

# THE JOURNAL

THE JOHN A. HARTFORD FOUNDATION 1997 ANNUAL REPORT

**“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 founder,

John A. Hartford and his

brother George L. Hartford,

both former chief execu-

tives of the Great Atlantic

and Pacific Tea Company,

the Hartford Foundation

seeks to make its best

contribution by supporting

efforts to improve health

care in America.



Report of the Chairman

4

Trustees

6

Staff

8

**Executive Summary/Our Aging Society:**  
Opportunities and Responsibilities

9

National Overview and Perspective

12

**Mission and Philosophy/The Hartford Foundation:**  
Creating Partnerships and Communities

21

Major Past Achievements and Lessons Learned

26

**1997 Grant Descriptions**

46

**Financial Reports**

53

Financial Summary

54

Independent Auditors' Report

56

Summary of Active Grants in 1997

65

**Application Procedures**

77



## Report of the Chairman

NINETEEN NINETY-SEVEN WAS A BANNER YEAR for the Hartford Foundation. Due to a favorable economic and investment climate our assets passed the half-billion dollar milestone. The closing valuation represents an increase of \$63.7 million after grant payments and administrative expenses of \$20.6 million. Fueled by solid economic growth, low inflation and record low interest rates, the bull market roared ahead. For an unprecedented third consecutive year, large capitalization stock indices had returns in excess of 20 percent. Looking ahead, we remain optimistic and are confident that the Foundation's portfolio will continue its excellent long-term growth to support a strong grants program.

**We also point with pride to the Foundation's record of simultaneously helping to improve health care services and educating current and future physicians, nurses, and other health professionals to care for the elderly. This year's major grant initiative was the Centers of Excellence in Geriatrics program. The Trustees committed a total of \$8,345,000 to twenty-six medical centers across the country with strong geriatric education and fellowship programs. The major purpose of these grants was to address the critical shortage of geriatric faculty members. With more and better trained physicians we will reach our ultimate goal of increasing the nation's capacity to provide effective and affordable care to its rapidly growing elderly population.**

We also made an important grant of \$8,037,369 to continue the Paul Beeson Physician Faculty Scholars in Aging Research Program. Named in honor of Dr. Paul B. Beeson, an early proponent of geriatrics, this initiative makes a substantial investment in helping outstanding junior faculty to conduct research on a wide range of topics relevant to aging Americans.

Support of this program will assure the development of a new cadre of geriatrics leaders from among today's most exceptional young academic physicians.

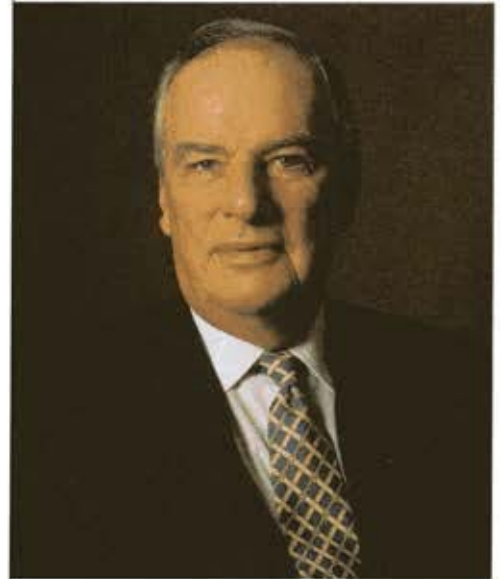
We continue to wind down our Health Care Cost and Quality program. The final payments under this program will end in 1999.

At our Annual Meeting last June, Norman H. Volk, Vice Chairman of the Board, was elected President. Norm became a Trustee in 1979. He is currently serving as Chairman of the Grants Committee and has also chaired the Finance Committee. With great sadness, I must report the death in January 1998 of our retired Trustee William Corbus. Bill joined our Board in 1977, and served with great distinction until his retirement in 1992.

After twelve years as the Foundation's Executive Director and Treasurer, Stephen C. Eyre retired on December 31, 1997. We are deeply grateful for his outstanding leadership and wish him a healthy and fulfilling retirement. Steve will be succeeded by Corinne H. Rieder, who joined the staff in 1996 as Associate Executive Director. We are pleased to have her on board.

In closing, I would like to thank all of my colleagues on the Board and our staff for their accomplishments and dedication this past year. They are a superb group and I look forward to another productive year.

  
JAMES D. FARLEY



## Trustees

*(right to left)*

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THOMAS A. REYNOLDS, JR.

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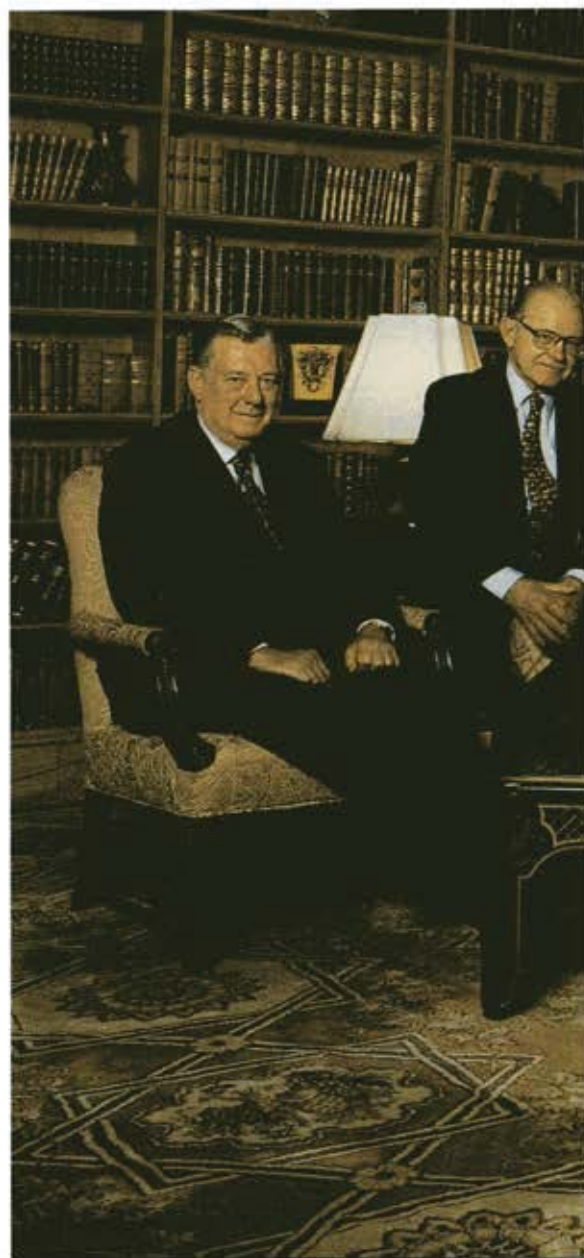
ALEXANDER M. LAUGHLIN

NUALA PELL

WILLIAM B. MATTESON

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VICE CHAIRMAN

MICHAEL D. DINGMAN  
*(not shown)*





## Staff

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FINANCE DIRECTOR AND CONTROLLER

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**MARGARET M. TRIMBLE**  
PROGRAM ASSISTANT-PROGRAM

**C. YVONNE WALLACE**  
PROGRAM ASSISTANT-GRANTS MANAGEMENT

\* Retired as of December 31, 1997

\*\* Executive Director and Treasurer as of January 1, 1998

## Our Aging Society: Opportunities and Responsibilities

CONVERGING TRENDS ARE CREATING A  
WATERSHED MOMENT IN U.S. HEALTH CARE.

It is a time of transition, a time of opportunity, a time to rethink, reimagine and reconfigure how we provide — and increase — affordable, quality health care to our rapidly increasing population of elderly citizens. New ideas, new programs, and new models are being tried, tested, replicated, disseminated and discussed.

**Executive Summary**





**Given the ferment and flexibility of the environment, successful small-scale initiatives have the potential, as never before, of resonating nationally. For those of us dedicated to improving the health care landscape for the elderly, this period offers a unique window of opportunity to improve a system that is fragmented and unprepared for the task that lies ahead.**

As a nation, we must recognize that caring for those elderly who are most in need is everyone's responsibility. Given the diversity of our people, as well as the diversity of today's health care options, it is a complex task. We need to re-examine our attitudes towards the elderly who, by and large, are healthier and contribute more to society than ever before. We need to confront a range of financial, manpower and quality issues — including what constitutes “good health” for the elderly — mindful of the elderly's contribution to society as well as their cost. The John A. Hartford Foundation looks forward to continued active participation in the on-going national challenge. It will continue to focus with intensity on training and service strategies and initiatives that make a difference.



## National Overview and Perspective

The U.S. health care system is in the midst of dramatic change. A confluence of economic, political and demographic trends and events are transforming the landscape.

They include:

- public disenchantment with big government solutions to social, health and welfare problems, which has precipitated a devolution of health care funds and responsibility from federal to state and local programs;
- incentives and constraints of the Balanced Budget Act;
- the increased political influence of today's rapidly growing elderly;
- concerns and debate about the solvency of the Medicare Trust Fund and Social Security in light of the looming tidal wave of aging baby boomers;
- a dramatic shift from large, multi-generational families to small, geographically dispersed, two-income families with fewer people available to care for the elderly.

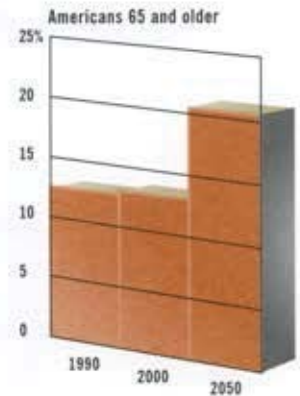
TO BETTER UNDERSTAND THE HEALTH CARE NEEDS OF TOMORROW, let us briefly examine where we are today, and how we got here.

Looking back, there is much to celebrate. To begin with, Americans are living longer than ever before. A testament to the miracles of modern medicine, today's elderly are the first generation to benefit from post-World War II advances in drugs, technology, public health and preventive care. Some 13 percent of the population is now past 65, in sharp contrast to the scant 7 percent who were in the 1940s, and the minuscule 4 percent at the turn of the last century.

Equally impressive, we are remaining healthier far longer. Eighty-nine percent of Americans between ages 65 and 74 are active with no disabilities; 40 percent over 85 are fully functional. In fact, Americans 85-plus are the nation's most rapidly growing population segment. More and more Americans expect to enjoy vital, productive lives well into their eighties and beyond. Today, 56,000 living Americans are over 100 years old. That figure is expected to surge to more than 2 million over the next 70 years.<sup>1</sup> In fact, the U.S. Census Bureau estimates a more than doubling of Americans 65 and older by the year 2050.

## A Century of Progress

Percentage of the Total US Population above 65 and 85\* (1990-2050)



\* Data and projections are from U.S. Bureau of the Census

1. *Aging into the 21st Century*, National Aging Information Center, May, 1996.

## The Aging Baby Boom Juggernaut

OVER THE NEXT THREE DECADES, 76 million Americans born between 1946 and 1964 will turn 65, a demographic juggernaut of unprecedented size and scope which will profoundly alter America's economic, social and political landscape.

**Paradoxically, while the prospect of living longer, healthier lives is good news for individual Americans, for U.S. society as a whole, the aging of America poses a complex challenge. How we meet the opportunities and responsibilities of that challenge will reflect who we are — our core values — as a nation.**

Perhaps, in part, because we are a youth-oriented culture, we are largely in denial about the aging of America. That is, as a society we have yet to grapple fully with the implications of this massive shift, especially when it comes to financing health care for Americans over 65. A key issue still facing this nation — a political powder keg threatening Social Security, Medicare and Medicaid — is who will pay for the medical and social service needs of an increasing number, and growing proportion, of our population?

To some extent, we are the victims of success. That is, the remarkable achievements of the past century — which improved health and longevity for more Americans regardless of cost — sowed the seeds of present and future health care dilemmas.

BEGINNING IN THE MID-1980S, with costs spiraling out of control, those largely footing the health care bill — government and corporate America — demanded fundamental reform. Our failure to arrive at a national consensus left us without a national health care reform strategy. Instead, a variety of state-by-state, community-by-community, company-by-company solutions are emerging or being proposed.

Some states have received Federal approval to experiment with pilot programs which use a managed care model to provide a continuum of care, including preventive and long-term services, drawing on both Medicare and Medicaid funds. There are, however, potential conflicts between Federally-funded Medicare, which covers acute care needs, such as hospitalization and physician visits, and Federal and State funded Medicaid, which underwrites long-term care, such as nursing homes, as well as gaps in medical health care and support services for elderly poor people.

Simultaneously, the nation's health care system is changing in many ways, moving towards managed care and for-profit institutions, and towards increased vertical integration of the system.

## Health Care in Transition

*"Acknowledging  
the truth about aging in  
America is critical...  
if we are to move ahead  
toward successful aging  
as individuals and as  
a society."*

**John W. Rowe and  
Robert L. Kahn,**  
*"Successful Aging"*  
Random House, NY, 1998

## Health Care Opportunities

THE GOOD NEWS — WITHIN THIS COMPLEX AND FLUID PICTURE — is the opportunity for states, localities, health care professionals and organizations to think more innovatively about how money is spent on behalf of the elderly.

**For the first time, budgetary incentives exist, within the framework of less restrictive regulation, to mix social service and medical dollars. Most health care experts expect to see an increase of programs whose goal is to keep the elderly at home longer, a strategy both the elderly and their families prefer, which is often a less costly solution to institutionalization.**

This era of innovation and change also provides the health care system with an opportunity to improve the coordination of comprehensive geriatric services. It is as critical to improving health care outcomes and system performance as increasing knowledge about chronic diseases and the basic processes of aging.

In the past, when medicine was simpler and physicians enjoyed life-long relationships with patients and families, it was less problematic. Today, however, despite the fact that health care is fragmented and medical options complex (even, at times, contradictory), typically, no single physician or family member is charged with the conductor's role of orchestrating the health care players or the patient's treatment. The results, frequently, are less than ideal during the long duration of chronic illness or the final stages of life.

Finally, there is the opportunity to examine large moral and medical issues affecting treatment of the elderly, including end-of-life health care goals. A society which regards its elderly as a valuable asset, and which takes seriously its responsibility to nurture, support and enhance that asset, needs to debate such questions as:

- what is our vision of “good health” for the elderly, and how can we better provide it?
- what is too much or not enough medical intervention and how is that decision made?
- do we care as much about psycho-social well being as physical health? If so, how do we ensure it?
- how do we attract more professionals to the field of geriatrics and, at the same time, suffuse general medical education and training with an understanding of wellness and illness in the elderly?
- how do we shift from an acute-care mentality to an integrated view which incorporates a comprehensive, long-term framework; how do we measure success and reward performance?

*“We need a better consensus on what Medicare should be in the twenty-first century, about what health care for the elderly should look like. We need to bring all the players together — employers with retirement coverage, delivery systems, Medicare, Medicaid, community-based agencies, and consumers — to get a better feel for what they are all working towards.”*

**Nancy Whitelaw, Ph.D.**

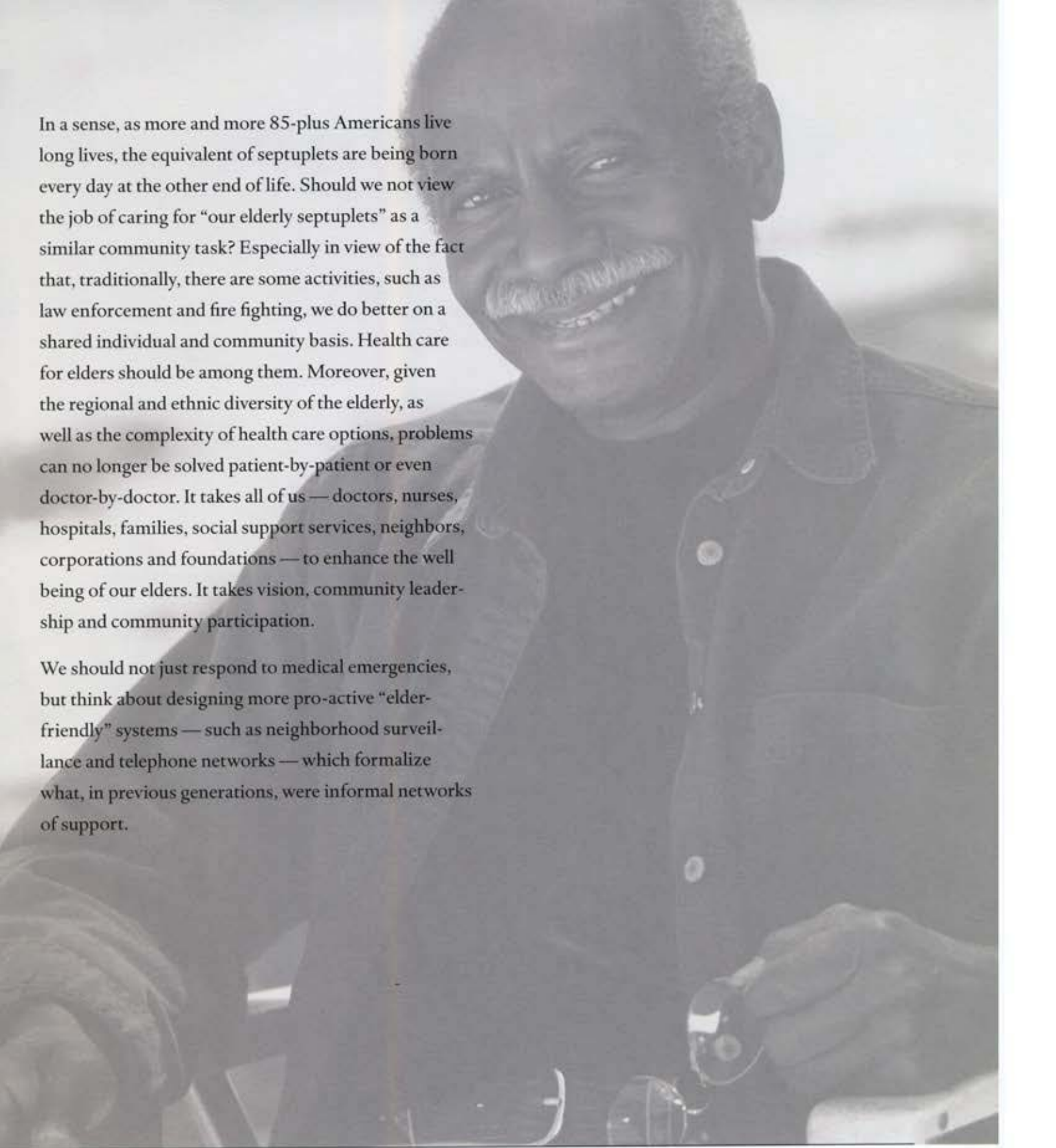
*Associate Director  
Center for Health System Studies,  
Henry Ford Health System*

DIRECTLY AND INDIRECTLY, ISSUES REVOLVING AROUND THE AGING OF AMERICA are driving societal change. Sooner or later, they will affect each and every American's quality of life. As one economist observed, "If Americans were prepared to let retired baby boomers subsist on Spaghettios, the savings issue could be ignored. But most of those future retirees are somebody's parents. And the fact that they are currently squirreling away just half of what they need to sustain their current living standard will soon be everyone's problem."<sup>2</sup>

What is everyone's problem is also everyone's responsibility. Clearly, responsibility begins with us. Each has an obligation to plan for his or her future, to save and invest for retirement and old age. We cannot cut taxes and agitate to reduce government intervention in our lives, yet expect services to remain uncut and government programs to take care of us after we turn 65. Yet, as a nation, we still appear to be more focused on what others should do for us than on what we should do for ourselves and each other.

In the past, a sense of shared, intergenerational responsibility was a natural part of community life. In good times and bad, family, friends and neighbors looked out for and took care of one another, as did an array of volunteer and charitable organizations. Community mindedness has not altogether vanished. This year, for example, a small Iowa town rallied to support a couple who were about to give birth to septuplets. There was much talk of "our babies" and everyone pitched in.

2. "Hidden in the Glitter of a Bountiful Economy, Problems Remain," Peter Passell, *The New York Times*, December 25, 1997.



In a sense, as more and more 85-plus Americans live long lives, the equivalent of septuplets are being born every day at the other end of life. Should we not view the job of caring for “our elderly septuplets” as a similar community task? Especially in view of the fact that, traditionally, there are some activities, such as law enforcement and fire fighting, we do better on a shared individual and community basis. Health care for elders should be among them. Moreover, given the regional and ethnic diversity of the elderly, as well as the complexity of health care options, problems can no longer be solved patient-by-patient or even doctor-by-doctor. It takes all of us — doctors, nurses, hospitals, families, social support services, neighbors, corporations and foundations — to enhance the well being of our elders. It takes vision, community leadership and community participation.

We should not just respond to medical emergencies, but think about designing more pro-active “elder-friendly” systems — such as neighborhood surveillance and telephone networks — which formalize what, in previous generations, were informal networks of support.

## A New Vision

BEYOND NEW PROGRAMS, SYSTEMS AND POLICIES, improving health care for the elderly requires a new vision. It means replacing out-of-date stereotypes of infirmity and rapid decline with positive images of the elderly as valuable, vital citizens who, collectively, are among our greatest social assets. It means spending less time, money and thought on relegating the elderly to nursing homes and more on building a network of support services which enable them to enjoy the last years of life with dignity at home. It means appreciating what the elderly give the community instead of how much their medical and social needs cost. It means welcoming the aging of America, both its opportunities and responsibilities.

The John A. Hartford Foundation is committed to that vision.

## The Hartford Foundation: Creating Partnerships and Communities

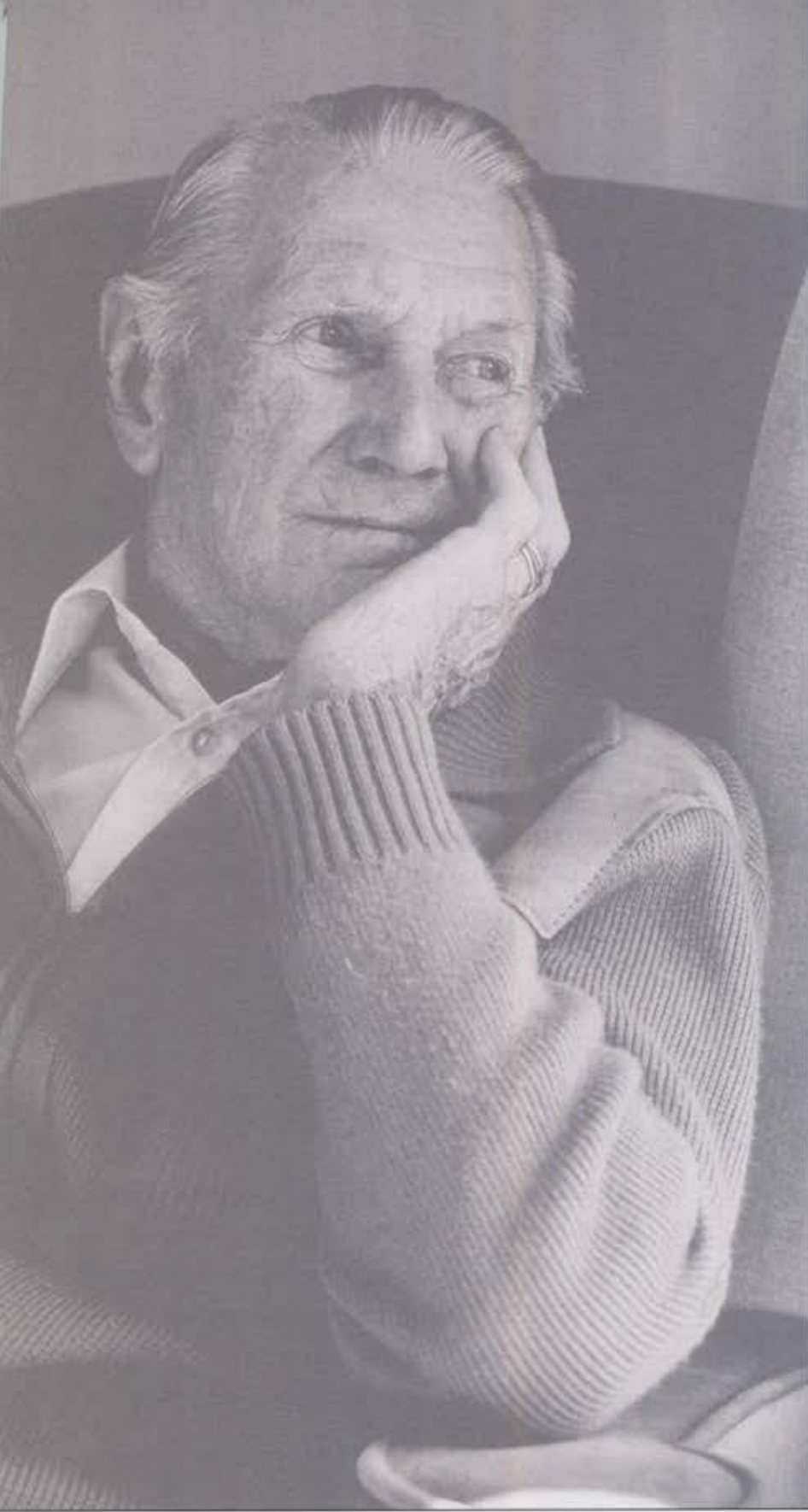
THE JOHN A. HARTFORD FOUNDATION HAS BEEN INVOLVED IN HEALTH CARE ISSUES FOR ALMOST 70 YEARS. However, it was only during the early 1980s that its prescient Board of Trustees, alarmed by the country's enormous unaddressed and unrecognized health care needs, decided to focus its primary attention on health and aging. Its broad mission: to increase the nation's capacity to provide effective and affordable elder care, and to concentrate on the practice of health care as the point where policy becomes reality for every older American.

## Mission and Philosophy: 1983-1997

For over a decade, the Foundation has pursued its mission on two fronts: training health professionals to become more effective in providing elder care, and improving and integrating the service systems in which they operate. It has also sought to turn negative attitudes, treatments and approaches within the health care community into more enlightened views of “healthy aging,” as well as broader goals and options for elder care.

Overall, the Foundation sees itself as a national catalyst, bringing people, institutions and groups together — creating layers of interactive communities — to focus on and coordinate a range of research, training and service issues. Thus, beyond augmenting and improving training and services at sites throughout the country, it seeks to launch movements, foster networks and build communities of people who can create a lasting legacy, one which will continue long after a single project or series of projects is over.

From the beginning, the challenge has been — given the now trillion-dollar U. S. health care industry — how to effect national change with a small staff and modest investment dollars?



## Pro-active Processes and Strategies

THE FOUNDATION'S APPROACH is a strategically-driven, pro-active process. In other words, it does not simply respond to grant requests. Instead, Trustees and staff, knowledgeable about national health care issues and players, and drawing on the best minds in the field, develop broad initiatives to address critical needs. Within those initiatives, such as increasing geriatric training among primary care physicians, it creates a series of programs to test new ideas and models, and invites leading academic and service institutions throughout the country — balanced regionally as well as with respect to other factors, such as rural vs. urban populations — to create projects which best implement and test those models.

The Foundation also believes that relatively small sums — seed money for new and innovative programs — invested with the right institutions at the right time, can profoundly influence and significantly alter the trajectory and outcome of national policies and debate. This is particularly true because the Foundation:

- builds partnerships into grant programs — with communities, with institutions, as well as between and among programs and projects — to further leverage Foundation dollars;
- requires grantees to disseminate new knowledge and lessons learned to other institutions and communities — through such efforts as national resource centers, regional and national forums, and the creation of replicable models, so as to generate an ever widening and powerful ripple effect throughout the nation.

Overall, creating synergy among grantees in a specific area — be it academic geriatrics or family health care — increases the staying power and influence of a project, and is the linchpin of significant social change.


Finally, the Foundation uses its evaluation process as a feedback system to enrich existing projects and point the way to future projects. Each grant is analyzed for its immediate success as well as lessons learned and what they imply for future grants. For example, if it is discovered that post-hospital family support is critical to the recovery process in the elderly, a subsequent program will include procedures to make certain such support exists before patients are discharged. In short, each project raises new issues, reveals new gaps and presents new opportunities.

Since the 1980s, the Foundation has built a body of knowledge and expertise which, like savings invested over a long term, has compounded and grown exponentially. Today, the Hartford Foundation is recognized as the number one national foundation in aging.

**Top Ten Foundation Contributors to Aging, 1995**

Rank/Foundation	Aging Grants	Aging Education Grants
1. The John A. Hartford Foundation	\$7,852,620	\$4,332,420
2. Retirement Research Foundation	6,255,043	1,026,624
3. Harry & Jeanette Weinberg Foundation	5,411,985	-
4. Pew Charitable Trusts	5,078,000	532,000
5. Marty & Dorothy Silverman Foundation	4,743,700	NA
6. Robert Wood Johnson Foundation	4,516,960	-
7. Commonwealth Fund	2,880,666	1,782,255
8. Robert W. Woodruff Foundation	2,000,000	2,000,000
9. Kate B. Reynolds Charitable Trust	1,978,023	96,075
10. William Penn Foundation	1,780,090	25,000

*Source: Aging Education and Training: Priorities for Grantmaking Foundations The Association for Gerontology in Higher Education*



## Major past achievements and lessons learned

At the Hartford Foundation, each program initiative raises new issues, reveals new gaps and leads to new ideas and opportunities. Therefore, looking back at the past to better understand the future mirrors an important component of the internal strategic planning process by which the Foundation builds its knowledge, evolves new programs and increases its efficiency and effectiveness.

At the same time, over the years, lessons learned on the training side often inspire fresh thinking and new initiatives on the services side and vice-versa — a kind of positive echo effect — as this section will amply demonstrate.

AN ALARMING SHORTAGE OF GERIATRICIANS existed twenty years ago. In 1977, for example, a mere 715 doctors, out of an overall physician population of almost 364,000, specialized in geriatrics. Moreover, as recently as 1983, only 250 full-time medical school faculty taught geriatrics in fewer than a dozen programs throughout the U.S. This critical shortage of physicians to care for the elderly as well as to create new knowledge and techniques for improving care, prompted the Foundation to focus on increasing geriatric education and training as its primary strategic objective. To date, the Foundation has committed about \$70 million to capacity-building on behalf of education and training.

In 1983, the Foundation launched its first academic training program, **The Hartford Geriatric Faculty Development Awards**, to support one year geriatric re-tooling for mid-career medical school faculty at four training sites. A successful first step designed to rapidly increase available leaders for new geriatric programs, it was followed, in 1987, by the **Academic Geriatrics Recruitment Initiative**, which fostered innovative methods of recruitment to a field traditionally viewed by many young medical students as unglamorous, with limited opportunities for research, and unattractive settings for clinical care.

*"The 1993 Institute of Medicine Report recommendations regarding the need for improved education in geriatrics included the following: ...increased geriatrics medicine experience in internal medical and family practice residency programs...combined training programs, and the development of a high-quality clinical scholars-type program in geriatrics. In addition, the report supported an increase in expertise in geriatric medicine by those in non-primary specialties."*

**Institute of Medicine**

*"Training Physicians to Care for Older Americans: Progress, Obstacles, and Future Directions," 1994*

As part of that effort, the Foundation launched its first **Centers of Excellence (CoE)** program. An ambitious \$6.5 million, six-year initiative, it addressed the critical shortage of faculty members by concentrating Foundation resources on 10 (later expanded to 13) leading academic programs — in geographically diverse public and private universities — with outstanding facilities and strategies for training geriatric faculty. So positive were follow-up evaluations that, in 1997, the Foundation renewed its Centers of Excellence initiative, providing on-going support for the strongest of the original centers as well as new grants for additional institutions.

An added feature of the second CoE initiative was a Coordinating Center, administered and run by the American Federation for Aging Research (AFAR), to share successful new teaching ideas and provide fellowship support for academically oriented trainees, chosen on a competitive basis.

The CoE program has yielded positive results on many fronts. Today, for example, a “Center of Excellence” designation is viewed as a “seal of approval” for high-quality academic geriatrics training and research centers. The CoEs have produced hundreds of expertly trained scientists, teachers and clinicians.

Equally significant, they have elevated geriatrics as a discipline and helped to establish geriatricians as attractive role models and mentors for new generations of students and residents.

Today, about 8,000 out of our physician population of some 700,000 specialize in geriatrics. Many got their start — or received support along the way — through a variety of Hartford programs, including, in addition to the above, the **John A. Hartford Foundation-American Federation for Aging Research (AFAR) Medical Student Geriatrics Scholars Programs**, and the more recent **Paul Beeson Physician Faculty Scholars in Aging Research Program**, administered through AFAR.

The Foundation's impact on academic training is widely recognized. Says Dennis W. Jahnigen, M.D., President of the American Geriatrics Society, "I think it has done a tremendous amount in terms of enhancing physician education — for students, for residents, for fellows — which we all felt was a primary deficiency. And the Foundation's Trustees have really been sustained in their commitment." David Reuben, M.D., Director of UCLA's geriatrics program, concurs. "I think the Foundation is the single most important, most effective organization to have helped education in geriatrics."

While the Foundation is pleased with the progress made to date, expert predictions are that there will be fewer geriatricians by the year 2010 than there are now. So, despite every effort to attract physicians to geriatrics, the U.S. still has a long way to go.



*AGS President  
Dennis W. Jahnigen,  
M.D., presents  
John A. Hartford  
Foundation  
Board President  
Norman H. Volk  
with the society's  
Special Recognition  
Award at its annual  
meeting in Atlanta.*

*A highlight of the Foundation's Annual Meeting, held in June in Baltimore, was a visit to the Hopkins Bayview Medical Center. These photographs show various aspects of the visit, ranging from greetings and a luncheon and presentation session, to a visit to the Bayview extended care facility.*



*"We were delighted to organize faculty presentations and guided tours of several of our geriatric services for the Foundation's Trustees during their 1997 Annual Meeting. The Foundation has made a vital difference in our research, training and service missions on behalf of our aging society."*

**John R. Burton, M.D.**  
*Mason F. Lord Professor,  
Clinical Director,  
Johns Hopkins Geriatrics Center*





## DISEASE - ERY

efined, best way  
primary lesion.

2-5%  
25-75%



*"The majority of practicing physicians have never been exposed to organized training in geriatrics. In addition, with changes in the health care delivery system and the rapidly growing elderly population, it is estimated that over 50% of primary care physicians' professional time will be spent caring for elderly patients. Consequently, the need for educating practicing physicians about the special needs of older adults is clearly urgent."*

**Patricia P. Barry, M.D., M.P.H.**  
*Director, Division of Geriatrics,  
Boston University  
School of Medicine*

In fact, a key lesson learned by the Foundation from its early training programs was that increasing the number of geriatricians and strengthening the quality of geriatric programs was not enough. Other steps needed to be taken to prepare the health care community for serving America's growing elderly population. They included:

- suffusing general medical education and training with geriatric knowledge, and reinforcing its importance by seeking inclusion of geriatric knowledge in relevant certification examinations;
- developing new training programs to reach specialists and subspecialists, such as orthopedists and emergency room physicians, cardiologists and oncologists, and others who routinely deal with the elderly;
- broadening the educational agenda to other health professionals in such disciplines as nursing, social work, rehabilitation therapies, pharmacology, etc.;
- reaching out to educate the approximately 600,000 practicing physicians trained before formal geriatric education existed in medical schools.

In 1994, the Foundation launched a \$5.1 million **Geriatrics in Primary Care Residency Training Initiative (GRTI)**, to increase the geriatric content of primary care residencies (tomorrow's internists and family physicians) funded at seven sites throughout the U.S., and also including a coordinating center. The Program's two-fold objective was:

(1) to awaken educators to the need for new and better curricula in residency training, including new instructional materials, examinations, rotations, training exercises, faculty, and strategies for moving trainees out of hospital settings into community settings;

(2) to develop solutions to meet those needs in the form of training "products" and strategies rapidly transferable to sites around the country.

**GRTI sites have developed specific "products." Among them are: computer-based learning modules, which eliminate the problems of distance and time in training; videotapes on patient-physician communication, which provide feedback by the elderly on the performance of residents conducting interviews and examinations; and pocket cards which physicians can carry with them for quick reference that contain essential information on a variety of diagnostic and treatment issues particularly relevant to the elderly.**

GRTI also included an award to Stanford University to serve as the program's resource and coordinating center. "The Center was the glue that held together the seven sites and offered them a chance for cross-fertilization," says Georgette Stratos, Ph.D., the Center's Director. In 1996 and 1997, renewal awards supported further dissemination and marketing by the Stanford Center of these "products." Explains Dr. Stratos, "The Hartford Foundation impressed upon us the fact that whatever they fund is intended to have a national impact. So while each of the sites' 'products' were developed and tested locally, they wanted them to be widely useful to improve geriatric training in residency programs around the country."

*"One of the things I applaud the Hartford Foundation for doing, is taking work to the next step and fostering the widest possible application of this material. We're very excited by our success."*

**Georgette Stratos, Ph.D.**  
*Senior Research Scholar,  
Stanford Faculty Development  
Program*



*Stanford's Faculty Development Program, collaborating with seven sites funded to create geriatric training models for primary care residency programs, developed a dissemination plan for the many products generated by this effort. Shown here are scenes from the two-day meeting at Stanford that led to the proposal for continued Foundation funding, which was approved by the Trustees in December.*



LONG-TERM DISSEMINATION OF GERIATRIC  
 BRAINSTORMING AREAS FOR

Steer

John /  
 Repr.



Dissemination

- Write book
- Co-marketing w/ countries
- Clearinghouse
- National Societies of Health Services, Consumers, etc.
- Roles of partnerships

Products

Content

Revised GRTI  
 Grant & Aid Programs  
 to Res Programs  
 New areas

Resources

Hartford:  
 GITT  
 AGS/CME  
 Specialties  
 Specialists (Nursing, etc.)

Other:  
 Geriatric Education

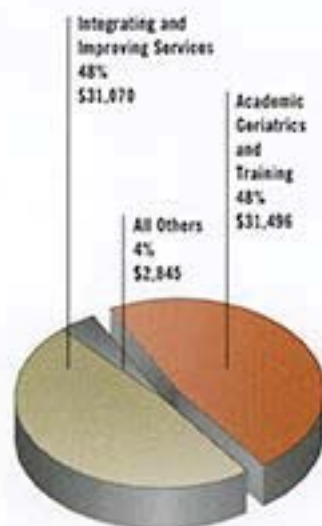
Audience

Societies for Health Professionals (AAHC) - Lobbying Group  
 - Health systems  
 - Health Policy Admin  
 - Other health progs (e.g. nurses, social work, etc.)

Federal Soc of Training Institutes  
 HEPA  
 Business for Administrators  
 CEOs, CFOs



The John A. Hartford  
Foundation  
Aging and Health Grants  
by Program Area  
(\$000 paid out, 1985-1997)



The program's dissemination strategy has created a unique family esprit among participants. Dr. Stratos has watched it develop. "I use the term family not just to describe the family of products that we've developed but this consortium we've formed to foster the dissemination of these materials and services. It feels like a family effort, a community consortium. You might not expect that outcome in a multi-institutional collaboration involving many highly competitive institutions and individuals, and yet the dedication, common mission and vision were very important threads in these projects."

The Foundation also supported creation of a model faculty development program in geriatrics for primary care physicians based on one Stanford had successfully developed. "It uses a 'train-the-trainer' model," says Dr. Stratos. "We bring faculty to Stanford who have no advanced geriatric training, and prepare them to go home and serve as local, regional and national resources for conducting geriatric faculty development programs." They go back supplied with a series of seven seminars and use multiple instructional methods (didactic, role playing exercises, case discussions, brainstorming, etc.) to teach their peers. The "train-the-trainer" model has a ripple effect because those trained can train others over and over again at meetings and conferences. "What we've learned through the years," notes Stratos, "is that having a peer as the diffuser of the content turns out to be a really critical piece of the program."

The Foundation continues to create peer partnerships and build information-sharing into its initiatives as the quickest and most effective way to leverage local innovation and bring about national transformation. In 1997, for example, Stanford received a two-year grant to further accelerate the dissemination of GRTI educational products. With the input of the seven GRTI resident training projects, it has created a catalogue which will be mass mailed to almost 1,000 internal and family medicine residency directors and geriatrics program leaders around the country.

These days the spotlight is often on biomedical breakthroughs and high-tech medicine. As important as these are, the Hartford Foundation continues to focus on the challenging, often neglected but critical service side of health care. It seeks to raise the medical community's consciousness about everyday service issues involved in working with vulnerable elders; continuing to support innovative service initiatives which improve care, and its coordination, whether at home, in hospitals, physicians' offices or other sites of care. Since 1985, the Foundation has committed to service-oriented awards a total of about \$31 million.

Improving patient care within a hospital setting and its integration with care beyond its walls, is another key component of comprehensive care for the elderly. In 1989, under the Foundation's **Hospital Outcomes Program for the Elderly (HOPE)**, University Hospitals of Cleveland (affiliated with Case Western Reserve University's School of Medicine), designed and tested a program, **Acute Care for Elders (ACE)**, which re-engineered how care is delivered on an inpatient basis to acutely ill elders. "Hospitals are characterized as a service industry, yet they're generally not structured as service to patients but to everyone else," notes C. Seth Landefeld, M.D., who led the ACE project, and now heads up a new division of geriatrics at the University of California at San Francisco.

**Key elements of the program changed that service perspective. They included: creating a therapeutic physical hospital environment; developing an interdisciplinary approach to patient-centered care; scrutinizing medication and diagnostic procedures; emphasizing and marshaling resources to improve the discharge process without delaying it.**

"In a randomized trial of 651 patients, our acute in-patient intervention had a clinically and statistically positive effect at discharge and three months later," reports Dr. Landefeld. "Older folks don't bounce back from an insult as quickly as younger people," he adds. "ACE facilitated and accelerated the bounce-back effect." A large number of hospitals have started up ACE Units since then but, says Landefeld, "We still have a long way to go to change the culture of hospitals to focus more fully on the concerns and interests of patients."

In 1992, prompted in part by the recognition that Generalist Physicians (GPs) are often frustrated in their ability to care for frail elders and frequently hampered by reimbursement policies and resource constraints from doing the best possible job, the Foundation launched its **Generalist Physician Initiative (GPI)**, designed to improve the treatment of elders in their primary care physicians' offices.

Projects within the HOPE initiative had turned up additional insights, including the realization that functional decline during hospitalization of elderly patients is as much a result of what happens before and after hospitalization as what happens during the increasingly abbreviated stay in the hospital. Therefore, it seemed more urgent than ever to find ways to help physicians better integrate the medical and non-medical components of health care delivery. Specifically, the Initiative focused on:

- 1) supporting the development, implementation and evaluation of innovative models of office partnering with other health practitioners, such as nurses and social workers;
- 2) expanding the capacity of generalist physicians' practices to encompass a broader set of psycho-social, clinical and family issues.

Since then, nine institutions have created a variety of models and approaches appropriate to a diversity of situations and locations — urban, rural, managed care, fee-for-service, high income, low income — for a mix of healthy, ill, disabled and recently-hospitalized patients.

*"While purists might argue that a patient's non-medical needs are beyond the purview of the physician, the geriatrician knows that they cannot be pragmatically separated from her more 'traditional' medical problems. More compellingly, the failure to address non-medical needs leads to adverse outcomes that are undeniably medical and undeniably costly."*

**Mark S. Lechs, M.D., M.P.H.**  
Chief, Division of Geriatrics and Gerontology, Cornell University Medical School, 1995 Paul B. Beeson Physician Faculty Scholars in Aging Research awardee

*"The Foundation not only supported the creation and evaluation of new models of ambulatory primary care especially appropriate for older persons, but also invested substantially in looking at solutions to problems commonly encountered at their funded sites. We have put this knowledge to work as we spread the word widely."*

**Frank G. Williams, Ph.D.**  
Professor, School of Health  
Administration and Policy,  
Arizona State University

A Coordinating Center at the Arizona State University, much like the GRTI Center at Stanford and the CoE Center now at AFAR, has been charged with creating and disseminating "best practices" and replicable models throughout the country.

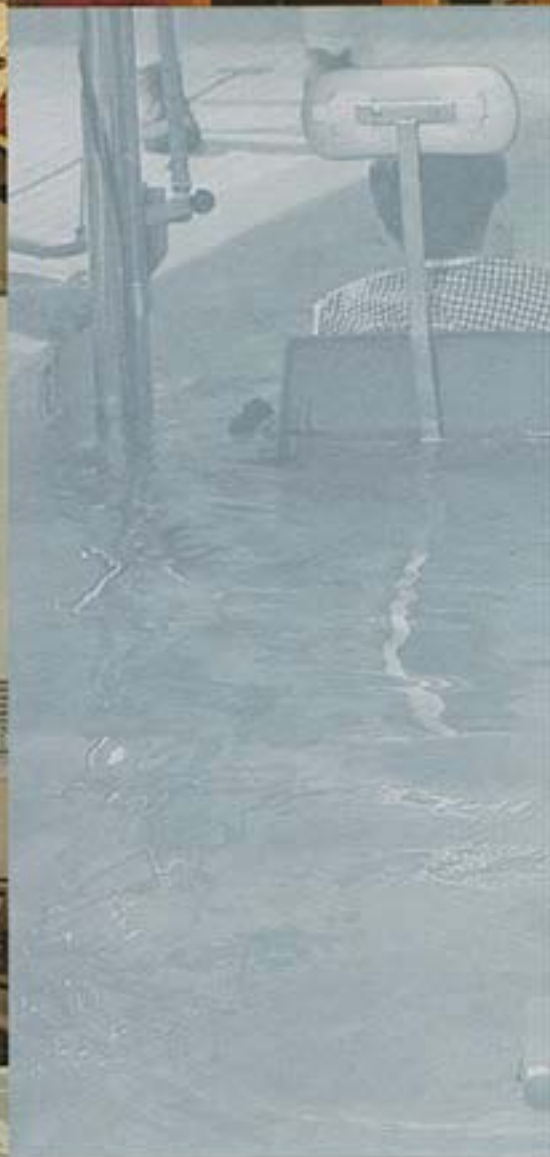
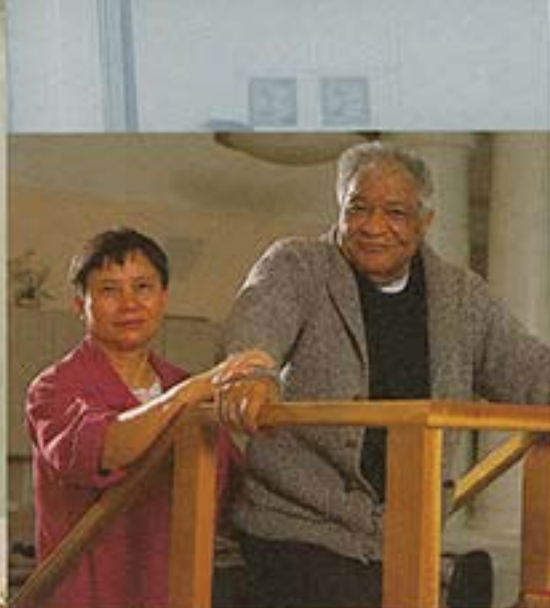
Frank G. Williams, Ph.D., Professor, School of Health Administration and Policy at Arizona State University's College of Business in Tempe, heads up the Center. He and his colleagues believe so much has been learned from the Initiative that they are editing a book about it. "We still find," says Williams, "that outside of those who are geriatricians, it's very challenging to convince people who have grown up in our youth-oriented culture to develop a real appreciation for taking care of elderly, where your successes are often measured in maintaining function or slowing decline rather than in cures, and where your rewards take much longer and come in smaller increments. Many doctors, too, don't appreciate the proportion of their Medicare patients who would, in fact, benefit from geriatric insights."

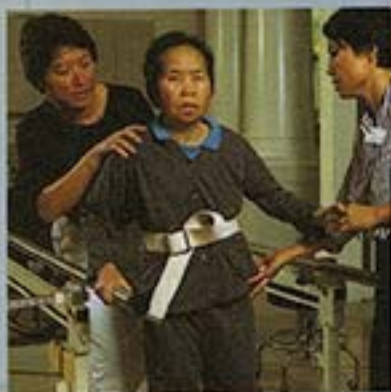
Williams also underscores the reality that elderly people with more chronic problems require "a totally different approach to providing care. In the long-term model, you try to get patients to do things for themselves, you need more psycho-social elements in their treatment, and you need more follow up after they are discharged from hospitals to make sure they are taking their medications, and so forth."

Today, physicians who have used GPI models of working with others in their offices to share the care of elderly patients are delighted with the system. They see that patients are doing better and that physicians can do better for their patients.

Bradford Whitney, M.D., a South Carolina geriatrician generalist associated with the Spartanburg Regional Healthcare System, is a GPI participant and has become “a raving advocate” of the GPI comprehensive care system. “One of the reasons we’re experiencing such frustration treating chronically ill and frail elderly,” he notes, “is that we’re trying to utilize systems primarily built for younger people with acute episodes and full recovery as an expected outcome. We have to build a system that deals with managing long-term care and that comes up with new measurements for success. I think that’s what the Hartford Foundation has done. I’ve not really seen anybody else paying attention to this kind of issue with full understanding of the complex interactions necessary to make a good encounter among physicians and between physician and patient.”

**A key lesson learned from GPI was that health care providers, educated and trained to work autonomously, lack the skills — even if they possess the will — to work well together in teams. Therefore, this prompted the Foundation to extend its efforts to improve physician training in geriatrics by developing a new initiative, the *Geriatric Interdisciplinary Team Training Program (GITT)*, to train multiple health care professionals, including physicians, in teamwork and collaboration. The \$10 million program has provided grants to develop eight models which will use clinical settings that mirror the diversity of services needed by elders.**





*On Lok's program for frail elders is the setting for these photographs. Currently active with the On Lok organization are two projects: one to develop a comprehensive medical record, and the other to implement geriatric team training.*



*"Both On Lok and the national PACE program have benefited enormously from the Foundation's sustained commitments to improving care for frail elders. Their latest efforts are helping us to advance the development and distribution of our Integrated Chronic Care Information System."*

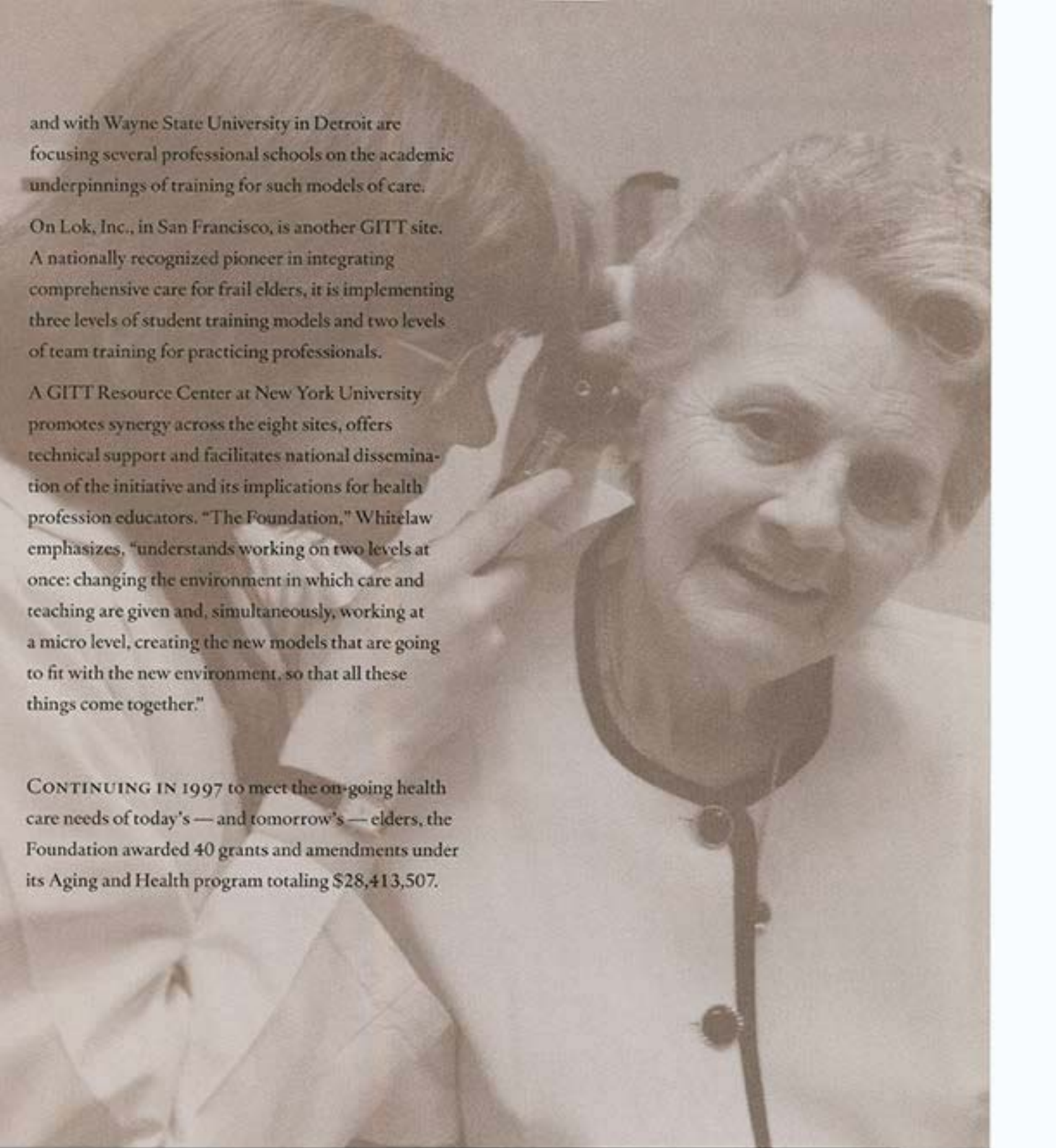
**Jennie Chin Hanson, R.N., M.S.**  
Executive Director,  
On Lok, Inc.

*\*The GITT program has added a lot of credibility to team training. It's added prestige to the sites due to the Foundation's imprimatur, as well as needed financial support to keep things well organized. Hartford's GITT Program is rewarding to the sites because it's about things they've been doing, which they believed in their hearts to be the right way to go, but until now lacked external confirmation.\**

**David B. Reuben, M.D.**  
*Director, Division of Geriatrics,  
UCLA*

They include: for-profit and not-for-profit managed care organizations, hospices, inpatient units, academically-based primary care clinics, and a variety of medical practices. GITT has just completed its first year of implementation after a three-step grant-making process which included \$1.3 million in planning year funding.

The Henry Ford Health Care System, in Detroit, is a GITT site, and had also developed a GP service model under a previous award. Nancy Whitelaw, Ph.D., Associate Director of Ford's Center for Health Systems Studies, was instrumental in developing its GP model, which focuses on nurse practitioner-physician teams for high-risk geriatric patients. "It isn't possible for me to express in strong enough terms what the Foundation's support has meant for the transformation of care of the elderly within the Henry Ford Health System," says Whitelaw. "We have made huge strides caring for the elderly and the Foundation's support has been a major part of it. Of course, the transformation from a physician-based practice to a team-based practice doesn't happen in one year or even in five. But," she adds, "we're moving down the road, tackling the barriers. Now, our physician-nurse-case manager model is in place at about 20 of our clinics and becoming the standard practice of care for high risk elderly patients. It still needs a lot of work but nobody now questions that integrating services is the right way to go." Under GITT, their partnerships with University Hospitals of Cleveland and Case Western Reserve University,



and with Wayne State University in Detroit are focusing several professional schools on the academic underpinnings of training for such models of care.

On Lok, Inc., in San Francisco, is another GITT site. A nationally recognized pioneer in integrating comprehensive care for frail elders, it is implementing three levels of student training models and two levels of team training for practicing professionals.

A GITT Resource Center at New York University promotes synergy across the eight sites, offers technical support and facilitates national dissemination of the initiative and its implications for health profession educators. "The Foundation," Whitelaw emphasizes, "understands working on two levels at once: changing the environment in which care and teaching are given and, simultaneously, working at a micro level, creating the new models that are going to fit with the new environment, so that all these things come together."

CONTINUING IN 1997 to meet the on-going health care needs of today's — and tomorrow's — elders, the Foundation awarded 40 grants and amendments under its Aging and Health program totaling \$28,413,507.

## 1997 Grant Descriptions/Aging and Health

### Academic Geriatrics and Training

#### Centers of Excellence

In 1988, the Foundation initiated its first Centers of Excellence (CoE) program, the Academic Geriatrics Recruitment Initiative, to address the critical shortage of geriatric faculty members in American medical schools. The purpose of the program was to enhance academic geriatric programs and training, with the ultimate goal of increasing the nation's capacity to provide effective and affordable care to its rapidly growing elderly population. This project yielded extremely positive results, including the production of hundreds of geriatrically knowledgeable scientists, teachers, and clinicians and the higher level of recognition and appreciation of the discipline throughout the medical center, university, and affiliated clinical service settings.

Following an internal strategic planning process in 1997, the Foundation's Trustees decided to renew and expand the previous CoE concept by increasing the geographic range of the Foundation's CoEs and expanding training capacity, particularly in dealing with the country's increasingly diverse elders. Uses of funds include protected time for research, faculty support and mentoring, tuition, research expenses.

#### Baylor College of Medicine

Houston, TX  
Robert J. Luchi, M.D.  
\$525,000  
Three years

#### Boston University

Boston, MA  
Patricia P. Barry, M.D., M.P.H.  
\$525,000  
Three years

#### Duke University

Durham, NC  
Harvey J. Cohen, M.D.  
\$300,000  
Two years

#### Harvard Medical School

Boston, MA  
Lewis A. Lipsitz, M.D.  
\$300,000  
Two years

#### Johns Hopkins University

Baltimore, MD  
John R. Burton, M.D.  
\$300,000  
Two years

#### Mount Sinai Medical Center

New York, NY  
Christine K. Cassel, M.D.  
\$300,000  
Two years

#### Northwestern University

Evanston, IL  
Janice B. Schwartz, M.D.  
\$525,000  
Three years

#### Southeast Center of Excellence in Geriatric Medicine

##### a. University of Alabama

Birmingham, AL  
Richard M. Allman, M.D.  
\$412,500  
Three years

##### b. Emory University

Atlanta, GA  
Joseph G. Ouslander, M.D.  
\$412,500  
Three years

#### University of California, Los Angeles

Los Angeles, CA  
David B. Reuben, M.D.  
\$300,000  
Two years

#### University of California, San Francisco

San Francisco, CA  
C. Seth Landefeld, M.D.  
\$525,000  
Three years

#### University of Colorado

Denver, CO  
Dennis W. Jahnigen, M.D.  
Andrew Kramer, M.D.  
\$525,000  
Three years

#### University of Hawaii

Honolulu, HI  
Patricia L. Blanchette, M.D.  
\$525,000  
Three years

**University of Kansas**  
Kansas City, KS  
Stephanie A. Studenski, M.D., M.P.H.  
\$525,000  
Three years

**University of Michigan**  
Ann Arbor, MI  
Jeffrey B. Halter, M.D.  
\$300,000  
Two years

**University of Rochester**  
Rochester, NY  
William J. Hall, M.D.  
\$525,000  
Three years

**University of Texas, San Antonio**  
San Antonio, TX  
Michael S. Katz, M.D.  
David Espino, M.D.  
\$525,000  
Three years

**University of Washington**  
Seattle, WA  
Itamar B. Abrass, M.D.  
\$400,000  
Two years

**Yale University**  
New Haven, CT  
Mary E. Tinetti, M.D.  
\$525,000  
Three years

The CoE program also includes an award to the American Federation for Aging Research (AFAR), Inc., to serve as its Coordinating Center. This center will organize meetings for trainees, prepare and circulate a newsletter, maintain a website on behalf of the program, and monitor current and previous trainees' career developments. In addition, funds were set aside for limited fellowship support at some of the designated centers.

**American Federation for Aging Research (AFAR), Inc.**  
New York, NY  
Stephanie Lederman  
\$1,027,020  
Two years

Finally, seven institutions received "Designation Awards," as Centers of Excellence, acknowledging their high quality of geriatrics training and research.

**Bowman Gray School of Medicine**  
Winston-Salem, NC  
William R. Hazzard, M.D.  
\$10,000  
Two years

**Case Western Reserve University**  
Cleveland, OH  
Jerome Kowal, M.D.  
\$10,000  
Two years

**Stanford University**  
Palo Alto, CA  
Peter Pompei, M.D.  
\$10,000  
Two years

**St. Louis University**  
St. Louis, MO  
John E. Morley, M.D., B.Ch.  
\$10,000  
Two years

**University of Arkansas**  
Little Rock, AK  
David A. Lipschitz, M.D., Ph.D.  
\$10,000  
Two years

**University of Connecticut**  
Farmington, CT  
Richard W. Besdine, M.D.  
\$10,000  
Two years

**University of Pennsylvania**  
Philadelphia, PA  
Risa Lavizzo-Mourey, M.D., M.B.A.  
\$10,000  
Two years

## Academic Geriatrics and Training

### Geriatric Interdisciplinary Team Training (GITT)

Geriatric Interdisciplinary Team Training, launched in 1995, is a major Foundation initiative. These innovative programs are designed to develop models for geriatric interdisciplinary team training, involving, at a minimum, nurses, social workers, and physicians.

In 1996 the second phase of the GITT effort was funded. Nine sites received implementation awards, from among thirteen who received one-year planning grants in 1995. In 1997, several additional awards related to this initiative were made, including:

#### Kaiser Foundation Hospitals

Oakland, CA  
Richard Della Penna, M.D.

#### *Training of Trainers in Interdisciplinary Team Managed Care*

While managed care providers are advancing interdisciplinary team care of frail elders, their capacity to serve as effective student training sites is less well developed. Building on curriculum piloted under a 1995 GITT planning award, Kaiser will create an inservice team training model designed to improve clinical care to older enrollees. By utilizing a "Training of Trainers" model to create a sustainable infrastructure, this program serves as a role model for geriatric training in interdisciplinary team work.

Grant awarded: \$490,426  
Duration of grant: Two years  
Start date: April 1, 1997

### University of California, Los Angeles

Los Angeles, CA  
David B. Reuben, M.D.  
Janet C. Frank, Dr.P.H.

#### *GITT National Program Evaluation*

The National Program Evaluation project with UCLA serves to compare and contrast factors related to individual sites' successes and failures, and to evaluate the overall GITT initiative. UCLA will design evaluation instruments and guides to assist in data collection and will conduct site visits to all of the initiative's grantees. The project will be accomplished in cooperation with nine individual sites that are implementing the Geriatric Interdisciplinary Team Training model, and New York University's National Resource Center, which coordinates activities, meetings, data collection and dissemination for the overall initiative.

Grant awarded: \$1,323,047  
Duration of grant: Three years  
Start date: April 1, 1997

### University of North Carolina

Chapel Hill, NC  
Jan Busby-Whitehead, M.D.

#### *Fostering Interdisciplinary Approaches to the Care of the Rural Elderly*

Currently, 12.5 million elders live in rural communities, where there is an inadequate supply of health practitioners to meet their needs, and few programs in place to attract future practitioners to such settings. This project will demonstrate ways to provide excellent geriatric care and minimize professional isolation. It will also develop and test a training model to enhance interdisciplinary geriatric teams in rural settings to serve as training sites for health professions students.

Grant awarded: \$598,000  
Duration of grant: 27 months  
Start date: April 1, 1997

## Academic Geriatrics and Training

### **American Federation for Aging Research (AFAR), Inc.**

New York, NY  
Stephanie Lederman  
T. Franklin Williams, M.D.

#### *Physician Faculty Scholars in Aging Research (Beeson Scholars Program)*

This award, which will double the number of Beeson awardees, is a continuation of a previous grant to the American Federation for Aging Research (AFAR), Inc. in 1994. The program is designed to develop a new cadre of geriatric leaders and to provide overall program direction, including recruitment, selection, and monitoring of Beeson Scholars. In collaboration with the Alliance for Aging Research and The Commonwealth Fund, this funding will bring to 54 the number of scholars to receive three years of funding as members of six annually selected cohorts.

Grant awarded: \$8,037,369  
Duration of grant: Six years

### **The American Geriatrics Society, Inc.**

New York, NY  
Patricia P. Barry, M.D., M.P.H.

#### *Enhancing Geriatric Care Through Practicing Physician Education: Phase II*

Most of today's primary care physicians, a major audience requiring special attention due to its importance in the care of elders, had little exposure to geriatrics in medical school or residency training. To address this issue, the American Geriatrics Society will implement a plan for Practicing Physician Education using the "Train-the-Trainer-model," in which skilled teachers are developed to train peer practitioners, and the "Opinion Leader" (OL) model, an educational model which builds on recent research on the way practicing physicians learn, and how innovations spread via a medical community's naturally occurring opinion leaders. Opinion leader activities may include formal presentations, informal interactions, and community level activities, but most importantly, this model encourages leaders of the local physician community to become involved in the quality of care delivered by their peers and empowers them to work jointly toward its improvement.

Grant awarded: \$1,992,957  
Duration of grant: Four years  
Start date: January 1, 1998

### **The American Geriatrics Society, Inc.**

New York, NY  
Dennis W. Jahnigen, M.D.  
David H. Solomon, M.D.

#### *Increasing Geriatrics Expertise in Non-Primary Care Specialties*

This award is a continuation of a 1993 grant to the American Geriatrics Society, which was designed to increase geriatric expertise in five non-primary care specialties (general surgery, gynecology, orthopedic surgery, urology, and emergency medicine). Funding will extend the original program to focus on five additional non-primary care specialties (anesthesiology, ophthalmology, otolaryngology, physical medicine and rehabilitation, and thoracic surgery). The development of a core geriatric curriculum, to be customized by inserting discipline-specific content, is also planned.

Grant awarded: \$1,523,217  
Duration of grant: Four years  
Start date: May 1, 1997

## Academic Geriatrics and Training

**The American Geriatrics Society, Inc.**  
New York, NY  
William R. Hazzard, M.D.

### *Integrating Geriatrics into the Subspecialties of Internal Medicine*

Responding to a 1993 Institute of Medicine report that recommended increased attention to geriatrics in the training provided to relevant subspecialists in internal medicine, an award to the American Geriatrics Society, Inc. supported geriatric education retreats (GERs) for six of the subspecialties of internal medicine (endocrinology, cardiology, oncology, arthritis/rheumatology, infectious disease, and immunology). Through this amended award, the remaining subspecialties of internal medicine (pulmonology, nephrology, and gastroenterology) and also general internal medicine, will be addressed. Such follow-up activities as geriatric/subspecialty meetings and colloquia, and efforts to increase geriatric content on examinations and in subspecialty journals will also be supported.

Grant awarded: \$1,998,545  
Duration of grant: Three years

**Stanford University**  
Palo Alto, CA  
Georgette A. Stratos, Ph.D.

### *Enhancing Dissemination of Innovations in Geriatric Education*

A continuation of a 1994 Geriatrics in Primary Care Residency Training Initiative (GRTI), this award is to: 1) continue dissemination of GRTI products developed by the seven sites participating in the original program, through a national resource center; 2) provide consultation to assist individual residency programs; and 3) continue to offer a "Train-the-Trainer" module on teaching geriatrics, which is a component of Stanford's highly regarded national faculty development program.

Grant awarded: \$1,570,465  
Duration of grant: Three years  
Start date: January 1, 1998

## Integrating and Improving Health Services

**Seattle Institute for Biomedical and  
Clinical Research**  
Seattle, WA  
Susan C. Hedrick, Ph.D.

### *Client Outcomes in Community Residential Settings in the State of Washington*

In 1990 the U.S. population above the age of 85 numbered 3 million and is projected to grow to about 7 million by 2020. These numbers will cause elder residential options with health service capacity or linkage to grow rapidly. Through this project, Seattle Biomedical's Center for Outcomes Research in Older Adults will analyze the results of relocating selected nursing home residents covered by Medicaid insurance in the state of Washington. The project will provide process and outcome information about long-term care clients who receive services in adult family homes (up to six residents), adult residential care (3 to 100 residents) and assisted living (20+ residents) settings.

Grant awarded: \$511,577  
Duration of grant: 43 months  
Start date: June 1, 1997

## Aging and Health Other

**George Washington University,  
National Health Policy Forum**  
Washington, DC  
Judith Miller Jones

### *Advancing Aging and Health Policy Understanding*

Through this project, the National Health Policy Forum seeks to broaden its audiences and expand understanding of aging issues and ways to improve elders' health care services. It will develop meetings and workshops, create a private market technical advisory group and assemble a chartbook which will document relationships between aging, frailty, poor health and probable needs for dependence on government programs by those with major health care needs.

Grant awarded: \$464,070  
Duration of grant: Two years  
Start date: July 1, 1997

**The People-to-People Health  
Foundation, Inc.**  
Washington, DC  
John K. Iglehart

### *Health Affairs* Thematic Issue on *Medicare's Future*

Efforts abound to change hospital or medical education reimbursement rates and step up audit surveillance. In order to ensure the integrity of Medicare trust funds and related government spending for today's 37 million Medicare beneficiaries and their successors, key decision makers, academics, and the educated public must also consider demographic and economic issues, housing options, and medical and other technologies. The People-to-People Health Foundation will create a special thematic issue of its journal, *Health Affairs*, which is scheduled to appear late in 1998. This issue will address such areas relevant to Medicare as graduate medical education, utilization of home care, adequacy of reimbursement for such geriatric imperatives as comprehensive assessment and team care, and such related government programs as Social Security, housing and transportation. This award is in partnership with the Henry J. Kaiser Family Foundation and The Commonwealth Fund.

Grant awarded: \$75,000  
Duration of grant: 15 months  
Start date: October 1, 1997

**University of Maryland**  
College Park, MD  
Daniel Leviton, Ph.D.

### *Expanding the National Network for Intergenerational Health*

A growing number of elders utilize health and social support systems which are undergoing dramatic changes and budgetary pressures. The University of Maryland's Adult Health and Development Program (AHDP) is an intergenerational health promotion and rehabilitation project that trains high school and university students and adult volunteers to work on a one-to-one basis with older adults to improve the latter's health status. This award will build upon the University of Maryland's AHDP, extending it to an additional sixteen colleges and universities. The project will follow the "Train-the-Trainer model" and is committed to serving a diverse population, including, but not limited to, older adults who are from varied ethnic and racial backgrounds, who have limited resources to cope with physical disabilities. AHDP is an exciting and effective model that inspires and trains volunteers, especially young adults, to make a significant difference in the lives of older people in their communities. Volunteers will develop and strengthen transferable interpersonal and gerontological skills in a mentoring environment.

Grant awarded: \$306,814  
Duration of grant: Three years  
Start date: October 1, 1997

## 1997 Grant Descriptions/Other

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### **National Foundation for Facial Reconstruction**

New York, NY

Michael T. Longaker, M.D.

#### *Fetal Wound Healing: The Potential to Heal Without Scarring*

This award is a continuation of a previous award to the National Foundation for Facial Reconstruction in 1993, which studied factors involved in the regulation mechanism of cells involved in wound repair and the biochemical environment which promotes scarless repair. Through this project, the National Foundation for Facial Reconstruction seeks to continue study in this area and ultimately to develop therapies using gene manipulation and the application of the associated products.

Grant awarded: \$565,000

Duration of grant: Three years

Start date: September 1, 1997



## Financial Summary

THE ANNUAL FINANCIAL STATEMENTS, which have been audited by Owen J. Flanagan & Co., appear on pages 56 to 76.

**On December 31, 1997 the Foundation's assets were \$497.5 million, an increase of \$63.7 million for the year after cash payments of \$20.6 million for grants, expenses and Federal excise tax. Total return on the investments, income plus realized and unrealized capital gains, was 19.7 percent. In 1997 revenues totaled \$11.9 million, a yield of approximately 2.5 percent for the year.**

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.

During 1997 the domestic equity market continued its unprecedented advance; for the third consecutive year large capitalization stock indices had returns in excess of 20 percent.

Recognizing that it was not likely that such performance would continue and that the probability of a market correction was increasing, the Foundation followed through on efforts begun in 1996 to reduce its exposure to the financial markets. In 1997 it funded previous commitments and made a new investment in 'event-driven' strategies that historically have high absolute returns and low correlation with the public markets. In addition, as technological change has been and will continue to be a major engine for economic growth, the Foundation placed about 4 percent of its portfolio with two new technology managers in order to achieve greater diversification and potentially higher returns.

At the end of 1997 the Foundation's asset mix was 63 percent equities, 27 percent fixed income, and a combined 10 percent in venture capital, private equity, real estate and event-driven funds.

As of December 31, 1997 the Foundation's investments were managed by Capital Guardian Trust Company, Sound Shore Management, Piper Capital Management, William Blair & Co., T. Rowe Price Associates, S Squared Technology and Dawson-Samberg Capital Management. In addition, the Foundation is an investor in venture capital funds managed by Oak Investment Partners, Brentwood Associates, the Mayfield Fund, Middlewest Ventures, Tullis-Dickerson and William Blair Capital Partners. Private equity partnerships are managed by GE Investments and Brentwood Associates. Real estate investments consist of funds managed by TA Associates Realty and Heitman/JMB Advisory Corporation. Event-driven investment managers are Halcyon/Alan B. Slifka Mangement Co., Whippoorwill Associates, and Angelo, Gordon & Co.

The Finance Committee and the Board of Trustees meet regularly with each of the investment managers to review their performance and discuss current investment policy. The Chase Manhattan Bank, N.A. is 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, 1997 and 1996 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 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, 1997 and 1996 and its changes in net assets and cash flows 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 65 to 76, 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 6, 1998

The John A. Hartford Foundation, Inc.  
Balance Sheets December 31, 1997 and 1996

Exhibit A

	1997	1996
<b>Assets:</b>		
Cash in operating accounts	\$ 4,943	\$ 5,857
Interest and dividends receivable	1,748,459	1,802,667
Prepaid Federal excise tax	26,744	187,095
Prepayments and deposits	74,177	32,041
	1,854,323	2,027,660
<b>Investments, at market or adjusted cost</b> (Notes 2 and 3)		
Short-term cash investments	53,301,070	59,281,953
Stocks	310,523,627	270,968,858
Long-term bonds	80,988,087	77,612,820
Investment partnerships	35,968,991	13,689,393
Real estate pooled funds	10,186,995	8,419,477
Total Investments	490,968,770	429,972,501
<b>Office condominium, furniture and equipment</b> (net of accumulated depreciation of \$2,454,542 in 1997 and \$2,243,102 in 1996) (Note 5)		
	4,719,134	1,810,345
Total Assets	\$497,542,227	\$433,810,506
<b>Liabilities and Net Assets</b>		
<b>Liabilities:</b>		
<b>Grants payable (Note 2)</b>		
Current	\$ 16,907,452	\$ 11,791,113
Non-current (Note 7)	22,329,845	15,071,750
Accounts payable	955,352	468,318
Deferred Federal excise tax (Note 2)	940,955	737,718
Total Liabilities	41,133,604	28,068,899
<b>Net Assets - Unrestricted:</b>		
Board designated (Note 2)	3,296,882	1,948,484
Undesignated	453,111,741	403,793,123
Total Net Assets (Exhibit B)	456,408,623	405,741,607
Total Liabilities and Net Assets	\$497,542,227	\$433,810,506

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, 1997 and 1996

1997

1996

**Revenues**

Dividends and partnership earnings	\$ 4,062,714	\$ 4,532,746
Long-term bond interest	5,528,394	5,297,397
Short-term investment earnings	2,358,245	1,791,150

Total Revenues	11,949,353	11,621,293
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**Grants and Expenses**

Grant expense (less cancellations and refunds of \$9,210 in 1997 and \$54,105 in 1996)	28,316,909	19,632,975
Foundation-administered projects	151,957	627
Grant-related direct expenses	79,818	78,160
Excise and unrelated business income taxes (Note 2)	97,033	97,934
Investment fees	2,040,428	1,701,853
Personnel salaries and benefits (Note 6)	1,466,642	1,338,893
Office and other expenses	737,240	577,063
Depreciation	211,440	205,043
Professional services	146,246	94,791

Total Grants and Expenses	33,247,713	23,727,339
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Excess (deficiency) of revenues over grants and expenses	(21,298,360)	(12,106,046)
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**Net Realized and Change in**

<b>Unrealized Gain on Securities Transactions (Note 3)</b>	71,965,376	58,550,989
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Increase in Net Assets	50,667,016	46,444,943
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Net Assets, beginning of year	405,741,607	359,296,664
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<b>Net Assets, End of Year (Exhibit A)</b>	<b>\$456,408,623</b>	<b>\$405,741,607</b>
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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, 1997 and 1996

Exhibit C

1997

1996

**Cash Flows Provided (Used)**

**From Operating Activities:**

Interest and dividends received	\$ 11,406,123	\$ 11,443,258
Cash distributions from partnerships and real estate pooled funds	2,370,249	3,749,242
Grants and Foundation-administered projects paid (net of refunds)	(16,091,991)	(16,645,945)
Expenses and taxes paid	(4,530,488)	(4,550,854)

Net Cash Flows Provided (Used) by Operating Activities	(6,846,107)	(6,004,299)
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**From Investing Activities:**

Proceeds from sale of investments	198,686,143	262,699,593
Purchases of investments	(194,912,934)	(229,074,015)
Purchase of fixed assets	(3,112,630)	(45,552)

Net Cash Flows Provided by Investing Activities	660,579	33,580,026
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Net Increase (Decrease) in Cash and Cash Equivalents	(6,185,528)	27,575,727
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Cash and equivalents, beginning of year	\$ 59,055,685	31,479,958
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<b>Cash and equivalents, end of year</b>	<b>\$ 52,870,157</b>	<b>\$ 59,055,685</b>
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**Reconciliation of Increase in Net Assets to Net Cash Used by Operating Activities**

Increase in Net Assets	\$ 50,667,016	\$ 46,444,943
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Adjustment to reconcile increase in net assets to net cash used by operating activities:

Depreciation	211,440	205,043
Decrease in interest and dividends receivable	54,208	76,875
Decrease (increase) in prepayments and deposits	(42,136)	4,277
Increase in grants payable	12,374,435	2,997,044
(Decrease) increase in accounts payable	466,396	(38,759)
Net realized and change in unrealized gain on securities transactions	(71,965,376)	(58,550,989)
Other	1,387,910	2,857,267

	\$ (6,846,107)	\$ (6,004,299)
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The John A. Hartford Foundation, Inc.  
 Statements of Cash Flows  
 Years Ended December 31, 1997 and 1996

Exhibit C

1997

1996

**Supplemental Information:**

**Detail of other:**

Investment partnerships and real estate pooled funds:		
Cash distributions	\$ 2,370,249	\$ 3,749,242
Less: reported income	597,438	254,909
	1,772,811	3,494,333
Tax expense	97,033	97,934
Less: Taxes paid	481,934	735,000
Excess (tax on realized gains and change in prepaid)	(384,901)	(637,066)
Total - Other	\$ 1,387,910	\$ 2,857,267

**Composition of Cash and Equivalents:**

Cash in operating accounts	\$ 4,943	\$ 5,857
Short-term cash investments	53,301,070	59,281,953
Unrealized (gain) loss on forward currency contracts	(377,088)	(232,125)
Unrealized (gain) loss on short sales	(58,768)	-
	\$ 52,870,157	\$ 59,055,685

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

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**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.

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**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 generally accepted accounting principles 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.

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*Investments*

Investments in marketable securities are valued at their fair value (quoted market price). Investment 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. Realized gains and losses from the sale of marketable securities are recorded by comparison of proceeds to cost determined under the average cost method.

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*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.

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*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 foreign denominated cash, master notes, money market mutual funds and discounted short-term notes. Short-term cash investments also include the unrealized gain or loss on open foreign currency forward contracts and short sales.

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*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 1997 and 1996 the Foundation's rate was 1%.

Investment expenses for 1997 include direct investment fees of \$2,040,428 and \$131,000 of allocated salaries, legal fees and other office expenses. The 1996 comparative numbers were \$1,701,853 and \$126,000.

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 \$18,965,000 of undistributed income in grants or qualifying expenditures by December 31, 1998 to comply with Internal Revenue Service regulations.

**The John A. Hartford Foundation, Inc.**  
**Notes to Financial Statements**  
**December 31, 1997 and 1996**

Exhibit D

*Tax Status (continued)*

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.

*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).

**3. Investments**

The net gain on investments in 1997 is summarized as follows:

	Cost	Fair Value	Appreciation
Balance, December 31, 1997	\$396,873,309	\$490,968,770	\$ 94,095,461
Balance, December 31, 1996	\$356,200,725	\$429,972,501	\$ 73,771,776
Increase in unrealized appreciation during the year, net of increased deferred Federal excise tax of \$203,237			\$ 20,120,448
Realized gain, net of provision for excise and unrelated business taxes of \$558,291			51,844,928
Net realized and change in unrealized gain on securities transactions			\$ 71,965,376

For 1996, the unrealized gain was \$12,711,663, net of increased deferred Federal excise tax of \$128,401. The realized gain was \$45,839,326 net of a provision for Federal excise tax of \$463,023.

Receivables and payables on security sales and purchases pending settlement at December 31, 1997 and 1996 were as follows:

	1997	1996
Proceeds from sales	\$ 878,091	\$ 1,414,106
Payables from purchases	(1,745,831)	(2,313,781)
Net cash pending settlement	\$ (867,740)	\$ (899,675)

At December 31, 1997, the Foundation had received \$286,734 of proceeds from open short sales. The cost to cover those sales would be \$227,966.

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

The detail of the Foundation's investment in long-term bonds is as follows:

	1997	1996
U.S. Government	\$12,729,098	\$13,981,254
U.S. agency	10,719,490	7,464,991
Corporate	44,597,175	43,297,229
Commingled fund	1,483,110	-
Foreign denominated	11,459,214	12,869,346
	\$80,988,087	\$77,612,820

The Foundation is a participant in ten investment limited partnerships. As of December 31, 1997, \$34,129,991 had been invested in these partnerships and future commitments for additional investment aggregated \$9,870,009.

In addition, the Foundation is a participant in four other investment partnerships which are either in liquidation or have reached the completion of their original term and are winding down. The recorded value of these investments is \$678,661.

Two of the Foundation's investment partnerships permit withdrawals at least once a year. These are valued at their fair value, \$14,935,065 (adjusted cost \$13,925,645).

Real estate investments included one limited partnership and four real estate investment trusts. The Foundation had invested \$10,850,000 at December 31, 1997 and future commitments for additional investment aggregated \$1,150,000

#### 4. Foreign Currency Forward Contract Commitments

The Foundation uses foreign currency forward contracts as a hedge against currency fluctuations in foreign denominated investments. At December 31, 1997 the Foundation's open foreign currency forward sale and purchase contracts totaled \$3,689,426. Total foreign denominated investments at the same date were \$39,979,185.

#### 5. Office Condominium, Furniture and Equipment

At December 31, 1997 and 1996 the fixed assets of the Foundation were as follows:

	1997	1996
Office condominium	\$3,616,815	\$3,616,815
New office condominium - in progress	3,070,860	-
Furniture and equipment	486,001	436,632
	7,173,676	4,053,447
Less: Accumulated depreciation	2,454,542	2,243,102
Office condominium, furniture and equipment, net	\$4,719,134	\$1,810,345

As a result of the growth of the Foundation, additional office space was needed. In July 1997, the Foundation purchased a larger floor in its current building. The cost of the new space, as well as fees incurred through December 31, 1997 to begin preparation of the space have been capitalized and shown as "in progress" above. Approximately \$80,000 of real estate taxes and maintenance incurred since taking ownership were expensed as part of regular office expenses.

In February 1998, the Foundation signed a contract for the office construction in the new space. The contract will cost \$1,160,000 and calls for completion by May 1998. As of the date of this report, work had begun.

In December 1997, the Foundation signed a contract for the sale of its existing condominium for \$2,224,590. The closing for the sale must take place by July 1, 1998.

**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 1997 and 1996 amounted to \$100,972 and \$114,647, respectively. The Foundation also incurred additional pension costs of approximately \$35,000 in 1997 and 1996 for payments to certain retirees who began employment with the Foundation prior to the initiation of the formal retirement plan.

In 1997 the Foundation adopted a deferred compensation plan to compensate certain employees whose retirement plan contributions were limited by IRS regulations.

**7. Grants Payable**

The Foundation estimates that the non-current grants payable as of December 31, 1997 will be disbursed as follows:

	1999	\$13,596,496
	2000	7,534,929
	2001	2,966,498
	2002	1,038,696
	2003	490,108
		25,626,727
Discount to present value		3,296,882
		<b>\$22,329,845</b>

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 1997 and 1996 was 8.5% 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:

	1997	1996
Partnership earnings	\$ 666,676	\$ 258,932
Realized gains - net of taxes of \$8,157 and \$23,708	738,968	2,347,019
Unrealized gain - recovery of valuation allowance - net of deferred excise tax of \$7,024 and \$2,765	695,330	273,758
	<b>\$2,100,974</b>	<b>\$2,879,709</b>

**Summary of Active Grants**

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>AGING AND HEALTH</b>				
<b>Academic Geriatrics and Training</b>				
<b>The American Academy of Family Physicians Foundation</b>	\$ 101,029			\$ 101,029
Kansas City, MO "Improving Geriatric Medicine Education in Community Hospital Family Practice Residency Programs" Gregg Warshaw, M.D.				
<b>American Federation for Aging Research (AFAR), Inc.</b>	5,452,475	\$ 8,037,369	\$ 2,231,064	11,258,780
New York, NY "Physician Faculty Scholars in Aging Research" Stephanie Lederman				
<b>American Federation for Aging Research (AFAR), Inc.</b>		1,027,020	258,543	768,477
New York, NY "Centers of Excellence Coordinating Center" Stephanie Lederman				
<b>American Federation for Aging Research (AFAR), Inc.</b>	1,132,235		289,955	842,280
New York, NY "Medical Student Geriatric Scholars Program" Odette van der Willik				
<b>The American Geriatrics Society, Inc.</b>	465,657	1,998,545	505,159	1,959,043
New York, NY "Integrating Geriatrics into the Subspecialties of Internal Medicine" William R. Hazzard, M.D.				
<b>The American Geriatrics Society, Inc.</b>	89,096		89,096	
New York, NY "Enhancing Geriatric Knowledge of Practicing Physicians through Continuing Medical Education" Patricia P. Barry, M.D., M.P.H.				
<b>The American Geriatrics Society, Inc.</b>		1,992,957	230,719	1,762,238
New York, NY "Enhancing Geriatric Knowledge of Practicing Physicians through Continuing Medical Education, Phase II" Patricia P. Barry, M.D., M.P.H.				

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>The American Geriatrics Society, Inc.</b> New York, NY "Increasing Geriatrics Expertise in Non-Primary Care Specialties" Dennis W. Jahnigen, M.D.		\$ 1,523,217	\$ 376,428	\$ 1,146,789
<b>Baylor College of Medicine</b> Houston, TX "Center of Excellence" Robert J. Luchi, M.D.		525,000	87,500	437,500
<b>Baylor College of Medicine</b> Houston, TX "Competency-Based Curriculum in Geriatrics for Residency Training in Internal Medicine and Family Medicine" Robert J. Luchi, M.D.	\$ 82,011		82,011	
<b>Baylor College of Medicine</b> Houston, TX "Geriatric Interdisciplinary Team Training" Nancy Wilson, L.M.S.W.	508,944		123,794	385,150
<b>Boston University</b> Boston, MA "Center of Excellence" Patricia P. Barry, M.D., M.P.H.		525,000	86,450	438,550
<b>Bowman Gray School of Medicine</b> Winston-Salem, NC "Center of Excellence Designation Award" William R. Hazzard, M.D.		10,000	10,000	
<b>Case Western Reserve University</b> Cleveland, OH "Center of Excellence Designation Award" Jerome Kowal, M.D.		10,000	10,000	
<b>Duke University</b> Durham, NC "Center of Excellence" Harvey Jay Cohen, M.D.		300,000	75,000	225,000
<b>Emory University</b> Atlanta, GA "Southeast Center of Excellence in Geriatric Medicine" Joseph G. Ouslander, M.D.		412,500	68,750	343,750
<b>Harvard Medical School</b> Boston, MA "Hartford Primary Care/Geriatrics Initiative" Thomas S. Inui, Sc.M., M.D.	76,069		76,069	

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>Harvard Medical School</b> Boston, MA "Center of Excellence" Lewis A. Lipsitz, M.D.		\$ 300,000	\$ 75,000	\$ 225,000
<b>Henry Ford Health System</b> Detroit, MI "Great Lakes Geriatric Interdisciplinary Team Training" Nancy A. Whitelaw, Ph.D.	\$ 454,716		112,663	342,053
<b>Johns Hopkins University School of Medicine</b> Baltimore, MD "Center of Excellence" John R. Burton, M.D.		300,000	73,442	226,558
<b>Johns Hopkins University School of Medicine</b> Baltimore, MD "Geriatrics in Primary Care Training Initiative at Johns Hopkins" John R. Burton, M.D.	86,119		86,119	
<b>Kaiser Foundation Hospitals</b> Los Angeles, CA "Training of Trainers in Interdisciplinary Team Training" Richard Della Penna, M.D.		490,426	237,082	253,344
<b>The Mount Sinai Medical Center</b> New York, NY "Geriatric Interdisciplinary Team Training" Christine K. Cassel, M.D.	500,000		125,000	375,000
<b>The Mount Sinai Medical Center</b> New York, NY "Center of Excellence" Christine K. Cassel, M.D.		300,000	74,848	225,152
<b>New York University</b> New York, NY "Geriatric Interdisciplinary Team Training Program: Resource Center" Terry T. Fulmer, R.N., Ph.D.	922,788		442,451	480,337
<b>New York University</b> New York, NY "The John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing Practice" Mathy Mezey, R.N., Ed.D., FAAN	4,186,538		771,153	3,415,385

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>Northwestern University</b> Evanston, IL "Center of Excellence" Janice B. Schwartz, M.D.		\$ 525,000	\$ 87,500	\$ 437,500
<b>On Lok, Inc.</b> San Francisco, CA "Geriatric Interdisciplinary Team Training" Jennie Chin Hansen, R.N., M.S.	\$ 501,148		125,106	376,042
<b>Rush-Presbyterian-St. Luke's Medical Center</b> Chicago, IL "Geriatric Interdisciplinary Team Training" Denis A. Evans, M.D.	500,000		125,000	375,000
<b>Stanford University</b> Palo Alto, CA "Geriatrics Educational Resource and Dissemination Center" Kelley M. Skeff, M.D., Ph.D.	214,333		214,333	
<b>Stanford University</b> Palo Alto, CA "Center of Excellence Designation Award" Peter Pompei, M.D.		10,000	10,000	
<b>Stanford University</b> Palo Alto, CA "Enhancing Dissemination of Innovations in Geriatric Education" Georgette Stratos, Ph.D.	148,332	1,570,465	148,332	1,570,465
<b>St. Louis University</b> St. Louis, MO "Center of Excellence Designation Award" John E. Morley, M.B., B.Ch.		10,000	10,000	
<b>University of Alabama at Birmingham</b> Birmingham, AL "Southeast Center of Excellence in Geriatric Medicine" Richard M. Allman, M.D.		412,500	68,750	343,750
<b>University of Arkansas for Medical Sciences</b> Little Rock, AK "Center of Excellence Designation Award" David A. Lipshitz, M.D., Ph.D.		10,000	10,000	
<b>University of California, Los Angeles School of Medicine</b> Los Angeles, CA "Increasing Geriatrics Training for Primary Care Residents" Alan M. Fogelman, M.D.	85,035		85,035	

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>University of California, Los Angeles School of Medicine</b> Los Angeles, CA "GITT National Program Evaluation" David B. Reuben, M.D.		\$ 1,323,047	\$ 375,770	\$ 947,277
<b>University of California, Los Angeles School of Medicine</b> Los Angeles, CA "Center of Excellence" David B. Reuben, M.D.		300,000	75,000	225,000
<b>University of California, San Francisco</b> San Francisco, CA "Center of Excellence" C. Seth Landefeld, M.D.		525,000	69,815	455,185
<b>The University of Chicago</b> Chicago, IL "Geriatrics in Primary Care Training" Greg A. Sachs, M.D.	\$ 87,090		87,090	
<b>University of Colorado</b> Denver, CO "Center of Excellence" Dennis W. Jahnigen, M.D. & Andrew Kramer M.D.		525,000	98,430	426,570
<b>University of Colorado</b> Denver, CO "Geriatric Interdisciplinary Team Training" Dennis W. Jahnigen, M.D.	500,000		125,000	375,000
<b>The University of Connecticut Center on Aging</b> Farmington, CT "Geriatrics in Primary Care Training Initiative" Gail Sullivan, M.D.	84,449		84,449	
<b>The University of Connecticut Center on Aging</b> Farmington, CT "Center of Excellence Designation Award" Richard W. Besdine, M.D.		10,000	10,000	
<b>University of Hawaii</b> Honolulu, HW "Center of Excellence" Patricia L. Blanchette, M.D., M.P.H.		525,000	80,669	444,331
<b>University Hospitals Health System</b> Cleveland, OH "Great Lakes Geriatric Interdisciplinary Team Training" Shirley Moore, R.N., Ph.D.	305,678		76,251	229,427

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>University of Kansas</b> Kansas City, KS "Center of Excellence" Stephanie A. Studenski, M.D., M.P.H.		\$ 525,000	\$ 72,149	\$ 452,851
<b>University of Medicine and Dentistry of New Jersey</b> Hackensack, NJ "Expansion of Home Care into Academic Medicine" R. Knight Steel, M.D.	\$ 728,503	150,000	264,198	614,305
<b>The University of Michigan</b> Ann Arbor, MI "Center of Excellence" Jeffrey B. Halter, M.D.		300,000	75,000	225,000
<b>University of Minnesota</b> Minneapolis, MN "Geriatric Interdisciplinary Team Training" Robert L. Kane, M.D.	513,896		125,886	388,010
<b>University of North Carolina</b> Chapel Hill, NC "Fostering Interdisciplinary Approaches to the Care of the Rural Elderly" Jan Busby-Whitehead, M.D.		598,000	272,492	325,508
<b>University of Pennsylvania</b> Philadelphia, PA "Center of Excellence Designation Award" Risa Lavizzo-Mourey, M.D., M.B.A.		10,000	10,000	
<b>The University of Rochester School of Medicine and Dentistry</b> Rochester, NY "A Program to Improve the Geriatric Content of Generalist Physician Residency Programs" William J. Hall, M.D.	89,829		89,829	
<b>The University of Rochester School of Medicine and Dentistry</b> Rochester, NY "Center of Excellence" William J. Hall, M.D.		525,000	79,003	445,997
<b>University of South Florida Foundation, Inc.</b> Tampa, FL "Geriatric Interdisciplinary Team Training" Eric Pfeiffer, M.D.	500,000		125,000	375,000

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>University of Texas, San Antonio</b> San Antonio, TX "Center of Excellence" David Espino, M.D. and Michael S. Katz, M.D.		\$ 525,000	\$ 87,266	\$ 437,734
<b>University of Washington</b> Seattle, WA "Center of Excellence" Itamar B. Abrass, M.D.		400,000	100,000	300,000
<b>Yale University</b> New Haven, CT "Center of Excellence" Mary E. Tinetti, M.D.		525,000	62,500	462,500
<b>Subtotal</b>	\$18,315,970	\$27,056,046	\$ 9,928,149	\$35,443,867
<b>Integrating and Improving Services</b>				
<b>Arizona State University</b> Tempe, AZ "Enhancing Generalist Physician Program Impact" Frank G. Williams, Ph.D.	\$ 908,297		\$ 542,029	\$ 366,268
<b>Dartmouth Medical School</b> Hanover, NH "Replication of Community Centers of Excellence in Aging" John H. Wasson, M.D.	157,091		157,091	
<b>Johns Hopkins Bayview Medical Center, Inc.</b> Baltimore, MD "Johns Hopkins Home Hospital" John R. Burton, M.D.	125,242		125,242	
<b>Mount Sinai Hospital of Greater Miami, Inc.</b> Miami, FL "Intervention Pathways to Integrate Eldercare Through Generalist Physician Offices" Gloria B. Weinberg, M.D.	58,176		58,176	
<b>National Chronic Care Consortium</b> Bloomington, MN "Using SASI to Advance System Integration" Deborah Paone	184,040		75,457	108,583
<b>New York University</b> New York, NY "Nurses Improving Care to the Hospitalized Elderly" Mathy Mezey, R.N., Ed.D., FAAN	214,133		107,067	107,066

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>On Lok, Inc.</b> San Francisco, CA "Integrated Chronic Care Information System" Catherine Eng, M.D.	\$ 781,357		\$ 299,181	\$ 482,176
<b>Seattle Institute for Biomedical and Clinical Research</b> Seattle, WA "Client Outcomes in Community Residential Settings in the State of Washington" Susan C. Hedrick, Ph.D.		\$ 511,577	122,418	389,159
<b>South Carolina Department of Health and Environmental Control</b> Columbia, SC "Integration of Care in Rural South Carolina Generalist Physician Practices" Michael Byrd, M.S.W., M.P.H.	129,727		129,727	
<b>Subtotal</b>	2,558,063	511,577	1,616,388	1,453,252
<b>Aging and Health – Other</b>				
<b>Brandeis University</b> Waltham, MA "National Policy and Resource Center on Women and Aging" Phyllis H. Mutschler, Ph.D.	625,000		250,000	375,000
<b>Cold Spring Harbor Laboratory</b> Cold Spring Harbor, NY "The Biology of Long-Term Memory" Timothy P. Tully, Ph.D.	569,998		126,146	443,852
<b>The George Washington University National Health Policy Forum</b> Washington, DC "Advancing Aging and Health Policy Understanding" Judith Miller Jones		464,070	115,561	348,509
<b>The People-to-People Health Foundation, Inc.</b> Bethesda, MD "Health Affairs Thematic Issue on Medicare's Future" John K. Iglehart		75,000	37,500	37,500
<b>University of California, Los Angeles School of Public Health</b> Los Angeles, CA "Development of an Elder Health Risk Appraisal" Lester Breslow, M.D., M.P.H.	75,033		75,033	

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>University of Maryland</b> Baltimore, MD "Exploring Opportunities to Advance Mental Health Care for an Aging Population" Howard H. Goldman, M.D., Ph.D.	\$ 125,644		\$ 125,644	
<b>University of Maryland</b> College Park, MD "Expanding the National Network for Intergenerational Health" Daniel Leviton, Ph.D.		\$ 306,814	57,122	\$ 249,692
<b>Vanderbilt University</b> <b>School of Medicine</b> Nashville, TN "Improving Pharmacotherapy in Home Health Patients" Wayne A. Ray, Ph.D.	523,194		159,813	363,381
<b>Subtotal</b>	\$ 1,918,869	\$ 845,884	\$ 946,819	\$ 1,817,934
<b>Total Aging and Health</b>	\$22,792,902	\$28,413,507	\$12,491,356	\$38,715,053
<b>HEALTH CARE COST AND QUALITY</b>				
<b>Community Health Reform</b>				
<b>Foundation for Health Care Quality</b> Seattle, WA "Health Care Quality Measurement Advisory Service" Richard D. Rubin	\$ 1,880,858		\$ 991,490	\$ 889,368
<b>Institute for Health Policy Solutions</b> Washington, DC "Health Plan Purchasing Cooperative Resource Center" Richard E. Curtis	1,354,627		485,640	868,987
<b>National Business Coalition on Health, Inc.</b> Washington, DC "Expanding and Strengthening the Community Health Reform Movement"	811,581		308,222	503,359
<b>Subtotal</b>	\$ 4,047,066		\$ 1,785,352	\$ 2,261,714

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>Community Health Management Information System (CHMIS)</b>				
<b>Foundation for Health Care Quality</b> Seattle, WA "Implementing the Washington State Community Health Management Information System (CHMIS)" Richard D. Rubin	\$ 699,466		\$ 349,876	\$ 349,590
<b>Foundation for Health Care Quality</b> Seattle, WA "Community Health Management Information System (CHMIS) National Resource Center" Richard D. Rubin	745,626		161,531	584,095
<b>Minnesota Institute for Community Health Information</b> St. Paul, MN "Implementation of MedNet: A Statewide Public/Private Electronic Health Care Information Network in Minnesota" Walter Suarez	290,000		175,000	115,000
<b>Ohio Corporation for Health Information</b> Columbus, OH "The Ohio CHMIS Demonstration Project" John Richards	95,000		95,000	
<b>Subtotal</b>	<b>\$ 1,830,092</b>		<b>\$ 781,407</b>	<b>\$ 1,048,685</b>
<b>Total Health Care Cost and Quality</b>	<b>\$ 5,877,158</b>		<b>\$ 2,566,759</b>	<b>\$ 3,310,399</b>
<b>New York Fund</b>				
<b>The American Jewish Committee</b> New York, NY		\$ 5,000	\$ 5,000	
<b>American National Red Cross</b> New York, NY		1,000	1,000	
<b>The Boys' Club of New York, Inc.</b> New York, NY		20,000	20,000	
<b>Children's Defense Fund</b> New York, NY		2,500	2,500	
<b>Cornell University Medical College</b> New York, NY		20,000	20,000	
<b>Creative Arts Team (CAT)</b> New York University New York, NY		10,000	10,000	
<b>The Hospital for Special Surgery Fund, Inc.</b> New York, NY		2,500	2,500	

	<i>Balance Due January 1, 1997</i>	<i>Grants Authorized During Year</i>	<i>Amount Paid During Year</i>	<i>Balance Due December 31, 1997</i>
<b>Memorial Sloan-Kettering Cancer Center</b> New York, NY		\$ 1,000	\$ 1,000	
<b>The Mount Sinai Medical Center</b> New York, NY		20,000	20,000	
<b>New York Hospital-Cornell Medical Center</b> New York, NY		25,000	25,000	
<b>The New York Public Library</b> New York, NY		10,000	10,000	
<b>The New York Academy of Medicine</b> New York, NY		5,000	5,000	
<b>Parkside School</b> New York, NY		10,000	10,000	
<b>Turtle Bay Music School</b> New York, NY		15,000	15,000	
<b>United Hospital Fund</b> New York, NY		2,500	2,500	
<b>Total New York Fund</b>		\$ 149,500	\$ 149,500	
<b>Other</b>				
<b>Association for Health Services Research</b> Washington, DC		\$ 2,500	\$ 2,500	
<b>The Foundation Center</b> New York, NY		8,000	8,000	
<b>Gateway Rehabilitation Center</b> Alliquippa, PA	\$ 37,988		17,536	\$ 20,452
<b>Grantmakers in Aging</b> New York, NY		5,000	5,000	
<b>Grantmakers in Health</b> Washington, DC		8,000	8,000	
<b>National Foundation for Facial Reconstruction</b> New York, NY		565,000	107,500	457,500
<b>New York Regional Association of Grantmakers, Inc.</b> New York, NY		9,000	9,000	
<b>Overlook Hospital Foundation</b> Summit, NJ	102,125		71,350	30,775
<b>Matching Grants*</b>		514,010	514,010	
<b>Total Other</b>	\$ 140,113	\$ 1,111,510	\$ 742,896	\$ 508,727
<b>Grants Refunded</b>	1,174	(9,210)	(8,036)	
<b>Discount to Present Value</b>	(1,948,484)	(1,348,398)		(3,296,882)
<b>Total (All Grants)</b>	\$26,862,863	\$28,316,909	\$15,942,475	\$39,237,297

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

	<i>Expenses Authorized, Not Incurred January 1, 1997</i>	<i>Projects Authorized During Year</i>	<i>Expenses Incurred During Year</i>	<i>Expenses Authorized, Not Incurred December 31, 1997</i>
<b>FOUNDATION ADMINISTERED PROJECT</b>				
<b>Aging and Health</b>				
"To Pursue Selected Activities Identified in the Strategic Plan"		\$ 400,000	\$ 151,957	\$ 248,043
<b>Totals</b>		<b>\$ 400,000</b>	<b>\$ 151,957</b>	<b>\$ 248,043</b>

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**ADDITIONAL ACTIVE GRANTS**

**Aging and Health**

**Dartmouth Medical School**

Hanover, NY

"A Program to Improve Treatment of Depression in the Elderly"

James E. Barrett, M.D.

1995; \$2,000,000; 4 years

**Society for Academic Emergency Medicine  
(The University Association for  
Emergency Medicine)**

Lansing, MI

"Emergency Care of the Elderly:  
Meeting the Needs"

Arthur B. Sanders, M.D.

1993; \$861,552; 5 years, 6 months

**Health Care Cost and Quality**

**Columbia University**

New York, NY

"The Washington Heights-Inwood Community  
Health Information System (WHICHIS):  
A Demonstration Project"

Paul D. Clayton, Ph.D.

1994; \$1,049,500; 4 years



## Grant Proposal Submission



<http://www.jhartfound.org>

THE FOUNDATION NORMALLY MAKES GRANTS to only 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 107(c)(1) of the code, or state colleges or universities. The Foundation does not make grants to individuals.

Due to its narrow funding focus, the Foundation primarily makes grants by invitation only. After familiarizing yourself with the Foundation's program areas and guidelines, if you feel that your project falls within this focus, please submit a letter of inquiry.

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.

Foundation staff can be reached at the following:

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New York, NY 10022

Phone: 212-832-7788

Fax: 212-593-4913

email: [mail@jhartfound.org](mailto:mail@jhartfound.org)

Or through our Web site:

<http://www.jhartfound.org>

Please do not send proposals by fax or e-mail.