schools of social work to increase the geriatrics content in their curriculum. Among the supported programs, faculty teams at each school will be formed to review content about aging in the core courses and funding will be provided to launch advanced courses in geriatric social work and recruit students to aging and social work through experiential learning.

New York Academy of Medicine
New York, NY
Practicum Partnership Program Adoption Initiative Continuation
Patricia J. Volland, MSW, MBA
\$4,685,376, Four Years

Funding from this renewal grant will provide \$75,000 each to 25 schools of social work to implement a rotational field training model for working with older adults. Funding will also be used to continue support of a coordinating center, create "starter kits" and other materials that can be used by schools of social work wishing to implement the training model in the future, and for meetings and workshops in support of the program.

Centers of Geriatric Nursing Excellence
\$4,000,000, Five Years

The Foundation has funded four new Centers of Geriatric Nursing Excellence to prepare over 500 nursing faculty members with expertise in geriatrics. These new centers will work closely with the five existing centers to advance academic geriatric nursing through education, research, practice, and policy activities.

Three of the centers will create regional consortia to expand their geographic reach and train nurses serving elderly populations most in need.

Arizona State University
Phoenix, AZ
Colleen Keller, PhD, RN
\$1,000,000, Five Years

Pennsylvania State University
University Park, PA
Ann Kolanowski, PhD, RN
\$1,000,000, Five Years

University of Minnesota
Minneapolis, MN
Jean F. Wyman, PhD, APRN, BC
\$1,000,000, Five Years

University of Utah
Salt Lake City, UT
Ginette A. Pepper, PhD, RN
\$1,000,000, Five Years

**Foundation for Health In Aging, Inc./
American Geriatrics Society**
New York, NY
*Hartford Geriatrics Health Outcomes
Research Scholars*
Eric A. Coleman, MD, MPH
\$2,798,057, Four Years

This renewal grant will support 12 junior faculty physicians to develop research focused on the effects of health care practices and interventions on older persons. \$200,000 grants will support aging-related health outcomes research—the study of functional status, impairments, perceptions, and health services utilization that are influenced by disease, injury, treatment, intervention, or health policy. Funding is also used to provide mentoring and networking opportunities for the scholars.

New York University
New York, NY
*How to Try This: Geriatric Assessment
Nursing Resources*
Mathy D. Mezey, EdD, RN
\$2,622,560, Three Years

This project will develop a series of geriatric nursing assessment videos and corresponding articles for use by community college nursing programs to improve the ability of nurses to care for elderly patients. In collaboration with the *American Journal of Nursing*, the Hartford Institute for Geriatric Nursing will incorporate the “Try This” geriatric nursing assessment series into community college nursing curricula through the development and publishing of 30 Web-based demonstration videos and 30 complementary articles.

**American Federation for Aging
Research, Inc.**
New York, NY
*Hartford Collaborative Research Awards:
Paul B. Beeson Career Development
Scholars Program*
Odette van der Willik
\$2,392,858, 30 Months

To support the development of interdisciplinary research, teams of alumni from the prestigious Paul B. Beeson Career Development in Aging Research Program were awarded \$400,000 over two years for projects that involve clinical, basic biomedical, biopsychosocial, epidemiological, ethics-related, or health services research relevant to aging and geriatrics.

**Association of Directors of Geriatric
Academic Programs**
New York, NY
*Chief Resident Immersion Training
in the Care of Older Adults*
Sharon A. Levine, MD
\$2,095,059, Four Years

This grant, in collaboration with Boston University, will replicate the Chief Resident Immersion Training (CRIT) Program in the Care of Older Adults at 13 medical schools. The CRIT demonstration will train up to 400 Chief Residents, who will in turn help transfer geriatric medicine skills to over 18,000 residents and medical students.

Society of Hospital Medicine
Philadelphia, PA
*Improving Hospital Care Transitions
for Older Adults*
Laurence Wellikson, MD
\$1,452,017, Three Years

Support to the Society of Hospital Medicine will be used to develop and nationally disseminate a quality improvement program to make the hospital discharge process safer for older patients, improving the process at over 100 hospitals and affecting over 270,000 discharges each year. This grant will provide funding to develop a set of interventions to optimize the hospital discharge transition for older adults.

American Academy of Nursing
Washington, DC
*The John A. Hartford Foundation
Geropsychiatric Nursing Collaborative*
Lois Evans, PhD, RN
\$1,200,000, Four Years

This grant supports the establishment of a core set of geropsychiatric nursing competencies for all levels of nursing education to articulate the essential knowledge and skills required by nurses to assure that quality mental health care is provided to older adults. The competencies, established by a working group representing major national nursing organizations, will be disseminated to all nursing schools nationwide, and curricula will be developed for basic, graduate, post-graduate, and continuing education nursing programs.

New York University
New York, NY
*Hartford Institute for Geriatric Nursing
Clinical Resources Expansion*
Mathy D. Mezey, EdD, RN
\$350,000, Three Years

This grant will expand and disseminate the clinical resources of the Hartford Institute for Geriatric Nursing, which for the past 10 years has launched pioneering projects to advance geriatric nursing in the areas of education, research, practice, and policy.

**American College of Cardiology
Foundation/Society of Geriatric
Cardiology**

Washington, DC
*Development and Dissemination of a
Curriculum in Geriatric Cardiology*
Susan Ziemann, MD
\$303,524, Two Years

This project will increase the geriatrics expertise of cardiologists through the development and dissemination of a geriatrics curriculum for physicians training to specialize in cardiology. In addition to reaching up to 3,500 cardiologists in fellowship training, the project expects to reach additional fellows and practicing cardiologists through the American College of Cardiology's well-developed, online training portal.

Preventive Medicine Research Institute
Sausalito, CA

*Developing New Models of Health Care
Delivery to Seniors*
Dean Ornish, MD
\$200,000, One Year

Funding will be used to develop a new model of dissemination of the Program for Reversing Heart Disease specifically targeted to older adults. The Program, consisting of optimal nutrition, moderate exercise, stress management, and social support, has been shown to reverse the progression of coronary heart disease as well as positively impact other chronic conditions.

INTEGRATING AND IMPROVING SERVICES

Oregon Health & Science University
Portland, OR

*Dissemination of Care Management Plus:
Information Technology Tools for the
Care of Seniors*
David A. Dorr, MD, MS
\$2,477,509, Four Years

The successful Care Management Plus model will be implemented in at least 32 primary care clinics and reimbursement methodology will be developed so that improving care to seniors and those with multiple chronic conditions is encouraged.

Care Management Plus uses computer technology and a nurse care manager to help patients and caregivers self manage their conditions, prioritize their health care needs, and navigate an increasingly complex health care system.

Visiting Nurse Service of New York
New York, NY

*Establishing a Framework for Geriatric
Home Care Excellence*
Penny Hollander Feldman, PhD
\$835,466, 16 Months

This project will establish a national framework of geriatric home care practice guidelines that can be used by accrediting agencies, public and private purchasers, and by home care organizations to guide and assess the delivery of home health services to older persons.

University of Colorado
Denver, CO

*The Practice Change Fellows: An
Interdisciplinary Leadership Program to
Improve Health Care for Older Adults*
Eric A. Coleman, MD, MPH
\$600,000, Four Years

This program will expand the number of health care leaders in medicine, nursing, and social work who can effectively promote high-quality care to older adults. In collaboration with funding from The Atlantic Philanthropies, the grant will support fellows with leadership potential and demonstrated ability to implement and sustain new geriatric services or aging-related programs.

**Sigma Theta Tau
International Honor Society of
Nursing Foundation**
Indianapolis, IN

Geriatric Nursing Leadership Academy
Mary Rita Hurley, RN, MPA
\$529,575, One Year

Funding to the honor society of nursing will be used to develop a geriatric nursing leadership academy. A national network of mentors will be established to provide expertise to the participants, and funding will also be used to develop two books on geriatric nursing and create an online geriatric nurse community.

AARP Foundation

Washington, DC
*Professional Partners Supporting
Family Caregiving*
Susan C. Reinhard, PhD, RN
\$511,874, 18 Months

Through this grant, the AARP Foundation will collaborate with the *American Journal of Nursing*, the Council on Social Work Education, and the Family Caregiver Alliance to convene a State of the Science symposium on family caregiving, and publish findings and resources to improve the care of older adults living at home.

National PACE Association

Alexandria, VA
*Establishing PACE as a Community Care
Option for Rural Elders*
Peter Fitzgerald
\$334,856, 21 Months

Support to the National PACE (Program for All-inclusive Care for the Elderly) Association will help 15 rural elder care providers apply for up to \$17.5 million in federal funds to develop local PACE sites.

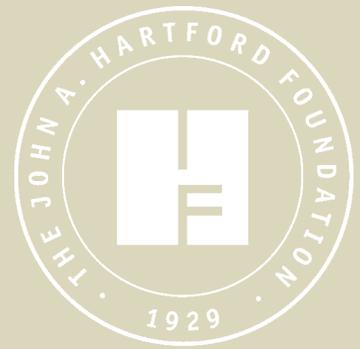
OTHER AGING AND HEALTH GRANTS

American Federation for Aging Research
New York, NY

*Kensington-Hartford Travel Award
in Geriatrics*
Stephanie Lederman
\$73,867, Three Years

The Kensington-Hartford Travel Award in Geriatrics is designed as a career building opportunity for up to 30 future professors from six Georgia universities. Students in the fields of social work, nursing, and medicine who demonstrate a commitment to faculty careers in geriatrics will attend annual scientific meetings to meet with leading researchers and develop contacts for furthering their career goals.

Financial Reports



Financial Summary

ON DECEMBER 31, 2007, THE FOUNDATION'S ASSETS were \$683.8 million, an increase of \$4.0 million for the year after cash payments of \$38.3 million for grants, administrative expenses, investment fees and taxes. Total return on the investments, income plus realized and unrealized capital gains, was 6.8 percent.



The strong investment performance in the first half of 2007 that propelled the Foundation to an all-time record high was reversed in the latter half of the year by the fallout from the problems that began with sub-prime mortgage loans. However, we were pleased that the Foundation was still able to achieve growth in its assets for the year after its spending. In 2007 the Foundation further increased its international equity exposure and added to its allocations to private equity, real estate and absolute return funds in its continuing effort to add value with acceptable levels of risk.

The Foundation's investment objective continues to be securing maximum long-term total return on its investment portfolio in order to maintain a strong grants program, while assuring continued growth of its assets at a level greater than the rate of inflation. While market dislocations, like those experienced in 2007, sometimes make that goal difficult to achieve, the Foundation is confident it can do so over the long term through value-added active management and prudent diversification.

At the end of the year the Foundation's asset mix was 58 percent public equities, 1 percent fixed income, and a combined 41 percent in absolute return, private equity funds and real estate funds, compared with 69 percent equities, 4 percent fixed income and 27 percent in the alternative asset classes as of the end of 2006.

The portion of the public equities managed with either a global or international mandate continued its growth to 52 percent from 40 percent in 2006.

As of December 31, 2007, Acadian Asset Management, AllianceBernstein Investment Research and Management, Sound Shore Management, T. Rowe Price Associates and Wasatch Advisors manage the Foundation's public equity investments.

In addition, the Foundation is an investor in venture capital funds managed by Oak Investment Partners, Brentwood Associates, Midwest Ventures and William Blair Capital Partners. Private equity partnerships are managed by GE Investments, Greenhill Capital Partners and Brentwood Associates. Real estate investments consist of funds managed by TA Associates Realty, Angelo, Gordon & Co., Heitman/JMB Advisory Corporation and High Rise Capital Management. Absolute return investment managers are Acadian Asset Management, Angelo, Gordon & Co., and Canyon Capital Partners.

The Finance Committee and the Board of Trustees meet regularly with each of the investment managers to review their performance and discuss current investment strategy. Northern Trust Company is custodian for all the Foundation's securities. A complete listing of investments is available for review at the Foundation offices.

Independent Auditors' Report

The John A. Hartford Foundation, Inc.
55 East 59th Street
New York, NY 10022

Ladies and Gentlemen:

We have audited the balance sheets of The John A. Hartford Foundation, Inc. (a New York not-for-profit corporation) as of December 31, 2007 and 2006 and the related statements of revenues, grants and expenses and changes in net assets and cash flows for the years then ended. 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 in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits 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. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The John A. Hartford Foundation, Inc. as of December 31, 2007 and 2006 and its changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The data contained in pages 78 to 87, inclusive, are presented for purposes of additional analysis and are not a required part of the basic financial statements. This information has been subjected to the auditing procedures applied in our audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Respectfully submitted,



Owen J. Flanagan & Company
New York, New York
March 10, 2008

The John A. Hartford Foundation, Inc.		Exhibit A
Balance Sheets		
December 31, 2007 and 2006		
	2007	2006
Assets		
Cash in operating accounts	\$ —	\$ 5,029
Interest and dividends receivable	491,351	834,104
Prepayments and deposits	57,837	51,369
Prepaid taxes	104,263	75,016
	653,451	965,518
Investments, at fair value or adjusted cost (Notes 2 and 3)		
Short-term cash investments	15,398,489	45,135,141
Stocks	493,889,357	503,426,864
Investment partnerships	79,638,280	58,675,693
Real estate pooled funds	91,774,118	68,808,170
Total Investments	680,700,244	676,045,868
Office condominium, furniture and equipment (net of accumulated depreciation of \$2,705,773 in 2007 and \$2,437,189 in 2006) (Note 5)		
	2,490,537	2,759,121
Total Assets	\$683,844,232	\$679,770,507
Liabilities and Net Assets		
Liabilities:		
Grants payable (Note 2)		
Current	\$ 28,593,955	\$ 23,459,043
Non-current (Note 7)	64,072,776	52,207,287
Accounts payable	780,582	937,266
Deferred Federal excise tax (Note 2)	650,553	1,033,435
Total Liabilities	94,097,866	77,637,031
Net Assets - Unrestricted		
Board designated (Note 2)	10,665,597	9,888,094
Undesignated	579,080,769	592,245,382
Total Net Assets (Exhibit B)	589,746,366	602,133,476
Total Liabilities and Net Assets	\$683,844,232	\$679,770,507

The accompanying notes to financial statements are an integral part of these statements.

The John A. Hartford Foundation, Inc.	Exhibit B	
Statements of Revenues, Grants and Expenses and Changes in Net Assets		
Years Ended December 31, 2007 and 2006		
	2007	2006
Revenues		
Short-term investment earnings	\$ 1,741,620	\$ 2,587,800
Dividends, interest and partnership earnings	9,516,738	8,267,949
Net realized capital gains	73,149,612	53,427,002
Net change in unrealized gains, net of deferred		
Federal excise tax (Note 3)	(37,905,232)	30,963,409
	46,502,738	95,246,160
Direct investment expenses	(6,486,692)	(5,191,348)
Excise and unrelated business income taxes	(759,333)	(1,735,028)
Net Investment Revenue	39,256,713	88,319,784
Grants and Expenses		
Grant expense (less cancellations and refunds of \$1,165,874 in 2007 and \$358,802 in 2006)	46,803,386	35,229,130
Foundation-administered projects	662,219	607,680
Grant-related direct expenses	105,829	122,408
Personnel salaries and benefits (Note 6)	2,612,672	2,182,523
Office and other expenses	1,068,409	950,883
Depreciation	268,584	267,408
Professional services	122,724	85,584
Total Grants and Expenses	51,643,823	39,445,616
Increase (Decrease) in Net Assets before Special Item	(12,387,110)	48,874,168
Special Item		
Contribution from liquidating foundation	—	73,867
Increase (Decrease) in Net Assets	(12,387,110)	48,948,035
Net Assets, beginning of year	602,133,476	553,185,441
Net Assets, End of Year (Exhibit A)	\$589,746,366	\$602,133,476

The accompanying notes to financial statements are an integral part of these statements.

The John A. Hartford Foundation, Inc. Statements of Cash Flows Years Ended December 31, 2007 and 2006	Exhibit C	
	2007	2006
Cash Flows Provided (Used)		
From Operating Activities:		
Interest and dividends received	\$ 8,290,207	\$ 7,943,392
Cash distributions from partnerships and real estate pooled funds	28,371,990	16,756,775
Contribution from liquidating foundation	—	73,867
Grants and Foundation-administered projects paid (net of refunds)	(30,438,535)	(19,420,638)
Expenses and taxes paid	(7,824,350)	(8,273,435)
Net Cash Flows Provided (Used) By Operating Activities	(1,600,688)	(2,920,039)
From Investing Activities:		
Purchase of equipment	—	(11,759)
Proceeds from sale of investments	356,395,977	254,247,022
Purchases of investments	(384,537,357)	(253,523,683)
Net Cash Flows Provided (Used) By Investing Activities	(28,141,380)	711,580
Net Increase (Decrease) in Cash and Equivalents	(29,742,068)	(2,208,459)
Cash and equivalents, beginning of year	45,135,706	47,344,165
Cash and equivalents, end of year	\$ 15,393,638	\$ 45,135,706
Reconciliation of Increase (Decrease) in Net Assets to Net Cash Used by Operating Activities:		
Increase (Decrease) in Net Assets	\$(12,387,110)	\$ 48,948,035
Adjustment to reconcile increase (decrease) in net assets to net cash used by operating activities:		
Depreciation	268,584	267,408
Decrease (Increase) in interest and dividends receivable	342,753	(47,968)
Decrease (Increase) in prepayments and deposits	(6,468)	9,059
Increase in grants payable	17,000,401	16,419,586
Decrease in accounts payable	(156,684)	(148,783)
Net realized and change in unrealized gains	(35,244,380)	(84,390,411)
Other	28,582,216	16,023,035
	\$ (1,600,688)	\$ (2,920,039)

The accompanying notes to financial statements are an integral part of these statements.

The John A. Hartford Foundation, Inc.
 Statements of Cash Flows
 Years Ended December 31, 2007 and 2006

Exhibit C

	2007	2006
Supplemental Information:		
Detail of other:		
Investment partnerships and real estate pooled funds:		
Cash distributions	\$28,371,990	\$16,756,775
Add: investment fees reported	3,550,376	2,059,273
Less: reported income	(3,310,903)	(2,864,389)
	28,611,463	15,951,659
Tax expense	759,333	1,735,028
Less: Net taxes paid	(788,580)	(1,663,652)
Difference (change in prepaid/payable)	(29,247)	71,376
Total - Other	\$28,582,216	\$16,023,035
Composition of Cash and Equivalents:		
Cash in operating accounts	\$ —	\$ 5,029
Short-term cash investments	15,398,489	45,135,141
Unrealized (gain) loss on forward currency contracts and foreign cash	(4,851)	(4,464)
	\$15,393,638	\$45,135,706

The accompanying notes to financial statements are an integral part of these statements.

The John A. Hartford Foundation, Inc.
Notes to Financial Statements
December 31, 2007 and 2006

Exhibit D

1. Purpose of Foundation

The John A. Hartford Foundation was established in 1929 and originally funded with bequests from its founder, John A. Hartford and his brother, George L. Hartford. The Foundation supports efforts to improve health care in America through grants and Foundation-administered projects.

2. Summary of Significant Accounting Policies

Method of Accounting

The accounts of the Foundation are maintained, and the accompanying financial statements have been prepared, on the accrual basis of accounting.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

All net assets of the Foundation are unrestricted.

Investments

Investments in marketable securities are valued at their fair value (quoted market price). Investment and real estate partnerships where the Foundation has the right to withdraw its investment at least annually are valued at their fair value as reported by the partnership. Investment partnerships, real estate partnerships and REIT's which are illiquid in nature are recorded at cost adjusted annually for the Foundation's share of distributions and undistributed realized income or loss. Valuation allowances are also recorded on a group basis for declines in fair value below recorded cost. Because of the inherent uncertainty of valuation, estimated values may differ significantly from the values that would have been used had a ready market for the entities existed. Realized gains and losses from the sale of marketable securities are recorded by comparison of proceeds to cost determined under the specific identification method.

Grants

The liability for grants payable is recognized when specific grants are authorized by the Board of Trustees and the recipients have been notified. Annually the Foundation reviews its estimated payment schedule of long-term grants and discounts the grants payable to present value using the prime rate as quoted in the *Wall Street Journal* at December 31 to reflect the time value of money. The amount of the discount is then recorded as designated net assets.

Definition of Cash

For purposes of the statements of cash flows, the Foundation defines cash and equivalents as cash and short-term cash investments. Short-term cash investments are comprised of cash in custody accounts and money market mutual funds. Short-term cash investments also include the unrealized gain or loss on open foreign currency forward contracts and foreign cash.

Tax Status

The Foundation is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code and has been classified as a "private foundation." The Foundation is subject to an excise tax on net investment income at either a 1% or 2% rate depending on the amount of qualifying distributions. For 2007 and 2006 the Foundation's rate was 1% and 2%, respectively.

The John A. Hartford Foundation, Inc.
Notes to Financial Statements
December 31, 2007 and 2006

Exhibit D

2. Summary of Significant Accounting Policies (Continued)

Investment expenses for 2007 include direct investment fees of \$6,486,692 and \$385,000 of allocated salaries, legal fees and other office expenses. The 2006 comparative numbers were \$5,191,348 and \$395,000.

Deferred Federal excise taxes payable are also recorded on the unrealized appreciation of investments using the Foundation's normal 1% excise tax rate.

The Foundation intends to distribute at least \$29,500,000 of undistributed income in grants or qualifying expenditures by December 31, 2008 to comply with Internal Revenue Service regulations.

Some of the Foundation's investment partnerships have underlying investments which generate "unrelated business taxable income." This income is subject to Federal and New York State income taxes at "for-profit" corporation income tax rates.

Property and Equipment

The Foundation's office condominium, furniture and fixtures are capitalized at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the assets (office condominium-20 years; office furniture and fixtures-5 years).

3. Investments

The net change in unrealized gains in 2007 are summarized as follows:

	<i>Cost</i>	<i>Fair Value</i>	<i>Appreciation</i>
Balance, December 31, 2007	\$615,644,901	\$680,700,244	\$ 65,055,343
Balance, December 31, 2006	\$572,702,411	\$676,045,868	\$103,343,457
Decrease in unrealized appreciation during the year, net of decreased deferred Federal excise tax of \$382,882			\$ 37,905,232

For 2006, the increase in unrealized appreciation was \$30,963,409, net of increased deferred Federal excise tax of \$312,762.

Receivables and payables on security sales and purchases pending settlement at December 31, 2007 and 2006 were as follows:

	2007	2006
Proceeds from sales	\$ 2,652,792	\$2,159,659
Payables from purchases	(2,085,679)	(905,335)
Net cash pending settlement	\$ 567,113	\$1,254,324

The John A. Hartford Foundation, Inc.
Notes to Financial Statements
December 31, 2007 and 2006

Exhibit D

3. Investments (Continued)

The net amount has been included with short-term cash investments in the accompanying balance sheet.

The Foundation is a participant in seven investment limited partnerships. As of December 31, 2007, \$69,049,099 had been invested in these partnerships and future commitments for additional investment aggregated \$61,450,901.

In addition, the Foundation was a participant in five other investment partnerships which were in liquidation. The recorded value of these investments is \$1,848,259.

One of the Foundation's investment partnerships permit withdrawals at least once a year. It is valued at its fair value, \$30,839,592 (adjusted cost \$32,160,354).

Real estate investments included six limited partnerships and four real estate investment trusts. The Foundation had invested \$104,200,000 at December 31, 2007 and future commitments for additional investment aggregated \$55,800,000. One of the real estate investments is considered liquid and is recorded at fair value, \$17,863,243 (adjusted cost \$16,504,064).

In addition, three other real estate investments are in liquidation. The recorded value of these investments is \$1,288,151.

4. Foreign Investments

At December 31, 2007 the Foundation's foreign denominated investments were \$61,753,158.

5. Office Condominium, Furniture and Equipment

At December 31, 2007 and 2006 the fixed assets of the Foundation were as follows:

	2007	2006
Office condominium	\$4,622,812	\$4,622,812
Furniture and equipment	573,498	573,498
	5,196,310	5,196,310
Less: Accumulated depreciation	2,705,773	2,437,189
Office condominium, furniture and equipment, net	\$2,490,537	\$2,759,121

6. Pension Plan

The Foundation has a defined contribution retirement plan covering all eligible employees under which the Foundation contributes 14% of salary for employees with at least one year of service. Pension expense under the plan for 2007 and 2006 amounted to \$230,070 and \$177,616, respectively. The Foundation also incurred additional pension costs of approximately \$24,000 in 2007 and 2006 for payments to certain retirees who began employment with the Foundation prior to the initiation of the formal retirement plan.

The John A. Hartford Foundation, Inc.
Notes to Financial Statements
December 31, 2007 and 2006

Exhibit D

7. Grants Payable

The Foundation estimates that the non-current grants payable as of December 31, 2007 will be disbursed as follows:

	2009	\$28,442,572
	2010	18,824,679
	2011	10,677,304
	2012	14,276,395
	2013	1,932,471
	2014-2016	584,952
		74,738,373
	Discount to present value	(10,665,597)
		\$64,072,776

The amount of the discount to present value is calculated using the prime rate as quoted in the *Wall Street Journal*. The prime rate for 2007 and 2006 was 7.25% and 8.25%, respectively.

8. Non-Marketable Investments Reported at Adjusted Cost

As previously mentioned, the Foundation values the majority of its investment partnerships and real estate investments at cost adjusted for the Foundation's share of distributions and undistributed realized income or loss. If a group of investments has total unrealized losses, the losses are recognized.

Income from these investments is summarized as follows:

	2007	2006
Partnership earnings	\$1,478,718	\$1,074,426
Realized gains	9,275,598	4,848,101
Unrealized gain (loss), net of deferred taxes		
\$6,814 in 2007 and \$6,814 in 2006	674,550	(674,550)
Investment management fees	(2,895,604)	(1,443,173)
	\$8,533,262	\$3,804,804

9. Alternative Investment Incentive Fees

Most alternative investment vehicles provide for an incentive allocation of gains to the general partner or organizer of the Fund. These fees are deducted from the share of gains reported to Foundation. It is estimated these fees were approximately \$4,700,000 in 2007 and 2006.

10. Other Investment Fees

Certain alternative investments organized offshore are in the legal form of corporate stock investments. Income is only recognized when dividends are declared or a sale of shares takes place. Unrealized gain (loss) is recorded for the change in value. Accordingly, investment fees paid by the corporation are not recorded in these financial statements. The approximate amount of fees by these investments was \$1,200,000 in 2007 and \$750,000 in 2006.

Summary of Active Grants

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
AGING AND HEALTH					
ACADEMIC GERIATRICS AND TRAINING					
American Academy of Nursing <i>Nursing Initiative Coordinating Center and Scholar Stipends</i> Patricia G. Archbold, DNSc, RN	Washington, DC	\$10,066,286		\$ 2,022,699	\$ 8,043,587
American Academy of Nursing <i>The John A. Hartford Foundation Geropsychiatric Nursing Collaborative</i> Cornelia Beck, PhD, RN Kathleen C. Buckwalter, PhD, RN Lois Evans, PhD	Washington, DC		\$ 1,200,000		1,200,000
American Association of Colleges of Nursing <i>Enhancing Gerontology Content in Baccalaureate Nursing Education Programs</i> Geraldine Polly Bednash, PhD, RN	Washington, DC	2,064,551		662,277	1,402,274
American Association of Colleges of Nursing <i>Creating Careers in Geriatric Advanced Practice Nursing</i> Geraldine Polly Bednash, PhD, RN	Washington, DC	1,148,467		435,026	713,441
American College of Cardiology Foundation <i>Development and Dissemination of a Curriculum in Geriatric Cardiology</i> Susan Ziemann, MD	Washington, DC		303,524	73,891	229,633
American Federation for Aging Research, Inc. <i>Paul B. Beeson Career Development Awards in Aging Research Partnership</i> Stephanie Lederman and Odette van der Willik	New York, NY	9,908,450		1,161,592	8,746,858
American Federation for Aging Research, Inc. <i>Hartford Collaborative Research Awards: Paul B. Beeson Career Development Scholars Program</i> Odette van der Willik	New York, NY		2,392,858	625,797	1,767,061
American Federation for Aging Research, Inc. <i>Medical Student Summer Research Training in Aging Program</i> Odette van der Willik	New York, NY	1,258,409		380,006	878,403
American Federation for Aging Research, Inc. <i>Hartford Center of Excellence in Geriatric Medicine and Training Network Resource Center</i> Odette van der Willik	New York, NY	350,165		121,060	229,105
American Geriatrics Society, Inc. <i>Geriatrics for Specialty Residents Program Expansion</i> Ronnie Ann Rosenthal, MD	New York, NY		5,082,481	704,732	4,377,749

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
American Geriatrics Society, Inc. <i>Increasing Geriatrics Expertise for Surgical and Related Medical Specialties - Phase IV</i> John R. Burton, MD	New York, NY	\$ 2,987,111		\$ 1,034,729	\$ 1,952,382
American Geriatrics Society, Inc. <i>Integrating Geriatrics into the Subspecialties of Internal Medicine</i> William R. Hazzard, MD	New York, NY	15,722		15,722	
Arizona State University <i>Center of Geriatric Nursing Excellence</i> Colleen Keller, PhD, RN	Tempe, AZ		\$ 1,000,000	67,434	932,566
ASCO Foundation <i>A Commitment to Geriatric Oncology</i> Hyman B. Muss, MD	Alexandria, VA	225,024		85,373	139,651
Association of American Medical Colleges <i>Dissemination of Hartford/AAMC Geriatric Education Models: Leveraging Further Change and Preparing for the Future</i> M. Brownell Anderson	Washington, DC	183,300		104,049	79,251
Association of Directors of Geriatric Academic Programs <i>Chief Resident Immersion Training in the Care of Older Adults</i> Sharon A. Levine, MD	New York, NY		2,095,059	235,965	1,859,094
Association of Directors of Geriatric Academic Programs <i>Geriatric Leadership Development Program</i> Marie A. Bernard, MD and David B. Reuben, MD	New York, NY	1,705,302		284,976	1,420,326
Association of Directors of Geriatric Academic Programs <i>The Status of Geriatrics Workforce Study - Phase III</i> Gregg A. Warshaw, MD	New York, NY	207,376		91,689	115,687
Association of Professors of Medicine <i>Integrating Geriatrics into the Specialties of Internal Medicine: Moving Forward from Awareness to Action</i> Kevin P. High, MD, MSc	Washington, DC	2,639,358		345,496	2,293,862
Baylor College of Medicine <i>Center of Excellence in Geriatric Medicine and Training</i> George E. Taffet, MD	Houston, TX	859,477		184,477	675,000
Beth Israel Deaconess Medical Center, Inc. <i>Harvard Center of Excellence in Geriatric Medicine and Training</i> Lewis A. Lipsitz, MD	Boston, MA	600,000		73,890	526,110

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
Boston Medical Center <i>Center of Excellence in Geriatric Medicine and Training</i> Rebecca A. Silliman, MD, PhD	Boston, MA	\$ 801,194		\$ 201,194	\$ 600,000
Community College of Philadelphia <i>Fostering Geriatrics in Associate Degree Nursing Education</i> M. Elaine Tagliareni, EdD, RN	Philadelphia, PA	590,547		183,599	406,948
Cornell University <i>Center of Excellence in Geriatric Medicine and Training</i> M. Carrington Reid, MD, PhD	New York, NY	256,630		136,146	120,484
Council on Social Work Education <i>National Center for Gerontological Social Work Education</i> Nancy Hooyman, PhD and Julia M. Watkins, PhD	Alexandria, VA	605,288	\$ 4,739,983	830,703	4,514,568
Council on Social Work Education <i>Increasing Gerontological Competencies in MSW Advanced Curriculum Areas</i> Sadhna Diwan, PhD	Alexandria, VA	1,500,000		534,543	965,457
Duke University <i>Center of Excellence in Geriatric Medicine and Training</i> Harvey J. Cohen, MD	Durham, NC	750,000		221,741	528,259
Emory University <i>Southeast Center of Excellence in Geriatric Medicine and Training</i> Joseph G. Ouslander, MD	Atlanta, GA	179,883		36,079	143,804
Foundation for Health in Aging Inc. <i>Hartford Geriatrics Health Outcomes Research Scholars</i> Eric A. Coleman, MD, MPH	New York, NY	897,994	2,798,057	497,976	3,198,075
Gerontological Society of America <i>Hartford Geriatric Social Work Faculty Scholars Program</i> Barbara J. Berkman, DSW and Linda Krogh Harootyan, MSW	Washington, DC	9,855,340		1,981,643	7,873,697
Gerontological Society of America <i>Hartford Doctoral Fellows in Geriatric Social Work Program</i> James E. Lubben, DSW, MPH and Linda Krogh Harootyan, MSW	Washington, DC	3,438,812	5,000,000	1,507,156	6,931,656
Indiana University <i>Center of Excellence in Geriatric Medicine and Training</i> Steven R. Counsell, MD	Indianapolis, IN	256,049		128,540	127,509

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
Johns Hopkins University <i>Center of Excellence in Geriatric Medicine and Training</i> Samuel C. Durso, MD, MBA	Baltimore, MD	\$ 61,423	\$ 750,000	\$ 117,469	\$ 693,954
Mount Sinai Medical Center, Inc. <i>Center of Excellence in Geriatric Medicine and Training</i> Rosanne M. Leipzig, MD, PhD	New York, NY	675,000		134,091	540,909
New York Academy of Medicine <i>Practicum Partnership Program Adoption Initiative</i> Patricia J. Volland, MSW, MBA	New York, NY	3,298,725	4,685,376	1,976,377	6,007,724
New York University <i>How to Try This: Geriatric Assessment Nursing Resources</i> Mathy D. Mezey, EdD, RN	New York, NY		2,622,560	1,022,606	1,599,954
New York University <i>The John A. Hartford Foundation Institute for Geriatric Nursing</i> Mathy D. Mezey, EdD, RN	New York, NY	496,234		393,469	102,765
New York University <i>Hartford Institute for Geriatric Nursing Clinical Resources Expansion</i> Mathy D. Mezey, EdD, RN	New York, NY		350,000	53,792	296,208
Oregon Health & Science University <i>Center of Geriatric Nursing Excellence</i> Heather M. Young, PhD, GNP	Portland, OR	1,050,000		327,334	722,666
Pennsylvania State University <i>Center of Geriatric Nursing Excellence</i> Ann Kolanowski, PhD, RN	University Park, PA		1,000,000		1,000,000
Preventive Medicine Research Institute <i>Developing New Models of Health Care Delivery to Seniors</i> Dean Ornish, MD	Sausalito, CA		200,000	200,000	
RAND Corporation <i>Developing Interdisciplinary Research Centers for Improving Geriatric Health Care Services: Phase II</i> Harold Alan Pincus, MD	Santa Monica, CA	2,243,325		587,274	1,656,051
Rhode Island Hospital <i>Brown University Center of Excellence in Geriatric Medicine and Training</i> Richard W. Besdine, MD	Providence, RI		450,000		450,000
Society of Hospital Medicine <i>Improving Hospital Care Transitions for Older Adults</i> Laurence Wellikson, MD	Philadelphia, PA	36,340	1,452,017	263,174	1,225,183

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
University of Alabama at Birmingham <i>Southeast Center of Excellence in Geriatric Medicine and Training</i> Richard M. Allman, MD	Birmingham, AL	\$ 174,668		\$ 78,384	\$ 96,284
University of Arkansas for Medical Sciences <i>Center of Geriatric Nursing Excellence</i> Claudia J. Beverly, PhD, RN	Little Rock, AR	976,000		116,316	859,684
University of California, Los Angeles <i>Center of Excellence in Geriatric Medicine and Training</i> David B. Reuben, MD	Los Angeles, CA	749,717		169,694	580,023
University of California, San Diego <i>Center of Excellence in Geriatric Psychiatry</i> Dilip V. Jeste, MD	La Jolla, CA	282,080		156,851	125,229
University of California, San Francisco <i>Center of Excellence in Geriatric Medicine and Training</i> C. Seth Landefeld, MD	San Francisco, CA	750,000		150,000	600,000
University of California, San Francisco <i>Center of Geriatric Nursing Excellence</i> Margaret I. Wallhagen, PhD, GNP	San Francisco, CA	953,075		220,281	732,794
University of Chicago <i>Center of Excellence in Geriatric Medicine and Training</i> William Dale, MD, PhD	Chicago, IL	852,920		102,920	750,000
University of Colorado <i>Center of Excellence in Geriatric Medicine and Training</i> Robert S. Schwartz, MD	Denver, CO	821,087		170,935	650,152
University of Hawaii <i>Center of Excellence in Geriatric Medicine and Training</i> Patricia L. Blanchette, MD, MPH	Honolulu, HI	108,471	\$ 750,000	108,471	750,000
University of Iowa <i>Center of Geriatric Nursing Excellence</i> Kathleen C. Buckwalter, PhD, RN	Iowa City, IA	955,504		223,249	732,255
University of Michigan <i>Center of Excellence in Geriatric Medicine and Training</i> Jeffrey B. Halter, MD	Ann Arbor, MI	675,000		102,198	572,802
University of Minnesota <i>Center of Geriatric Nursing Excellence</i> Jean F. Wyman, PhD	Minneapolis, MN		1,000,000	100,000	900,000
University of North Carolina at Chapel Hill <i>Center of Excellence in Geriatric Medicine and Training</i> Jan Busby-Whitehead, MD	Chapel Hill, NC	222,413			222,413

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
University of Pennsylvania <i>Center of Geriatric Nursing Excellence</i> Neville E. Strumpf, PhD, RNC	Philadelphia, PA	\$ 1,050,000		\$ 243,135	\$ 806,865
University of Pennsylvania <i>Center of Excellence in Geriatric Medicine and Training</i> Jerry C. Johnson, MD, PhD	Philadelphia, PA	750,000		75,000	675,000
University of Pittsburgh <i>Center of Excellence in Geriatric Medicine and Training</i> Neil M. Resnick, MD	Pittsburgh, PA	146,371	\$ 750,000	221,371	675,000
University of Pittsburgh <i>Center of Excellence in Geriatric Psychiatry</i> Charles F. Reynolds III, MD	Pittsburgh, PA	314,101		71,747	242,354
University of Rochester <i>Center of Excellence in Geriatric Medicine and Training</i> William J. Hall, MD	Rochester, NY	103,437	750,000	103,437	750,000
University of Texas Health Science Center at San Antonio <i>Center of Excellence in Geriatric Medicine and Training</i> David V. Espino, MD	San Antonio, TX	850,773		175,773	675,000
University of Utah <i>Center of Geriatric Nursing Excellence</i> Ginette A. Pepper, PhD, RN	Salt Lake City, UT		1,000,000	83,541	916,459
University of Utah <i>Geriatric Training Program Development</i> Mark A. Supiano, MD	Salt Lake City, UT	50,000		50,000	
University of Washington <i>Center of Excellence in Geriatric Medicine and Training</i> Itamar B. Abrass, MD	Seattle, WA	228,613		95,286	133,327
University of Wisconsin <i>Center of Excellence in Geriatric Medicine and Training</i> Sanjay Asthana, MD	Madison, WI		450,000		450,000
Wake Forest University Health Sciences <i>Center of Excellence in Geriatric Medicine and Training</i> Jeff D. Williamson, MD, MHS	Winston-Salem, NC		450,000		450,000
Yale University <i>Center of Excellence in Geriatric Medicine and Training</i> Mary E. Tinetti, MD	New Haven, CT	100,000	750,000	100,000	750,000
Sub-Total Academic Geriatrics and Training		\$72,326,012	\$42,021,915	\$22,964,375	\$91,383,552

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
INTEGRATING AND IMPROVING SERVICES					
AARP Foundation <i>Professional Partners Supporting Family Caregiving</i> Susan C. Reinhard, PhD, RN	Washington, DC		\$ 511,874	\$ 255,937	\$ 255,937
Boston Medical Center <i>Clinical Service Challenge Grant: Redesigning Long-Term Care Services for Urban Vulnerable Elders to Improve Efficiency, Quality, and Satisfaction</i> Rebecca A. Silliman, MD, PhD	Boston, MA	\$ 73,854		73,854	
Intermountain Health Care <i>Evaluating the Impact of Geriatric Care Teams in Ambulatory Practice</i> Cherie Brunner, MD	Salt Lake City, UT	30,000		30,000	
International Honor Society of Nursing Foundation, Inc. (Sigma Theta Tau) <i>Geriatric Nursing Leadership Academy Planning Grant</i> Mary Rita Hurley, RN, MPA	Indianapolis, IN		529,575	264,788	264,787
Johns Hopkins University <i>Guided Care: Demonstration Project and Diffusion Planning</i> Charles E. Boulton, MD, MPH, MBA	Baltimore, MD	1,429,319	83,000	746,113	766,206
Johns Hopkins University <i>Translating Research into Practice: The Johns Hopkins Home Hospital</i> Bruce Leff, MD	Baltimore, MD	1,090,846		424,921	665,925
Johns Hopkins University <i>Clinical Service Challenge Grant: Johns Hopkins Hospital Geriatrics Floating Interdisciplinary Team</i> Samuel C. Durso, MD, MPA	Baltimore, MD	90,474		90,474	
Mount Sinai Medical Center, Inc. <i>Advancing the Palliative Care Field: A Consortium Funded Initiative</i> Diane E. Meier, MD	New York, NY	625,000		250,000	375,000
Mount Sinai Medical Center, Inc. <i>Clinical Service Challenge Grant: The Four "C"s of Excellent Geriatric Hospital Care: Coordination, Collaboration, Communication, Continuity</i> Rosanne M. Leipzig, MD, PhD	New York, NY	78,151		19,114	59,037
National PACE Association <i>Establishing PACE as a Community Care Option for Rural Elders</i> Peter Fitzgerald	Alexandria, VA		334,856	112,339	222,517

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
Oregon Health & Science University <i>Dissemination of Care Management Plus: Information Technology Tools for the Care of Seniors</i> David A. Dorr, MD, MS	Portland, OR		\$2,477,509	\$ 403,024	\$ 2,074,485
Paraprofessional Healthcare Institute, Inc. <i>The Nurse as Supervisor of Direct-Care Staff</i> Sara Joffe	Bronx, NY	\$ 2,114,696		569,534	1,545,162
Partners in Care Foundation, Inc. <i>Preventing Medication Errors: Evidence- Based Medication Management Intervention</i> W. June Simmons, MSW	San Fernando, CA	1,446,279		319,304	1,126,975
State University of New York, Albany <i>Elder Network of the Capital Region Implementation Plan</i> Philip McCallion, PhD, MSW	Albany, NY	122,325		79,506	42,819
University of California, Los Angeles <i>Clinical Service Challenge Grant: Redesigning a Geriatrics Practice to Manage Chronic Conditions</i> David B. Reuben, MD	Los Angeles, CA	102,996		51,748	51,248
University of California, San Francisco <i>Clinical Service Challenge Grant: Going Home Clinical Services Project</i> C. Bree Johnston, MD, MPH	San Francisco, CA	78,585		78,585	
University of Colorado <i>Dissemination of Geriatric Interdisciplinary Teams in Practice</i> Eric A. Coleman, MD, MPH	Denver, CO	905,049		439,807	465,242
University of Colorado <i>The Practice Change Fellows: An Interdisciplinary Leadership Program to Improve Health Care for Older Adults</i> Eric A. Coleman, MD, MPH	Denver, CO		600,000	59,482	540,518
University of Pennsylvania <i>Translating Research into Practice: Transitional Care for Elders</i> Mary D. Naylor, PhD, RN	Philadelphia, PA	338,683			338,683
University of Washington <i>Improving Depression Care for Elders - IMPACT Model Dissemination</i> Jürgen Unützer, MD, MPH	Seattle, WA	1,999,568		129,187	1,870,381
Visiting Nurse Service of New York <i>Establishing a Framework for Geriatric Home Care Excellence</i> Penny Hollander Feldman, PhD	New York, NY		835,466	417,733	417,733
Sub-Total Integrating and Improving Services		\$10,525,825	\$5,372,280	\$4,815,450	\$11,082,655

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
AGING AND HEALTH - OTHER					
American Federation for Aging Research, Inc. <i>Kensington-Hartford Travel Awards in Geriatrics</i> Stephanie Lederman	New York, NY		\$73,867		\$73,867
Florida Health Care Education and Development Foundation, Inc. <i>Hurricane and Disaster Preparedness for Long-Term Care Facilities</i> LuMarie Polivka-West, MSP	Tallahassee, FL	\$ 269,499		\$180,778	88,721
George Washington University <i>Advancing Aging and Health Policy Understanding</i> Judith Miller Jones	Washington, DC	839,004		425,229	413,775
Institute of Medicine of the National Academies <i>Healthcare Workforce Consensus Report for an Aging Society</i> Roger Herdman, MD	Washington, DC	200,000		144,047	55,953
The Foundation for the L.S.U. Health Sciences Center <i>Rebuilding Geriatric Medicine and Training at Louisiana State University: A Response to the Flooding of New Orleans</i> Charles A. Cefalu, MD, MS	New Orleans, LA	389,675		155,870	233,805
Sub-Total Aging and Health - Other		\$1,698,178	\$73,867	\$905,924	\$866,121
NEW YORK FUND					
American Federation for Aging Research, Inc. <i>AFAR 2007 Annual Awards Dinner</i> Stephanie Lederman	New York, NY		\$14,040	\$14,040	
Association of Baccalaureate Social Work Educators <i>BPD 25th Anniversary Meeting</i> Linda Moore, PhD	Alexandria, VA		15,000	15,000	
Foundation for Health in Aging Inc. <i>2007 Lifetime of Caring Gala</i> Linda M. Hiddemen-Barondess	New York, NY		11,800	11,800	
New York University <i>NYU College of Nursing 75th Anniversary Celebration</i> Terry T. Fulmer, PhD, RN	New York, NY		23,650	23,650	
United Hospital Fund <i>Annual Support</i> James R. Tallon, Jr.	New York, NY		2,500	2,500	
University of California, San Francisco <i>Celebration Reception in Honor of Dr. Jeanie Kayser-Jones</i> Margaret I. Wallhagen, PhD, GNP	San Francisco, CA		15,000	15,000	

		Balance Due January 1, 2007	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2007
Visiting Nurse Service of New York <i>2007 Benefit Dinner</i> John Billeci	New York, NY		\$ 13,900	\$ 13,900	
Sub-Total New York Fund			\$ 95,890	\$ 95,890	
OTHER GRANTS					
The Foundation Center <i>Annual Support</i> Sara L. Engelhardt	New York, NY		\$ 10,000	\$ 10,000	
Grantmakers in Aging <i>Annual Support</i> Carol A. Farquhar	Dayton, OH		5,000	5,000	
Grantmakers in Health <i>Annual Support</i> Lauren LeRoy, PhD	Washington, DC		10,000	10,000	
Make-A-Wish Foundation of Idaho <i>In Memory of Charles E. Murphy, Jr.</i> Marcia Karakas	Boise, ID		5,000	5,000	
New York Regional Association of Grantmakers <i>Annual Support</i> Ronna Brown	New York, NY		14,200	14,200	
The Philanthropy Roundtable <i>Annual "Friend" Support</i> Adam Meyerson	Washington, DC		1,000	1,000	
Sub-Total Other Grants			\$ 45,200	\$ 45,200	
Matching Grants*			\$ 968,610	\$ 968,610	
Discretionary Grants**			\$ 169,000	\$ 169,000	
Grants Refunded or Cancelled		1,004,409	(1,165,874)	(161,465)	
Discounts to Present Value		(9,888,094)	(777,503)		(10,665,597)
Total (All Grants)		\$75,666,330	\$46,803,385	\$29,802,984	\$92,666,731
*Grants made under the Foundation's program for matching charitable contributions of Trustees and staff.					
** Grants made under the Foundation's program for charitable contributions designated by Trustees and staff.					
		Expenses Authorized Not Incurred Jan. 1, 2007	Projects Authorized During Year	Expenses Incurred During Year	Expenses Authorized Not Incurred Dec. 31, 2007
FOUNDATION-ADMINISTERED PROJECTS					
<i>Evaluation of the Foundation's Geriatric Nursing Programs</i>		\$300,004		\$280,182	\$ 19,822
<i>Communications & Dissemination Initiative</i>		513,426		233,953	279,473
<i>To Pursue Selected Activities in the Strategic Plan</i>			\$148,084	148,084	
Total		\$813,430	\$148,084	\$662,219	\$299,295

Application Procedures

THE JOHN A. HARTFORD FOUNDATION'S OVERALL GOAL is to increase the nation's capacity to provide effective and affordable care to its rapidly increasing elderly population. In order to maximize the Foundation's impact on the health and well-being of the nation's elders, grants are made in two priority areas:

Academic Geriatrics and Training

The Foundation supports efforts, on an invitational basis, in selected academic medical centers and other appropriate institutions to strengthen the geriatric training of America's physicians, nurses, and social workers.

Integrating and Improving Health-Related Services

The Foundation supports a limited number of sustainable efforts to improve and integrate the "system" of services needed by elders and the effectiveness of selected components of care. The emphasis is on nationally replicable models and is typically by invitation.

The Foundation normally makes grants to organizations in the United States which have tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (and are not private foundations within the meaning of section 107(c)(1) of the code), and to state colleges and universities. The Foundation does not make grants to individuals.

Due to its narrow funding focus, the Foundation makes grants primarily by invitation. After familiarizing yourself with the Foundation's program areas and guidelines, if you feel that your project falls within this focus, you may submit a brief letter of inquiry (1-2 pages) which summarizes the purpose and activities of the grant, the qualifications of the applicant and institution, and an estimated cost and time frame for the project. The letter will be reviewed initially by members of the Foundation's staff and possibly by outside reviewers. Those submitting proposals will be notified of the results of this review in approximately six weeks and may be asked to supply additional information.

Please do not send correspondence by fax or e-mail. Mail may be sent to:

The John A. Hartford Foundation
55 East 59th Street
New York, NY 10022

Detailed information about the Foundation and its programs is available at our Web site, <http://www.jhartfound.org>.

credits

editorial:
Lynne Christensen

design:
Donald Battershall Design

photography:
Donald Battershall/William Mebane

printing:
Brodock



For more information on this and other initiatives of the John A. Hartford Foundation, visit our Web site at www.jhartfound.org.