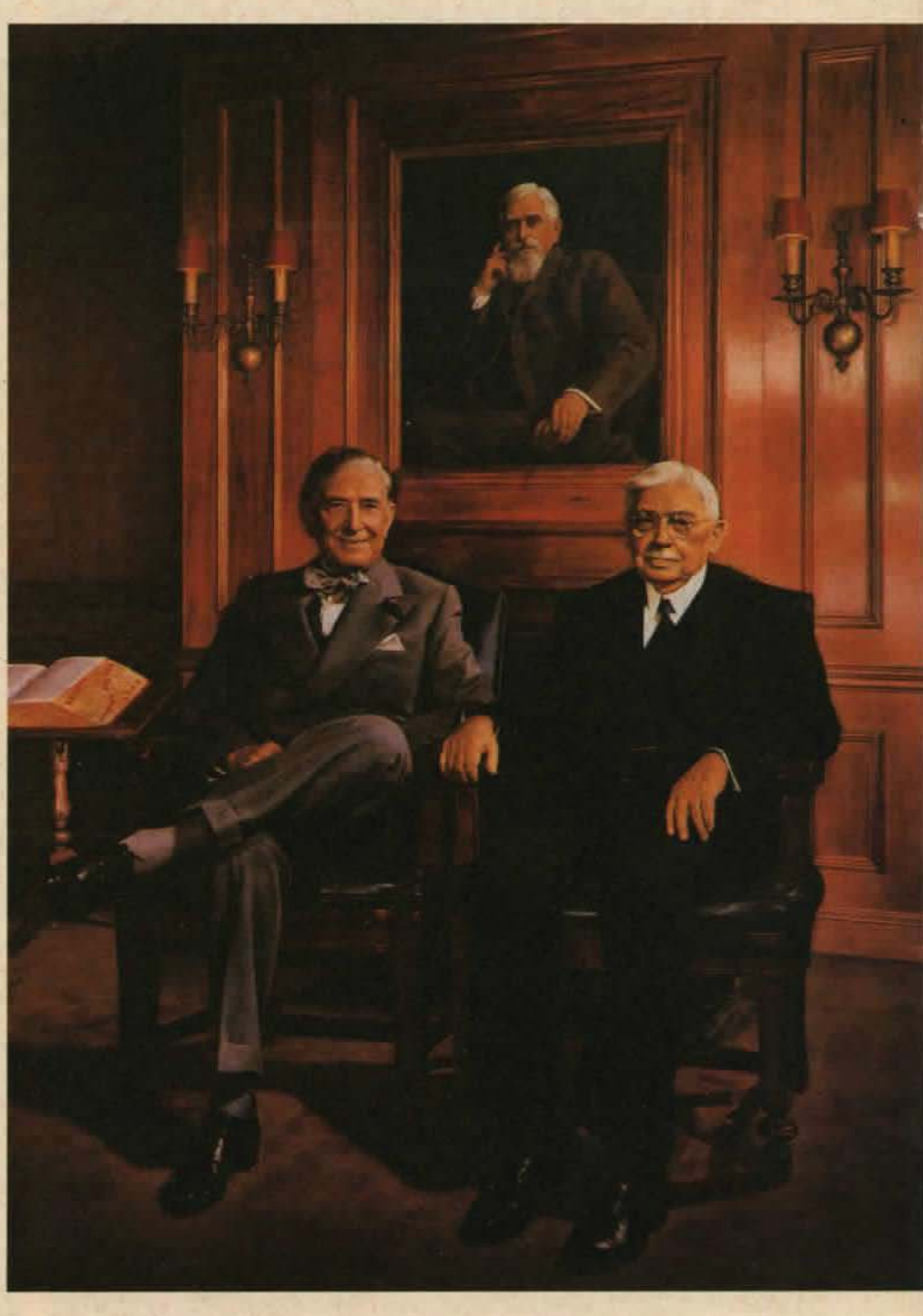
THE JOHN A. HARTFORD FOUNDATION 1993 ANNUAL REPORT



John A. (left) and George L. Hartford, circa 1950. The portrait in the background is of their father, George Huntington Hartford. (Courtesy of the Hartford Family Foundation)

Contents

"Hartford, oh yes, the insurance company, your office is in Connecticut." How many times have we heard this over the years? "No," we reply, "Our office is in New York, and we were started in 1929 by John A. Hartford, whose father founded The Great Atlantic & Pacific Tea Company."

As years pass, the Foundation's origin is known to fewer people. To set the record straight, our cover this year depicts our founder, John, seated next to his brother George in front of the portrait of their father. John died in 1951, and the bulk of his estate was left to the Foundation. His brother George died in 1957, and his entire estate was left to the Foundation at that time.

In his wisdom, John felt future Trustees should have the freedom to determine the Foundation's direction, within the overall rubric of "doing the greatest good for the greatest number." Thus, with the exception of several special areas of Trustee interest, such as Lincoln Center, and a short-lived energy conservation program in the early eighties, the Foundation has concentrated attention on the health care field since its founding, an area where it was felt the greatest good could be done for mankind.

Since our inception, we have always had a member of the Hartford family on our Board. Today we are very fortunate to have John's grandniece Nuala Pell, who succeeded her mother, Josephine Hartford Bryce, when she stepped down in 1981.

For the last decade our grantmaking has focused on two principal areas – health care cost containment and issues of quality and health in the aging population. In 1993 our grants totalled $12,150,000, and they were divided evenly between these two areas. Much of the work supported under the Health Care Cost and Quality program is reflected in leading proposals for reform, principally Community Health Reform, and the Community Health Management Information System (CHMIS), as discussed in the text of this Report. Now that the national political debate is underway, we are putting on hold much of our work in this area until we see which initiatives the Congress and the President will enact into law.

In the Aging and Health program we also have contributed to cutting-edge reform. We have continued our efforts to strengthen geriatric training in America's medical schools. This past year also saw completion of grant-making aimed at better integration of care for elders through their primary care physicians' offices. The Trustees reviewed our work in this area in December, and renewed their commitment to addressing the health care needs of the elderly over the coming years.

Year end 1993 saw our assets at $339.3 million, an increase of $35.2 million, or almost 12 percent, for the year. We benefitted greatly from our international investments as well as from our small capitalization equities. We thank our Vice Chairman, Charlie Murphy, and his Finance Committee for their stewardship of our assets.

In 1993 two of our Trustees left our Board. Matthew E. Welsh reached mandatory retirement age, and did not stand for reelection at the Annual Meeting last May. Matt joined our Board in 1969, and contributed greatly to our growth and success during his service as a Trustee. Later in the year, Richard A. Cramer, who had been a member since 1985, resigned for personal and business reasons. Our Board now numbers nine, and is pictured in the Report. Pictures of our staff are also included in the Report. My thanks go to our Trustees and our staff for their efforts in 1993. The year was a good one and we look ahead with confidence.

James D. Farley

James D. Farley

(Rear, left to right) Alexander M. Laughlin, Robert H. Mulreany, Michael D. Dingman, Thomas A. Reynolds, Jr.
(Front, left to right) Charles E. Murphy, Jr., Nuala Pell, James D. Farley, Norman H. Volk, Kathryn D. Wriston

James D. Farley
Chairman

Charles E. Murphy, Jr.
Vice Chairman

Norman H. Volk
Vice Chairman

Robert H. Mulreany
Secretary

Richard A. Cramer*

Michael D. Dingman

Alexander M. Laughlin

Nuala Pell

Thomas A. Reynolds, Jr.

Matthew E. Welsh**

Kathryn D. Wriston

** Resigned December 1993*
*** Retired May 1993*

AS OUR NATION MOVES FORWARD IN REFORMING ITS HEALTH CARE SYSTEM, IT CAN DRAW ON THE RESULTS OF HARTFORD FOUNDATION GRANTS IN FOUR AREAS, DESCRIBED IN THE FOLLOWING PAGES.

Strengthening Geriatrics in America's Medical Schools

"The committee concludes that major deficits already exist in the supply of faculty for teaching and conducting research and that recruitment and training efforts under way will fall far short of producing enough skilled geriatricians to form a 'core' for improved geriatrics education."

Strengthening Training in Geriatrics for Physicians, *Committee on Strengthening the Geriatric Content of Medical Training, Division of Health Care Services, Institute of Medicine, National Academy Press, Washington, D.C., 1993*

For many older Americans, the post-retirement years bring rewards of travel and leisure that were inconceivable only decades ago. Greater income security and life-saving medical technology have yielded a quality of life that is the envy of the world.

But as our senior citizens move beyond being "young old," they almost invariably develop chronic medical conditions and require far more medical care. Our fastest-growing age group is the "oldest old" — those 85 years old and over — who numbered three million in 1990 and could increase to nearly nine million by 2030. A special understanding of their maladies and needs is essential, yet most physicians to whom they turn sorely lack such specialized training.

At the core of the problem is the lack of geriatric training. In the 1992-93 academic year, geriatric courses were required in only 14 medical schools. Less than three percent of the medical students who graduated in 1992 reported having taken an elective in geriatrics. And a recent study by the Association of American Medical Colleges reported that, in 1987, only 44 out of 15, 836 medical school graduates had enrolled in a geriatric fellowship program.

Part of the reason for these dismal statistics is a severe shortage of faculty with expertise in geriatrics at U.S. medical schools. There are, according to recent estimates, 909 geriatric physician faculty in internal medicine, 574 in family practice, 267 in neurology, 438 in psychiatry, and 86 in physical medicine and rehabilitation—a total of only 2,274.

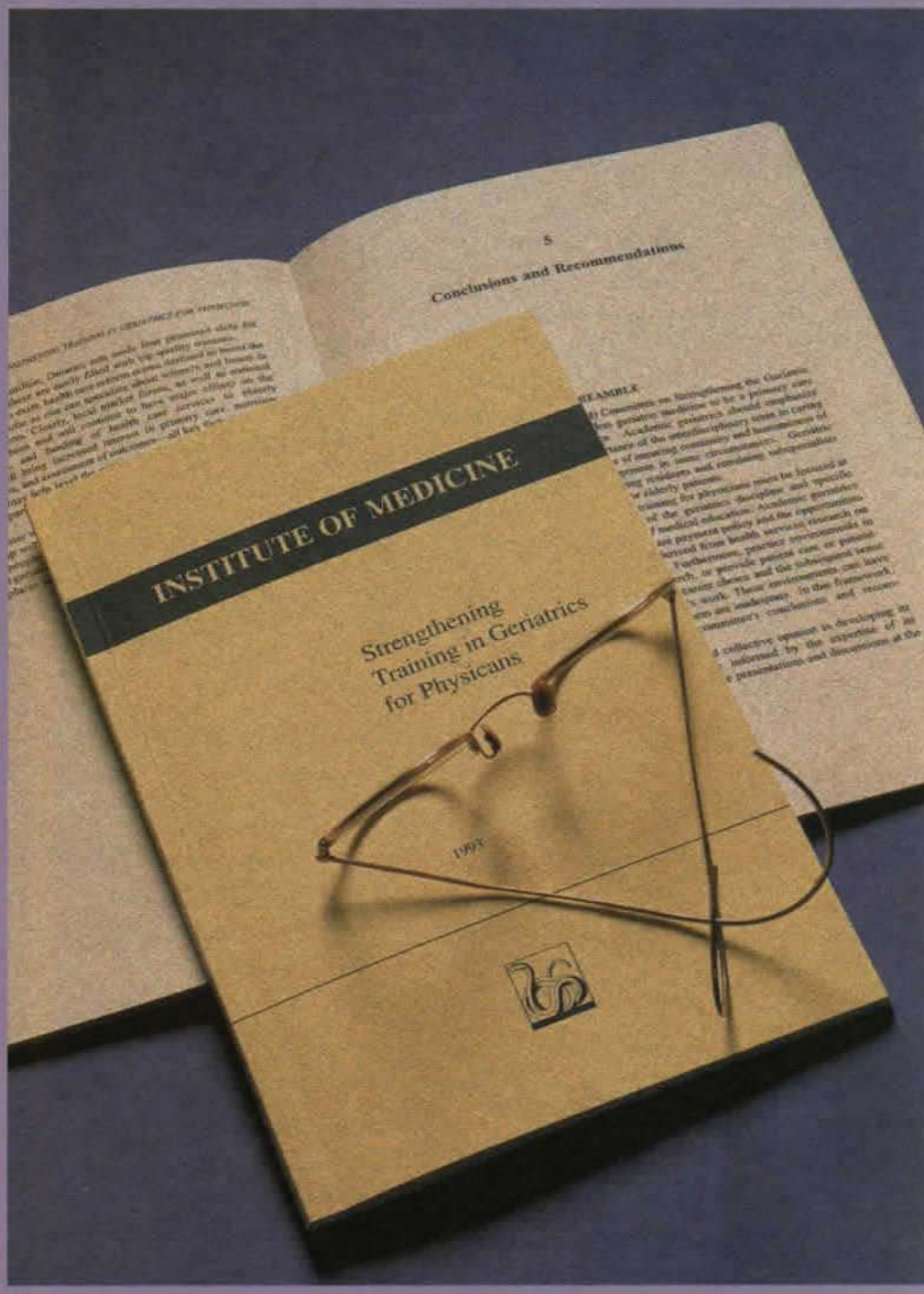
In 1983 the Hartford Foundation offered fellowships to mid-career faculty interested in pursuing advanced training in geriatrics. While 29 physicians did complete one year of training under the program, it was apparent that more effective recruitment, at all levels, would be required to meet the overwhelming need.

For this reason the Foundation's Trustees revised their grant-making strategy in 1988. Following the suggestions of a Hartford-supported study by the Institute of Medicine, the new program established "centers of excellence" at a number of medical schools to attract outstanding individuals to careers in academic geriatrics. Grants were made to ten schools, totalling some $3 million over three years. By May 1991 the program had been so successful that a further commitment of $3 million was made for grants to 13 such centers.

In 1993 the Foundation once again asked for help from the Institute of Medicine, which at mid-year convened an expert committee with Hartford's support. Its report,

Strengthening Training in Geriatrics for Physicians, included recommendations to attract medical students to careers in academic geriatrics, increase attention to geriatrics in primary care training and in the training of medical and surgical specialists, and continue fellowship support in geriatrics.

In response to these recommendations and their own assessment of past projects, the Foundation's Trustees in 1993 approved two grants to strengthen academic geriatrics and agreed to consider additional awards over the next few years. A major grant was awarded to the American Federation for Aging Research to provide research opportunities to medical students and nurture their career development in academic geriatric medicine. The American Geriatrics Society will use Hartford's support to improve the geriatric content of training in non-primary care specialties. Future grants under consideration include projects to bring more emphasis on geriatrics to generalist physician training, and fellowship support for senior fellows and younger faculty who wish to add geriatric expertise to their academic qualifications.



Integrating Health-Related Services for the Elderly

"...given that one's elderly patients are, as often as not, suffering from a complex of social, mental, and physical as well as biomedical problems, it is unrealistic, as those who practice geriatric medicine have found, to separate the medical treatment of the latter from the managerial aspects of the former. Physician participation in patient management should not be equated with dominance of the management role. But...active physician involvement in multidisciplinary case management decisions is a high-priority, non-traditional role essential to the practice of geriatric medicine."

*William H. Barker, M.D., **Adding Life to Years**, Baltimore: Johns Hopkins University Press, 1987, p. 153–154*

A frail 85-year-old suffering from, for example, arthritis and angina, and recovering from a hospital stay for hip surgery, will face a dizzying array of caregivers — an orthopedic surgeon, a cardiologist, a rheumatologist, a primary care physician, a visiting nurse, a physical therapist, several pharmacists, a social worker or case manager, probably a home health aide, and possibly local "meals-on-wheels" volunteers.

Confusion reigns. All too rarely is there effective communication among such caregivers, or adequate consultation with the patient and his or her family. What can be done to provide frail elders and their families with user-friendly, integrated health care?

One cause of this confusion is our fragmented system for financing health care. Unfortunately, current health care reform proposals offer little hope that integrative financing will be achieved soon. But some progress can be made in the meantime, particularly in better integrating the delivery of services themselves.

Hartford Foundation interest in this area dates from its initial support of San Francisco's On Lok project in 1983, which utilized prepaid funds from Medicaid and Medicare to deliver fully integrated medical and social services to frail elders who otherwise would be in nursing homes. With subsequent support from Hartford, the federal government, and other foundations, On Lok has demonstrated that its approach is feasible in a wide range of settings.

A 1986 grant to the Community Care Organization of Milwaukee County helped 13 agencies in Milwaukee develop a system to coordinate their services so that frail elders could remain in their own homes.

Rochester's Community Coalition for Long-Term Care, supported by Hartford from 1987 until 1993, designed a financing and service model for providing long-term care to the area's elderly, regardless of their income or health status.

One promising approach centers on generalist physicians —the family practitioners and internists who typically supply primary care to older patients. These physicians are often asked to coordinate caregivers or identify community-based services for their patients. Yet they rarely have the expertise, time, or staff to play such a role effectively, and they are seldom compensated adequately for such services.

In 1992 the Foundation's Trustees approved a new program, the Generalist Physician Initiative, to support projects that help generalist physicians assume responsibility for the broad range of services that their aging patients require. These model projects would feature increased teamwork; new roles for specialists, nurses, nurse practitioners, social workers, and other health personnel; and care plans that go beyond the biomedical to include community-based social and supportive services. The initiative would also strive to make the care of elders more satisfying for these physicians, both professionally and financially.

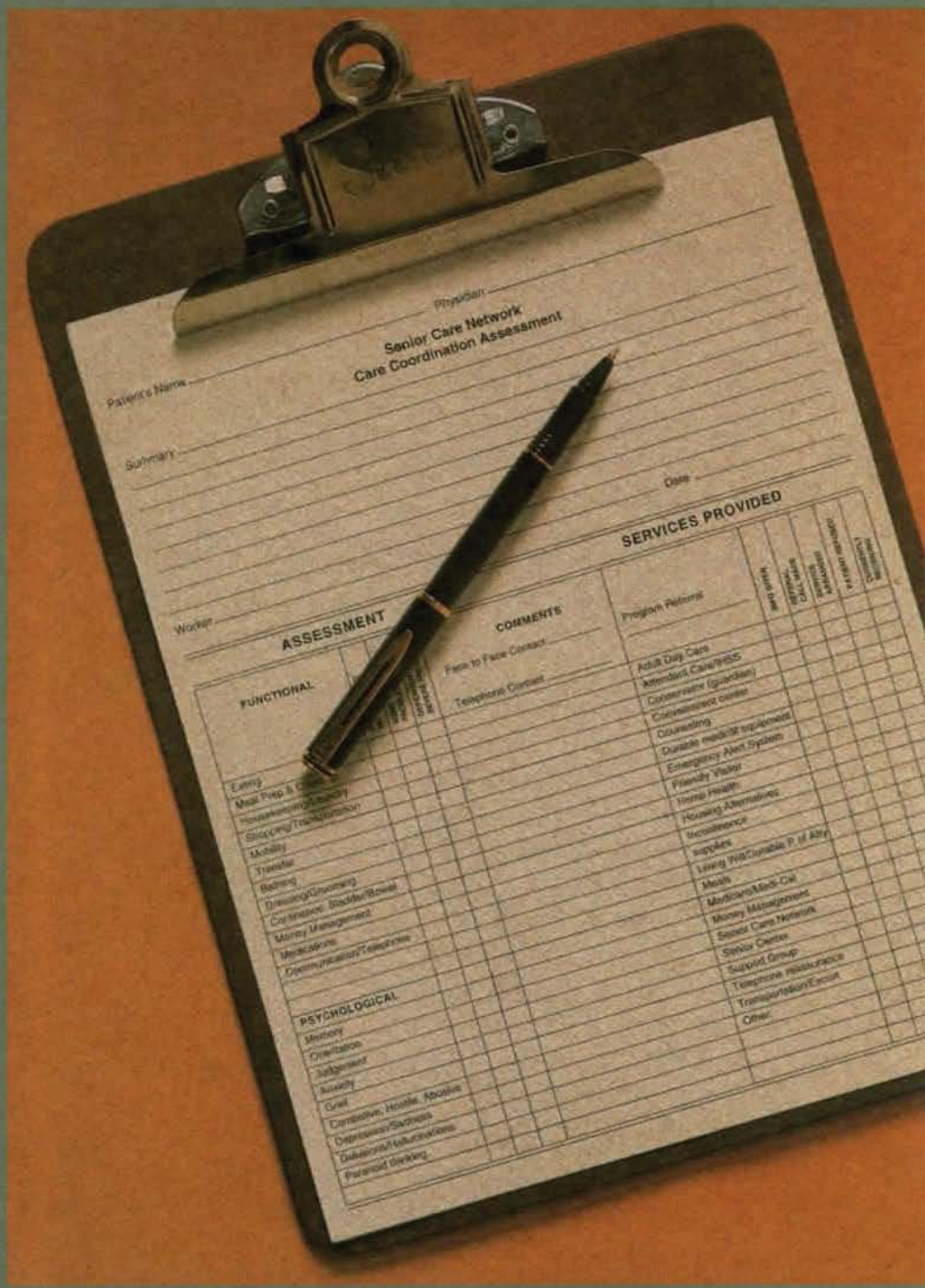
Six grants were made in 1992 under the Generalist Physician Initiative. In 1993 the Foundation approved three new projects, based at Detroit's Henry Ford Health System, Mount Sinai Hospital of Greater Miami, and South Carolina's Department of Health and Environmental Control. The nine grants made to date under

the initiative total almost $7 million. In the future the Foundation expects to support efficient coordination among the projects and a thorough evaluation of the demonstrations.

Abt Health Care Research Foundation received support in 1993 to conduct an actuarial analysis of data on the utilization of services by elderly patients collected by San Diego's Sharp Health Care System. Their report will be disseminated to insurers and health plans to convince them that paying for a mix of tightly integrated health and social services would entail manageable risk and produce a high level of customer satisfaction.

In 1993 Hartford's Trustees also renewed their support for the National Chronic Care Consortium, which is committed to advancing the cause of integrating acute and long-term care through the production of training materials and technical assistance. In Rhode Island, the Interfaith Health Care Ministries received continuing Foundation support to work with a local HMO in developing care networks which better integrate medical and social services for seniors through "Aging 2000," an ambitious statewide reform plan.

The results of the grants made under the Generalist Physician Initiative will help determine the Foundation's further efforts. One area of interest, which will be explored in 1994, is whether the hospitalization of elders can be reduced through more effective integration of home-based medical care and supportive services.



Community Health Reform

"Community health reform is based on a clear set of principles:

- **purchasing the best *value* care (the highest quality at the lowest justifiable cost);**
- **measuring the comparative quality and efficiency of providers to determine the best value;**
- **establishing clear rewards for providers delivering superior value;**
- **working with providers to improve the overall *health* of the community."**

Statement of Principles, *National Business Coalition on Health, Washington, D.C.*

Impending national health care reform has focused new attention on a true grassroots movement taking shape across America. Community by community, employers are demonstrating that by harnessing their buying power they can keep costs under control, and by gathering timely, accurate information they can gain access to the highest quality medical care.

From Memphis to Denver, from Tampa to San Francisco, come reports of a dramatic slowing in the rise of health care costs, and innovative schemes for assessing quality. This success has not been lost on those shepherding proposals for reform in the nation's capital. Many have come to realize that meaningful, long-term solutions to our current health care crisis can be built on the business-led, local reform already under way.

From the beginning, the Hartford Foundation was able to play a role in what came to be called the Community Health Reform movement. In 1980 a Foundation grant to the Central Iowa Development Corporation mobilized the state's business leaders to pursue a market incentive approach to health care cost containment. The result: hospital admissions declined, HMO enrollment increased, and purchasers contained costs through managed care and direct negotiation with providers. The business group went on to form the Health Policy Corporation of Iowa, which, with Hartford's support, is now experimenting with new forms of collective purchasing and working closely with government to design statewide programs for purchasing and measuring the quality of health care.

Another promising Community Health Reform prototype, the Memphis Business Group on Health, gained Hartford support in 1991. Founded in 1985 with the proclaimed goal of exerting "a moderating influence on rising health care costs in the community, without sacrificing quality or access to medical care," the group has grown to represent just under 20 percent of the private health care dollars spent in Memphis. Owing to preferred provider contracts with local institutions and a utilization management program to reduce inappropriate services, its members' health care costs have risen, on average, only six percent annually over the past five years, in contrast with the national average of 14.6 percent.

Washington State's Health Care Purchasers Association has also been at the cutting edge of Community Health Reform. With Foundation support since 1990, it has launched the Employers' Health Purchasing Co-op and has worked with other health care stakeholders to design and gain support for a statewide health care information system.

In 1989 a dozen of the local business groups that exemplified Community Health Reform founded the National Business Coalition Forum on Health, to help business groups around the country undertake purchaser-led health care reform in their communities. The organization expanded, and in 1992 the National Business Coalition on Health, as it is now called, incorporated as a freestanding non-profit organization. Aided by a major three-year Hartford Foundation grant approved in 1992, the coalition has assumed national leadership of the Community Health Reform movement. Its rapidly growing membership now totals over 70 groups, representing some 5,000 employers who are responsible for over 25 million lives.

Despite the success of Community Health Reform, the fate of the local business groups is uncertain in the face of national reform. A highly regulatory approach could eliminate their collective purchasing role or prompt them to promote

competition by becoming health plans themselves. On the other hand, under less regulation the local business groups could continue to serve as voluntary purchasing alliances, helping businesses of all sizes obtain competitively priced health care services and insurance.

So that local business groups can move swiftly once the shape of reform is known, the Foundation's Trustees approved in 1993 an 18-month grant to the Colorado Health Care Purchasing Alliance, one of the country's most successful business-led collective purchasing groups. The project's purpose is to prepare business plans for several possible reform outcomes and to share those plans with other groups through the National Business Coalition on Health.

With the Foundation's support, renewed in 1993, the Institute for Health Policy Solutions based in Washington, D.C., has helped groups around the country design collective purchasing arrangements to serve the needs of their communities. The business groups in Memphis, Washington State, and Iowa are among the beneficiaries of this assistance. Equitable risk-sharing must be at the core of any successful purchasing arrangement, so that small businesses can buy health care services and insurance at a fair price. The institute has amply demonstrated its expertise in this important area.

The question of further involvement by the Foundation in Community Health Reform will be answered only after the outcome of the national health reform process is known.

The Community Health Management Information System–CHMIS

"Without the information they need to reward high-quality plans with their business, consumers are powerless to force health plans to compete."

Health Security – The President's Report to the American People, *White House Domestic Policy Council, A Touchstone Book, Simon & Schuster, New York, 1993*

Imagine a shopping center where there are no price tags, where it is impossible to compare merchandise, and where prices go up 15 to 20 percent a year without fail. In order to sell their wares, merchants must file a bewildering variety of forms and wait weeks for their money, without knowing how much they will eventually be paid.

This, unfortunately, describes our health care system as it is today. For all the wonders and sophistication of modern medicine, the American way of purchasing and delivering health services is costly, wasteful, and irrational. Consumers purchase health care without information, unable to compare the value of services offered by individual physicians, hospitals, and health plans. Providers find themselves in a puzzling, constantly changing bureaucratic labyrinth.

Information is the key to reforming our health care system. Information allows consumers to reward those physicians, hospitals, and health plans that offer the best quality at the best price. It can ease the administrative logjam created by government regulation and claims processing in the fee-for-service environment. And for patients it can mean better informed, timely, higher quality treatment and care.

Addressing the information vacuum is the primary goal of the Community Health Management Information System — CHMIS. The CHMIS has three operating functions. It is a *transaction system* linking health care providers electronically with purchasers and payers to verify eligibility, speed claims and payments in the fee-for-service environment, and reduce paperwork. It serves as a *database* through which employers, providers, insurers, consumers, and government can all get information on provider performance and other cost, utilization, and public health issues. It is also a *network*, a data highway system where lab reports, scanned images, and prescriptions can be sent almost instantaneously, patient referrals can be made by electronic mail, and up-to-date medical research can be tapped at a moment's notice.

Access to CHMIS data is tightly restricted to protect the privacy of patients. The system locks up data with state-of-the-art technology similar to that used for national security systems. Patients typically access their medical history through a PIN similar to that used with bank machines. They have strict control over how their medical information is used, and can block sensitive items.

A Foundation-Administered Project has been employed since 1990 to promote the CHMIS concept and to assist local groups interested in adopting it for their communities. Much of this work has been carried out under contract by Benton International, a private consulting firm that designs and manages computer systems for the financial services industry. The American Civil Liberties Union Privacy and Technology Project has assisted local CHMIS groups with issues of privacy and confidentiality, and an expert committee of the Institute of Medicine has drawn on a 1991 Hartford grant to offer recommendations on protecting privacy and confidentiality, and to address a range of potential obstacles to these regional data systems.

Since 1991 the Foundation has awarded grants for CHMIS projects in seven states. Groups receiving support in past years include Washington State's Health Care Purchasers Association, the Health Policy Corporation of Iowa, the Memphis Business Group on Health, the Ohio Corporation for Health Information, and the Vermont Health Care Information Consortium. In 1993 the Foundation's Trustees approved grants for CHMIS planning to Health Research, Inc. on behalf of the New York State Department of Health, and to the Minnesota Institute for Community Health Information. They also renewed support to the Memphis Business Group on Health for its CHMIS, and awarded a grant to the Foundation for Health Care Quality, which is assuming responsibility for CHMIS planning in Washington State.

A guide will be prepared by the RAND Corporation, with Foundation support, to help the local CHMIS groups plan how to acquire, analyze, and report data to meet the community's shared information needs.

To date the Foundation has committed approximately $9 million to its CHMIS initiatives. Enthusiasm for the concept continues to build nationally. The CHMIS concept has been incorporated into leading reform proposals, including that of President Clinton, which bodes well for its future. Support for CHMIS planning beyond the seven Hartford grantee groups will depend on the outcome of national health reform and the availability of federal and local financing.

THE HARTFORD FOUNDATION AWARDED 16 GRANTS IN 1993 IN THE FOUR AREAS DESCRIBED IN THE PRECEDING PAGES, FOR COMMITMENTS TOTALLING $10,270,413. NINE OF THESE GRANTS FELL WITHIN THE AGING AND HEALTH PROGRAM AND TOTALLED $5,429,879. SEVEN WERE UNDER THE HEALTH CARE COST AND QUALITY PROGRAM AND TOTALLED $4,840,534.

Strengthening Geriatrics in America's Medical Schools

American Federation for Aging Research (AFAR), Inc.
New York, NY
Stephanie Lederman
Medical Student Geriatric Scholars Program

The goal of this project is to develop future geriatric faculty by offering research opportunities to medical students and nurturing their subsequent career development. Each student scholar will receive stipends and travel support to participate in a geriatric research project at a designated geriatric training center. There, with the help of a training site mentor, the student will have clinical exposure to geriatrics and meet regularly for didactic sessions and group reinforcement with the other students at the training site. The students will be invited to present their research at a poster session at the annual meeting of the American Geriatrics Society. A special outreach effort will be made at medical schools with a high proportion of minority students to help address the particularly acute shortage of minority geriatric faculty.

Grant Award: $1,383,645; 2 years
Starting Date: December 15, 1993

The American Geriatrics Society, Inc.
New York, NY
Dennis W. Jahnigen, M.D.
Increasing Geriatric Expertise in Non-Primary Care Specialties

This project seeks to improve the geriatric content of training in non-primary care specialties. Five such specialties will be targeted: emergency medicine, general surgery, gynecology, orthopedic surgery, and urology. Other specialties might include oncology, physical medicine and rehabilitation, cardiology, ophthalmology, cardiothoracic surgery, radiology, and anesthesiology. Strategies will be customized for each discipline, and will include educational symposia and the dissemination of training materials. In all disciplines stipends will be made available for geriatricians and specialists to work together on curricular materials. Resources will also be applied to increasing the geriatric content of residency review requirements and certifying examinations.

Grant Award: $754,106; 3 years
Starting Date: February 1, 1994

National Academy of Sciences/ Institute of Medicine
Washington, DC
Joseph S. Cassells, M.D.
Strengthening the Geriatric Content of Medical Training

Under this award, the Institute of Medicine convened a committee of experts — in medical education, geriatrics, and other disciplines involved in health care for the elderly — to help produce a paper assessing progress and unmet needs in strengthening academic geriatrics, including relevant specialist disciplines. A workshop of experts, including the planning panel, met to review the paper and deliberate on strategies by which to address the unmet needs. The final report, which was widely disseminated, proposed a national strategy for strengthening the geriatric content of medical training in the nation's medical schools.

Grant Award: $123,400; 5 months
Starting Date: May 15, 1993

Integrating Health-Related Services for the Elderly

Abt Health Care Research Foundation
Cambridge, MA
Laurence G. Branch, Ph.D.
The Effect of Type of Insurance on the Use and Cost of Health Care Among Frail Elders

This project aims to provide the actuarial basis for developing new, more comprehensive insurance products to cover acute and long-term care for the elderly. Data collected by Sharp HealthCare in San Diego under a previous Hartford award have helped to fill the knowledge gap about the potential cost and utilization of preventive and supportive services when covered by insurance. Abt Health Care Research Foundation will analyze these data to produce actuarial tables needed to price new insurance products. Its findings will be disseminated through papers and presentations directed to the broader insurance community.

Grant Award: $351,404; 18 months
Starting Date: January 1, 1994

Interfaith Health Care Ministries
Providence, RI
James W. Thomas
Aging 2000: Systemic Change in Care for the Elderly in Rhode Island

This renewal grant will test key recommendations of "Aging 2000," a statewide health reform initiative in Rhode Island. A demonstration with the United Healthcare Medicare HMO will develop care networks for enrolled elders, involving their primary care physicians, other local providers, and specially trained patient advocates. An important purpose of the demonstration will be to determine the extent to which the financing for changes in health care delivery recommended by Aging 2000 would require Federal waivers to permit payment under Medicare and Medicaid. This award will also help Aging 2000 to begin the transition from its current level of development to an appropriate post-health reform operating mode.

Grant Award: $200,000; 9 months
Starting Date: December 17, 1993

National Chronic Care Consortium
Bloomington, MN
Richard J. Bringewatt
Capacity Building in Geriatric Chronic Care

This renewal award supports continued efforts by the National Chronic Care Consortium to advance the evolution of high quality integrated care systems for elders. The consortium will pursue two key strategies. The first is the development of a tool — a "report card" — for use by consortium members to guide and assess their integration efforts. The second strategy involves the production and dissemination of issue briefs and training materials, and technical assistance to advance the best practices in the field. Consortium members will be heavily involved in the development and testing of all products.

Grant Award: $363,734; 2 years
Starting Date: January 1, 1994

Integrating Health-Related Services for the Elderly

Generalist Physician Initiative

In 1992, the Foundation awarded six grants to launch its Generalist Physician Initiative, in which the primary care, or "generalist," physician is seen as the coordinator of a team of providers who can effectively integrate the medical treatment of elderly patients with the social support services they need. In 1993, grants at three new sites were added. These demonstrations will be evaluated with regard to costs, medical outcomes, and the degree of satisfaction felt by providers, patients, and patients' families.

Henry Ford Health System
Detroit, MI
Nancy A. Whitelaw, Ph.D.
Complementary Geriatric Generalist Practice Model

Henry Ford Health System is testing a model for integrating care for elderly patients that teams geriatric nurse practitioners with generalist physicians. Nurse practitioners will provide primary services and coordinate care for senior patients, while physicians address more serious medical needs. The approximately 500 fee-for-service patients will be elders who are at risk of hospitalization, show cognitive impairment or mental health problems, or need hospice care. This model will be tested at the inner-city Henry Ford Center for Seniors and a suburban site. The level of satisfaction felt by providers, patients, and families, and a variety of clinical and functional outcomes, will be assessed, as will the utilization and cost of services.

Grant Award: $626,082; 3 years
Starting Date: May 10, 1993

Mount Sinai Hospital of Greater Miami, Inc.
Miami Beach, FL
Gloria B. Weinberg, M.D.
Intervention Pathways to Integrate Eldercare Through Generalist Physician Offices

Mount Sinai Hospital is working with generalist physicians, specialists, nurse practitioners, and social workers to develop and test a new team approach, called "intervention pathways," to meet the full range of elder patient needs. The nurse practitioner will be responsible for coordinating preventive health care, timely physician contact both by phone and through office visits, and psychiatric treatment when appropriate, and might directly provide such services as medications monitoring and home visits. The social worker will facilitate access to community resources such as "meals-on-wheels," senior centers, and transportation. The effectiveness of the project will be assessed by collecting data on patients' health care utilization and functional status, and on the degree of satisfaction expressed by providers and patients.

Grant Award: $829,905; 3 years
Starting Date: September 1, 1993

South Carolina Department of Health and Environmental Control
Columbia, SC
Thomas E. Brown, Jr.
Integration of Care in Rural South Carolina Generalist Physician Practices

This award incorporates paraprofessional "geriatric specialists" into rural generalist physician office practices. These specialists, working under the supervision of physicians and a clinical nurse specialist, will monitor patients' compliance with care plans, assist with paperwork, facilitate communication between physicians and home health providers, and arrange for non-medical support services, particularly those available through local volunteer programs. They might be recruited among experienced home health aides as well as high school or community/technical college graduates, for whom additional training will be provided by the University of South Carolina School of Medicine and Palmetto Senior Care, South Carolina's On Lok replication project. Project evaluation will analyze data on physical and mental function, patient and provider satisfaction, and health service utilization.

Grant Award: $797,603; 3 years
Starting Date: July 1, 1993

Community Health Reform

Colorado Health Care Purchasing Alliance
Denver, CO
Louise Probst
Positioning Coalitions for the Age of Reform

The Colorado Health Care Purchasing Alliance is one of a growing number of organizations around the country that have been created by local businesses to collectively purchase health care for employees and their dependents. This value-based purchasing rewards those who offer the best quality at the best price. Faced with the possibility of drastic reform at the national and state levels, the Colorado group will use the Foundation's grant to formulate business plans for the two most likely reform scenarios. It will share the results of the project with counterpart organizations throughout the country, enabling them to take prompt action once the shape of reform is known.

Grand Award: $394,028; 18 months
Starting Date: January 3, 1994

Institute for Health Policy Solutions
Washington, DC
Richard E. Curtis
Assisting Private Sector Health Purchasing Alliance Planning and Implementation

Even before passage of federal reform legislation, health care purchasing alliances are being formed in more and more states. Their principal goal is to help small businesses gain access to health care services and insurance at competitive prices. With previous Hartford Foundation support, over the past year the Institute for Health Policy Solutions has helped a number of these groups deal with some highly technical challenges. Under this grant the institute will continue to provide hands-on assistance to such private-sector purchasing alliances, including the small business alliances expected to be mandated by Congress and state legislatures; alliances formed by larger businesses; and perhaps even consumer-driven health plans. Through workshops, electronic media, and other means, the institute will facilitate information-sharing and networking among these groups and will revise and expand resource materials to meet their needs.

Grant Award: $672,550; 2 years
Starting Date: September 14, 1993

The Community Health Management Information System – CHMIS

Foundation for Health Care Quality
Seattle, WA
Richard D. Rubin
Implementing the Washington State Community Health Management Information System (CHMIS)

Thanks to the efforts of the Health Care Purchasers Association of Puget Sound, supported by previous Hartford grants, Washington State's initiative is the most advanced of the seven CHMIS projects assisted by the Foundation. Using the clout of its employer members, the Purchasers Association forged an alliance with providers and government that led to passage of a state law in April 1993 mandating a statewide health care information system, inspired by the CHMIS concept. Drawing on the Purchasers Association's efforts, the non-profit Foundation for Health Care Quality, created in 1988 by all of the relevant stakeholders, will now work closely with the state as the planning process for Washington's CHMIS variation moves forward. Grant funds will be used primarily for a pilot CHMIS demonstration involving at least four hospitals, a leading HMO, and several hundred physicians in Seattle.

Grant Award: $650,000; 2 years
Starting Date: October 6, 1993

Health Research, Inc.
Albany, NY
Raymond D. Sweeney
The New York State Community Health Management Information System Program

This grant will be used by the New York State Department of Health to develop a Community Health Management Information System Program (CHMIS) for the state. (Health Research, Inc., a non-profit organization, administers the department's grants and contracts.) New York's CHMIS approach calls for a state-run infrastructure that can serve individual communities as well as the state as a whole. This project will support CHMIS demonstrations in several communities, collecting baseline data to measure the cost and impact. If the results of the demonstration sites are positive, the final five months of the project will be devoted to planning a statewide system. The project will take advantage of a computerized system that has been created for the Department of Health to facilitate claims processing.

Grant Award: $752,495; 30 months
Starting Date: May 1, 1993

Memphis Business Group on Health
Memphis, TN
Donna Miller, Ph.D.
Implementation of the MidSouth Health Care Alliance – A Community Health Management Information System

The Memphis Business Group on Health is one of the country's most successful examples of how the collective purchasing of health care can contain costs by rewarding value and reducing inappropriate services. With previous Hartford support, the group has been planning a variation on the CHMIS concept, by which local hospitals and physicians would voluntarily demonstrate their quality and reduce administrative costs. Key to their approach is the creation of a non-profit operating entity for CHMIS, the MidSouth Health Care Alliance, which will be governed by local health care stakeholders. This grant will support the organization of the Alliance and the completion of the CHMIS planning process.

Grant Award: $667,581; 2 years
Starting Date: May 16, 1993

The Community Health Management Information System – CHMIS

Minnesota Institute for Community Health Information
St. Paul, MN
Dale V. Shaller
Project to Develop and Implement a Statewide Community Health Information System in Minnesota

The MinnesotaCare reform passed by the Minnesota state legislature last year has called for "managed competition," under which consumers will choose among competing integrated health care service networks. In order to meet crucial information needs, a powerful purchasing consortium of local employers and the Minnesota Department of Employee Relations (which buys health care for the state government employees) has joined with the state health department to organize a CHMIS for Minnesota. Hartford's grant will support the cost of planning the system through the newly formed non-profit Minnesota Institute for Community Health Information. Also included under the award will be support for a "report card" pilot test to compare health plan performance in the short term.

Grant Award: $624,668; 2 years
Starting Date: August 23, 1993

The RAND Corporation
Santa Monica, CA
Elizabeth A. McGlynn, Ph.D.
Technical Support for CHMIS Data and Reporting

As Hartford's CHMIS grantees make progress in developing the infrastructure, financing, and organizational arrangements for the system, they are now focusing more intensively on how the CHMIS data will actually be interpreted and used. Under this grant, leading experts at the RAND Corporation will prepare and disseminate a guide to help CHMIS groups with data acquisition, analysis, and reporting. The guide will offer analytic strategies to help consumers compare the effectiveness and appropriateness of health plans, and to help providers improve the quality of their services. It will cover a wide range of methodological issues, including meeting the need for statistical validity. Under the project, RAND also will undertake special studies in response to needs identified by the CHMIS groups, the results of which will be incorporated into the planned guide.

Grant Award: $1,079,212; 3 years
Starting Date: October 1, 1993

The annual financial statements, which have been audited by Owen J. Flanagan & Co., appear on pages 27 to 42.

On December 31, 1993, the Foundation's assets were $339.3 million, an increase of $35.2 million for the year after cash payments of $15.7 million for grants, expenses and Federal excise tax. Total return on the investments, income plus realized and unrealized capital gains, was 17.2 percent. In 1993 revenues totaled $9.7 million, a yield of approximately 3.0 percent for the year.

The Foundation's investment objective continued 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 our assets at a level greater than the rate of inflation.

In light of this objective, the Foundation continually sought opportunities to further diversify its assets and to add value. This will become especially important in the 1990's as the returns from domestic financial assets are expected to continue at levels near their historic norms. Recognizing this, in 1993 the Foundation made additional allocations to equities of small capitalization companies and to equities of companies in emerging markets. It also invested in a new venture capital partnership and approved a future investment in an additional real estate pooled fund. At the end of 1993 the Foundation's asset mix was 70 percent equities, 27 percent fixed income and a combined 3 percent in venture capital, real estate and other investments.

On December 31, 1993 the Foundation's investment managers were Capital Guardian Trust Company, Towneley Capital Management, Sound Shore Management, Luther King Capital Management, Morgan Stanley Asset Management, William Blair & Co. and T. Rowe Price Associates. In addition, the Foundation was an investor in the Oak Investment Partners III, Brentwood Associates IV and VI, Mayfield V and Middlewest Ventures II venture capital limited partnerships, and the Tullis-Dickerson Capital Focus Limited Partnership. Real estate investments consisted of funds managed by TA Associates Realty and JMB Institutional Realty Corp. The Finance Committee and the Board of Trustees met regularly with each of the investment managers to review their performance and discuss current investment policy. The Chase Manhattan Bank, N.A. was custodian for all the Foundation's securities. A complete listing of investments is available for review at the Foundation offices.

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

Ladies and Gentlemen:

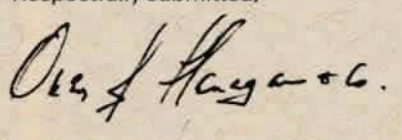
We have audited the balance sheets of The John A. Hartford Foundation, Inc. (a New York not-for-profit corporation) as of December 31, 1993 and 1992 and the related statements of revenues, grants and expenses and changes in fund balance for the years then ended. These financial statements are the responsibility 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 generally accepted auditing standards. 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, 1993 and 1992 and the results of its operations and changes in fund balance for the years then ended in conformity with generally accepted accounting principles.

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 31 to 42, 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
Certified Public Accountants
New York, New York
March 2, 1994

The John A. Hartford Foundation, Inc.
Balance Sheets, December 31, 1993 and 1992

	1993	1992
Assets		
Cash in operating accounts	$ 5,870	$ 6,744
Interest and dividends receivable	1,648,619	1,521,645
Prepayments and deposits	100,301	23,280
	1,754,790	1,551,669
Investments, at market or adjusted cost (Notes 1 and 2)		
Short-term cash investments	18,022,321	15,112,628
Stocks	232,606,166	204,895,680
Long-term bonds	73,008,310	67,390,840
Venture capital partnerships	4,231,679	4,254,247
Real estate pooled funds	6,197,414	4,628,505
Other	517,778	3,160,367
Total Investments	334,583,668	299,442,267
Program loan receivable (Note 7)	648,305	650,000
Office condominium, furniture and equipment (net of accumulated depreciation of $1,700,461 in 1993 and $1,508,518 in 1992)	2,314,590	2,462,147
Total Assets	$339,301,353	$304,106,083
Liabilities and Fund Balance		
Liabilities:		
Grants payable (Note 1)		
Current	$ 7,205,372	$ 7,091,682
Non-current (Note 6)	5,972,529	6,290,672
Accounts payable	649,812	444,262
Federal excise tax payable		
Current	10,421	13,025
Deferred (Note 1)	500,666	396,442
Total Liabilities	14,338,800	14,236,083
Fund Balance (Exhibit B)	324,962,553	289,870,000
Total Liabilities and Fund Balance	$339,301,353	$304,106,083

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

EXHIBIT B

The John A. Hartford Foundation, Inc.,
Statements of Revenues, Grants and Expenses and Changes in Fund Balance
Years Ended December 31, 1993 and 1992

	1993	1992
Revenues		
Dividends and partnership earnings	$ 4,145,705	$ 4,021,647
Long-term bond interest	4,938,163	5,225,092
Short-term investment earnings	569,000	484,788
Total Revenues	9,652,868	9,731,527
Grants and Expenses		
Grants awarded (less cancellations and refunds of $5,822 in 1993 and $11,997 in 1992)	10,896,891	12,794,781
Foundation-administered projects	975,810	967,810
Grant-related direct expenses	86,581	100,384
Federal excise tax on net investment income (Note 1)	80,038	82,964
Investment fees	1,553,131	1,349,839
Personnel salaries and benefits (Note 5)	1,063,831	1,048,669
Office and other expenses	586,188	534,829
Depreciation	191,943	199,622
Professional services	72,968	62,200
Total Grants and Expenses	15,507,381	17,141,098
Excess (deficiency) of revenues over grants and expenses	(5,854,513)	(7,409,571)
Net Realized and Change in Unrealized Gain on Securities Transactions (Note 2)	40,947,066	16,611,265
Increase in Fund Balance	35,092,553	9,201,694
Fund Balance, beginning of year	289,870,000	280,668,306
Fund Balance, end of year (Exhibit A)	$324,962,553	$289,870,000

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, 1993 and 1992

1. 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 liability for grants payable is recognized when specific grants are authorized by the Trustees and the recipients have been notified.

Investments

Investments in marketable securities are stated at quoted market prices. Investments in venture capital, health care industry and real estate partnerships or REIT's, are carried at cost adjusted annually for the Foundation's share of distributions and undistributed realized income or loss; cost is also adjusted for overall unrealized losses of any group of such entities. Convertible preferred stocks included in other investments are carried at the lower of cost, or estimated net realizable value. Realized gains and losses from the sale of marketable securities are recorded by comparison of proceeds to cost determined under the average cost method.

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 1993 and 1992 the Foundation's rate was 1%.

Deferred Federal excise taxes payable are also recorded on the unrealized appreciation of investments using the current year's excise tax rate.

The Foundation intends to distribute at least $ 15,178,224 of undistributed income in grants or qualifying expenditures by December 31, 1994 to comply with I.R.S. regulations.

Fixed Assets

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).

2. Investments

The net gain on investments in 1993 is summarized as follows:

	Cost	Quoted Market Price	Appreciation
Balance, December 31, 1993	**$284,517,050**	**$334,583,668**	**$ 50,066,618**
Balance, December 31, 1992	**$259,798,060**	**$299,442,267**	**$ 39,644,207**
Increase in unrealized appreciation during the year, net of increased deferred Federal excise tax of $ 104,224			**$ 10,318,187**
Realized gain, net of provision for Federal excise tax of $309,383			**30,628,879**
Net realized and change in unrealized gain on securities transactions			**$ 40,947,066**

Receivables and payables on security sales and purchases pending settlement at December 31, 1993 and 1992 were as follows:

	1993	1992
Proceeds from sales and distributions	**$ 1,438,201**	**$ 1,223,859**
Payables from purchases	**(1,477,062)**	**(1,992,205)**
Net cash pending settlement	**$ (38,861)**	**$ (768,346)**

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

The Foundation is a participant in five venture capital limited partnerships. As of December 31, 1993, $8,310,000 had been invested in these partnerships and future commitments for additional investment aggregated $2,490,000.

Real Estate investments included one limited partnership and two real estate investment trusts. The Foundation had invested $6,876,000 at December 31, 1993 and future commitments for additional investment aggregated $124,000.

Other investments included $880,000 invested in a limited partnership. At December 31, 1993 the Foundation had a future commitment for an additional investment of $120,000.

3. Foreign Currency Forward Contract Commitments

At December 31, 1993 the Foundation's foreign currency forward sale contracts totaled $12,892,393.

4. Office Condominium, Furniture and Equipment

At December 31, 1993 and 1992 the fixed assets of the Foundation were as follows:

	1993	1992
Office condominium	**$3,616,815**	**$3,616,815**
Furniture and equipment	**398,236**	**353,850**
	4,015,051	**3,970,665**
Less: Accumulated depreciation	**1,700,461**	**1,508,518**
Office condominium, furniture and equipment, net	**$2,314,590**	**$2,462,147**

5. 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 1993 and 1992 amounted to $96,759 and $94,918, respectively. The Foundation also incurred additional pension costs of approximately $35,000 in 1993 and 1992, for payments to certain retirees who began employment with the Foundation prior to the initiation of the formal retirement plan.

6. Grants Payable

The Foundation estimates that the non-current grants payable as of December 31, 1993 will be disbursed as follows:

1995	**$5,146,440**
1996	**826,089**
	$5,972,529

During 1993 the Foundation conducted two Foundation-administered projects. At the end of the year, the following amounts previously authorized had not been expended and are being carried over to 1994.

Community Health Management Initiative	**$295,527**
Generalist Physician Initiative	**50,843**
	$346,370

7. Program Loan Receivable

On December 28, 1992 the Foundation loaned $650,000 to a non-profit organization to provide working capital for a new program. The note is due June 30, 1995 and bears interest, payable semi-annually at the prime rate less 3%. During 1993, $1,695 was repaid on principal.

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
Health Care Cost and Quality				
Community Health Reform				
Colorado Health Care Purchasing Alliance, Inc. Denver, CO "Positioning Coalitions for the Age of Reform" Louise Probst		**$ 394,028**	**$ 148,156**	**$ 245,872**
The George Washington University National Health Policy Forum Washington, DC "National Health Policy Forum Meetings on Collective Health Care Purchasing and Community Health Management" Judith Miller Jones	**$ 155,352**		**155,352**	
Health Care Purchasers Association of Puget Sound Seattle, WA "The Community Health Management Initiative" Andrea B. Castell	**92,800**		**92,800**	
Health Policy Corporation of Iowa Des Moines, IA "Strengthening Community Health Reform in Iowa" Paul M. Pietzsch	**338,785**		**338,785**	
Institute for Health Policy Solutions Washington, DC "Assisting Private Sector Health Purchasing Alliance Planning and Implementation" Richard E. Curtis		**672,550**	**173,290**	**499,260**
National Business Coalition on Health, Inc. Washington, DC "Expanding the Community Health Reform Movement" Sean Sullivan	**1,887,877**		**932,260**	**955,617**
Subtotal	**$ 2,474,814**	**$ 1,066,578**	**$ 1,840,643**	**$ 1,700,749**

	Balance Due January 1, 1993	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1993
Community Health Management Information System				
Foundation for Health Care Quality Seattle, WA "Implementing the Washington State Community Health Management Information System (CHMIS)" Richard D. Rubin		$ 650,000	$ 174,750	$ 475,250
Health Research, Inc. Albany, NY "The New York State Community Health Management Information System Program" Raymond D. Sweeney		752,495	320,433	432,062
Indiana University Indianapolis, IN "Coordination of a Unified Set of Standards for Health Care Information Messages" Clement J. MacDonald, M.D.	$ 298,129		115,819	182,310
InterStudy Bloomington, MN "Community Health Management Information System: TyPE Development Project" Harry P. Wetzler, M.D.	51,336		51,336	
Memphis Business Group on Health, Inc. Memphis, TN "Implementation of the MidSouth Health Care Alliance — A Community Health Management Information System" Donna Miller, Ph.D.		667,581	352,738	314,843
Minnesota Institute for Community Health Information St. Paul, MN "Project to Develop and Implement a Statewide Community Health Information System in Minnesota" Dale V. Shaller		624,668	156,375	468,293

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
National Academy of Sciences/ Institute of Medicine Washington, DC "Overcoming Impediments to Regional Data Repositories" Kathleen N. Lohr, Ph.D.	**$ 188,000**		**$ 188,000**	
Ohio Corporation for Health Information Columbus, OH "Designing a Statewide Health Management Information System to Support Community-based Reform Efforts in the State of Ohio" William Petrarca	**163,300**		**163,300**	
The Rand Corporation Santa Monica, CA "Technical Support for CHMIS Data and Reporting" Elizabeth A. McGlynn, Ph.D.		**$ 1,079,212**	**179,928**	**$ 899,284**
Vermont Health Care Information Consortium, Inc. Montpelier, VT "Planning and Development of a Vermont Health Management Information System and a Vermont Lifetime Patient Record" Bruce S. Post	**551,625**		**183,875**	**367,750**
Subtotal	**$ 1,252,390**	**$ 3,773,956**	**$ 1,886,554**	**$ 3,139,792**
Health Care Cost and Quality — Other				
American Enterprise Institute for Public Policy Research Washington, DC "New Ways of Contracting for Health Care and Health Care Financing" Robert B. Helms, Ph.D.	**$ 55,330**		**$ 55,330**	
Institute for Healthcare Improvement Boston, MA Core support Donald M. Berwick, M.D.	**806,992**		**398,900**	**408,092**

	Balance Due January 1, 1993	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1993
National Fund for Medical Education Knoxville, TN "Management Education Program for Physician Leaders" Diane M. Hare	$ 110,524		$ 110,524	
University of Pennsylvania Philadelphia, PA "Corporate Hospital Rating Project" Mark V. Pauly, Ph.D.	250,000		250,000	
Subtotal	$ 1,222,846		$ 814,754	$ 408,092
Total Health Care Cost and Quality	$ 4,950,050	$ 4,840,534	$ 4,541,951	$ 5,248,633
Aging and Health				
Medications and the Elderly				
American Federation for Aging Research (AFAR), Inc. New York, NY "Geriatric Pharmacology Scholarships for Medical Students" Stephanie Lederman	$ 126,591		$ 126,591	
Brigham & Women's Hospital Boston, MA "Improving Medication Use Among the Nation's Elderly: Defining the Problem and Identifying Solutions" Jerome L. Avorn, M.D.	111,514		111,514	
Indiana University Indianapolis, IN "Medication Use and Depressed Elderly Patients in Primary Care" W. Tierney, M.D.; C. Callahan, M.D.	96,164		96,164	

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
University of California, Los Angeles School of Medicine Los Angeles, CA "Improving the Appropriateness of Medication Prescribing in Nursing Homes" Hal Morgenstern, Ph.D.	**$ 52,727**		**$ 52,727**	
Subtotal	**$ 386,996**		**$ 386,996**	
Strengthening Geriatrics in Medical Schools				
American Federation for Aging Research (AFAR), Inc. New York, NY "Gero-Physician-Scientist Development Program" Stephanie Lederman	**$ 458,580**		**$ 233,583**	**$ 224,997**
American Federation for Aging Research (AFAR), Inc. New York, NY "Medical Student Geriatric Scholars Program" Stephanie Lederman		**$ 1,383,645**	**637,986**	**745,659**
The American Geriatrics Society, Inc. New York, NY "Increasing Geriatrics Expertise in Non-Primary Care Specialties" Dennis W. Jahnigen, M.D.		**754,106**	**129,516**	**624,590**
Bowman Gray School of Medicine Winston-Salem, NC "Academic Geriatrics Recruitment Initiative" William R. Hazzard, M.D.	**103,680**		**69,120**	**34,560**
Case Western Reserve University School of Medicine Cleveland, OH "Academic Geriatrics Recruitment Initiative" Jerome Kowal, M.D.	**159,043**		**96,802**	**62,241**

SUMMARY OF ACTIVE GRANTS

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
Duke University Medical Center Durham, NC "Academic Geriatrics Recruitment Initiative" Harvey J. Cohen, M.D.	**$ 82,060**		**$ 57,420**	**$ 24,640**
Harvard Medical School Boston, MA "Academic Geriatrics Recruitment Initiative" Lewis A. Lipsitz, M.D.	**90,750**		**60,500**	**30,250**
The Johns Hopkins University School of Medicine Baltimore, MD "Academic Geriatrics Recruitment Initiative" J. Burton, M.D.; J. Roth, M.D.	**108,499**		**74,000**	**34,499**
Mount Sinai School of Medicine New York, NY "Academic Geriatrics Recruitment Initiative" Myron Miller, M.D.	**95,700**		**64,000**	**31,700**
National Academy of Sciences/ Institute of Medicine Washington, DC "Strengthening the Geriatric Content of Medical Training" Joseph S. Cassells, M.D.		**$ 123,400**	**123,400**	
Society for Academic Emergency Medicine (The Univ. Assoc. for Emergency Med.) Lansing, MI "Emergency Care of the Elderly: Meeting the Needs" Arthur B. Sanders, M.D.	**726,590**		**134,962**	**591,628**
Stanford University Stanford, CA "Academic Geriatrics Recruitment Initiative" Gerald M. Reaven, M.D.	**169,211**		**115,095**	**54,116**

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
St. Louis University Medical Center St. Louis, MO "Academic Geriatrics Recruitment Initiative" John E. Morley, M.B., B.Ch.	**$ 154,613**		**$ 102,244**	**$ 52,369**
University of California, Los Angeles School of Medicine Los Angeles, CA "Academic Geriatrics Recruitment Initiative" David B. Reuben, M.D.	**122,388**		**92,928**	**29,460**
The University of Connecticut Health Center Farmington, CT "Academic Geriatrics Recruitment Initiative" Richard W. Besdine, M.D.	**104,379**		**69,872**	**34,507**
University of Michigan Medical School Ann Arbor, MI "Academic Geriatrics Recruitment Initiative" Jeffrey B. Halter, M.D.	**125,734**		**94,301**	**31,433**
University of Michigan Medical School Ann Arbor, MI "Coordinating Center: Academic Geriatrics Recruitment Initiative" Jeffrey B. Halter, M.D.	**156,954**		**112,576**	**44,378**
University of Pennsylvania School of Medicine Philadelphia, PA "Academic Geriatrics Recruitment Initiative" Allan I. Pack, M.D., Ph.D.	**117,305**		**86,505**	**30,800**
University of Washington School of Medicine Seattle, WA "Academic Geriatrics Recruitment Initiative" Itamar B. Abrass, M.D.	**169,168**		**98,451**	**70,717**
Subtotal	**$ 2,944,654**	**$ 2,261,151**	**$ 2,453,261**	**$ 2,752,544**

SUMMARY OF ACTIVE GRANTS

	Balance Due January 1, 1993	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1993
Integrating Health-Related Services				
Abt Health Care Research Foundation Cambridge, MA "The Effect of Type of Insurance on the Use and Cost of Health Care Among Frail Elders" Laurence G. Branch, Ph.D.		$ 351,404	$ 115,241	$ 236,163
California Pacific Medical Center San Francisco, CA "Senior Care Connections" Janeane Randolph, M.S.W.	$ 639,716		564,045	75,671
Carle Foundation Hospital Urbana, IL "A Generalist Physician Model for Geriatric Collaborative Practice" Cheryl D. Schraeder, R.N., Ph.D.	624,840		183,305	441,535
County of Monroe Rochester, NY "Innovative Financing and Delivery Systems for Long-Term Care" Kenneth J. Naples	115,107		115,107	
Dartmouth Medical School Hanover, NH "Community Centers of Excellence in Aging" John H. Wasson, M.D.	610,514		120,531	489,983
Henry Ford Health System Detroit, MI "Complementary Geriatric Generalist Practice Model" Nancy A. Whitelaw, Ph.D.		626,082	207,503	418,579
Huntington Memorial Hospital (Pasadena Hospital Association, Ltd.) Pasadena, CA "Physicians and the Aging Network: A Chronic Care Partnership" W. June Simmons, M.S.W.	403,176		269,788	133,388

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
Interfaith Health Care Ministries Providence, RI "Aging 2000: Systemic Change in Care for the Elderly in Rhode Island" James W. Thomas	$ 250,000	$ 200,000	$ 387,275	$ 62,725
Mount Sinai Hospital of Greater Miami, Inc. Miami Beach, FL "Intervention Pathways to Integrate Eldercare Through Generalist Physician Offices" Gloria B. Weinberg, M.D.		829,905	143,921	685,984
National Chronic Care Consortium Bloomington, MN "Capacity Building in Geriatric Chronic Care" Richard J. Bringewatt		363,734	95,346	268,388
San Diego Hospital Association (Sharp HealthCare) San Diego, CA "San Diego Senior Health Initiative" Bettina Experton, M.D., M.P.H.	69,625		69,625	
South Carolina Department of Health and Environmental Control Columbia, SC "Integration of Care in Rural South Carolina Generalist Physician Practices" Thomas E. Brown, Jr.		797,603	141,263	656,340
St. Joseph Healthcare System Albuquerque, NM "Coordinated Care Partnership" Lynne Anker	595,600		104,850	490,750
United Health Services, Inc. Binghamton, NY "System Case Management" Linda J. Battaglini	635,198		114,801	520,397

SUMMARY OF ACTIVE GRANTS

	Balance Due January 1, 1993	*Grants Authorized During Year*	*Amount Paid During Year*	*Balance Due December 31, 1993*
University Hospitals of Cleveland Cleveland, OH "Senior Care" Philip A. Anderson, M.D.	**$ 614,782**		**$ 134,824**	**$ 479,958**
Subtotal	**$ 4,558,558**	**$ 3,168,728**	**$ 2,767,425**	**$ 4,959,861**
Aging and Health — Other				
Bowman Gray School of Medicine Winston-Salem, NC "HOPE Data Analysis and Dissemination" Timothy M. Morgan, Ph.D.	**$ 200,141**		**$ 103,278**	**$ 96,863**
Columbia University School of Nursing New York, NY "Building on HOPE Projects to Improve Geriatric Nursing Care" Terry T. Fulmer, R.N., Ph.D.	**208,758**		**208,758**	
University of California, Los Angeles School of Public Health Los Angeles, CA "Development of an Elder Health Risk Appraisal" Lester Breslow, M.D., M.P.H.	**103,197**		**103,197**	
Subtotal	**$ 512,096**		**$ 415,233**	**$ 96,863**
Total Aging and Health	**$ 8,402,304**	**$ 5,429,879**	**$ 6,022,915**	**$ 7,809,268**
Development of Biomedical Technology				
The People-to-People Health Foundation, Inc. (Project HOPE) Millwood, VA "Health Affairs Thematic Issue on Medical Innovation" John K. Iglehart	**$ 30,000**		**$ 30,000**	
Total Development of Biomedical Technology	**$ 30,000**		**$ 30,000**	
New York Fund				
ArtsConnection New York, NY		**$ 15,000**	**$ 15,000**	

	Balance Due January 1, 1993	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1993
Boys Harbor, Inc. New York, NY		$ 25,000	$ 25,000	
Elders Share The Arts, Inc. Brooklyn, NY		10,000	10,000	
The Hospital for Special Surgery Fund, Inc. New York, NY		1,000	1,000	
The New York Public Library Astor, Lenox and Tilden Foundation New York, NY		20,000	20,000	
United Hospital Fund of New York New York, NY		2,500	2,500	
United Negro College Fund, Inc. New York, NY		50,000	50,000	
Upward, Inc. New York, NY		10,000	10,000	
Youth Service League, Inc. Brooklyn, NY		10,000	10,000	
Total New York Fund		$ 143,500	$ 143,500	
Other				
The Foundation Center New York, NY		$ 8,000	$ 8,000	
Grantmakers In Health Washington, DC		5,000	5,000	
National Foundation for Facial Reconstruction New York, NY		180,000	60,000	120,000
New York Regional Association of Grantmakers New York, NY		7,700	7,700	
Matching Grants*		288,100	288,100	
Total Other		$ 488,800	$ 368,800	$120,000
Grants Cancelled or Refunded		(5,822)	(5,822)	
Total (All Grants)	$13,382,354	$10,896,891	$11,101,344	$13,177,901

**Grants made under the Foundation's program for matching charitable contributions of Trustees and Staff*

SUMMARY OF ACTIVE GRANTS

	Expenses Authorized Not Incurred January 1, 1993	*Projects Authorized During Year*	*Expenses Incurred During Year*	*Expenses Authorized Not Incurred December 31, 1993*
Foundation-Administered Projects				
Health Care Cost and Quality "Community Health Management Inititative"	**$1,170,000**		**$874,473**	**$295,527**
Aging and Health "Generalist Physician Initiative"	**152,180**		**101,337**	**50,843**
Total Foundation-Administered Projects	**$1,322,180**		**$975,810**	**$346,370**

Additional Active Grants

Health Care Cost and Quality

Beth Israel Hospital
Boston, MA
"Using a Computer-based, Patient Information System for Quality Assurance: A Research and Demonstration Program"
Lisa I. Iezzoni, M.D.
1989; $599,979; 4 years

Cleveland Tomorrow
Cleveland, OH
"Greater Cleveland Health Quality Choice"
John C. Morley
1991; $400,000; 2 years, 7 months

The RAND Corporation
Santa Monica, CA
"Developing Criteria of Appropriateness of Use for Operations and Procedures"
R. Brook, M.D.; L. Leape, M.D.; D. Solomon, M.D.
1990; $975,000; 3 years, 4 months

Stanford University
Stanford, CA
"Management Education Program for Physician Leaders"
Alain C. Enthoven, Ph.D.
1989; $296,825; 5 years, 4 months

University of California, San Francisco
San Francisco, CA
"Project to Explore the Feasibility of a Community Health Management Information System for the State of California"
Harold S. Luft, Ph.D.
1990; $207,250; 3 years, 1 month

University of Rochester
Rochester, NY
"Development and Evaluation of a Cooperative Primary Care Physicians Network at the Community Level"
Robert J. Panzer, M.D.; Edgar R. Black, M.D.
1989; $598,918; 3 years, 9 months

Aging and Health

University of Southern California
Los Angeles, CA
"The Impact of Clinical Pharmacist Services on Drug Use in Residential Care Facilities for the Elderly"
Bradley R. Williams, Pharm.D.
1989; $496,610; 4 years, 8 months

Organizations seeking grant awards from the Foundation may submit proposals at any time. No formal application forms are required. Proposed projects should be consistent with the Foundation's interests and within the scale of other Foundation supported activities, as described in this Report.

Within each program area, preference is given to projects that seek to demonstrate and evaluate specific innovative solutions to clearly defined problems. There also is a preference for projects that, if successful, can serve as models for other organizations or decision-makers facing similar problems. Support is not provided for general research or for general activities not clearly linked to specific objectives. Foundation support rarely is provided for longer than three years.

Those seeking support should submit a brief letter describing the proposed project. However, if a project is adequately described in a prepared proposal, the Foundation will accept the proposal for review without further introduction.

Project descriptions and proposals should be concise and should outline: the nature and importance of the problem to be addressed; the specific solution to be designed or evaluated; how the proposed solution differs from other projects addressing the same problem; what the unique contributions of the project are anticipated to be; the criteria for measuring the project's success; the relevant experience and expertise of the persons and organizations proposing to conduct and sponsor the project; and the funds required.

The Foundation normally makes grants only to two types of organizations in the United States: those having tax exempt status under Section 501(c)(3) of the Internal Revenue Code which are not private foundations within the meaning of Section 509(a) of the Code, and States or political subdivisions thereof within the meaning of Section 170(c)(1) of the code, or state colleges or universities. The Foundation does not make grants to individuals.

Initial inquiries should be made at least six months before funding is needed. The proposed project will be reviewed 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 one month and may be asked to supply additional information.

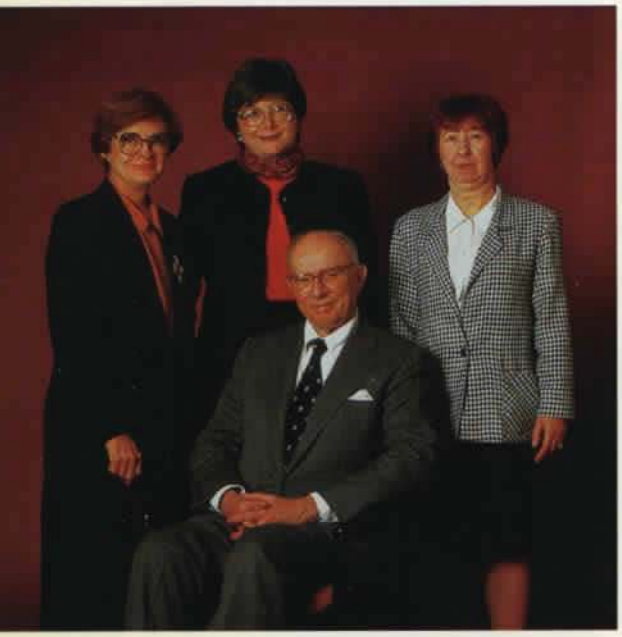
Program-Related Investments

The Foundation sometimes provides conventional financing on a loan, guarantee, or equity basis to organizations working in its program areas. Organizations conducting work in the Foundation's program areas are encouraged to inquire about the possibility of a program-related investment.

Further Information

Inquiries about the Foundation's programs should be addressed to:

Program Director
The John A. Hartford Foundation, Inc.
55 East 59th Street
New York, NY 10022
Phone: (212) 832-7788
Fax: (212) 593-4913



Administration Staff *(Rear left to right) Rita A. Henry, Diane C. Brewer, Maureen Carroll (Front) Stephen C. Eyre*

Finance Staff *(Rear left to right) Sean B. Fegan, Mayra I. Figueroa (Front) Samuel R. Gische*

Program Staff

(Rear left to right)
Rani E. Snyder,
Laura A. Robbins,
Nancy E. Brenner
(Front)
Richard S. Sharpe,
Donna I. Regenstreif

Stephen C. Eyre
Executive Director and Treasurer

Samuel R. Gische
Finance Director and Controller

Richard S. Sharpe
Program Director

Diane C. Brewer
Administrative Officer

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Senior Program Officer

Laura A. Robbins
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