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THE JOHN A. HARTFORD FOUNDATION 1999 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."

JAHF FOUNDERS

John A. Hartford and George L. Hartford

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

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DURING THE NEXT FEW DECADES, the number of older adults in the United States will more than double. And while they will, on the whole, have more healthy and active lives than their parents and grandparents, many will benefit from increasing doses of medical and other supportive care. To this end, our society will need more geriatricians, gerontological nurses and social workers — in other words, people with specialized training in the care of older people. Just as important, we must ensure that most doctors and other health care professionals, whatever their specialty, are prepared to understand and respond to the unique challenges posed by our aging nation.

Our Annual Report for 1999 focuses on a multi-faceted and long-term effort to ensure that more physicians, particularly those in Internal Medicine and its subspecialties, as well as other surgical and medical specialties, are geriatrically prepared. Begun in 1994 with a series of grants to the American Geriatrics Society, these initiatives are expanding the capacity and will of professional communities in many specialties and subspecialties to infuse their members with geriatric and gerontological knowledge.

The centerpiece of the subspecialty approach is the Geriatric Education Retreat or GER, an intensive, five-day meeting that convenes leaders in a particular subspecialty along with top geriatricians. Many participants emerge from these gatherings energized to play leadership roles within their institutions and professional societies. They have redesigned curricula, published articles and book chapters, even developed new research agendas. The experiences of two very successful GERs — one in Pulmonary-Critical Care and the other in Oncology — as well as the exciting follow-up to their respective retreats, are featured in this report. Information on complementary approaches in other disciplines is also provided.

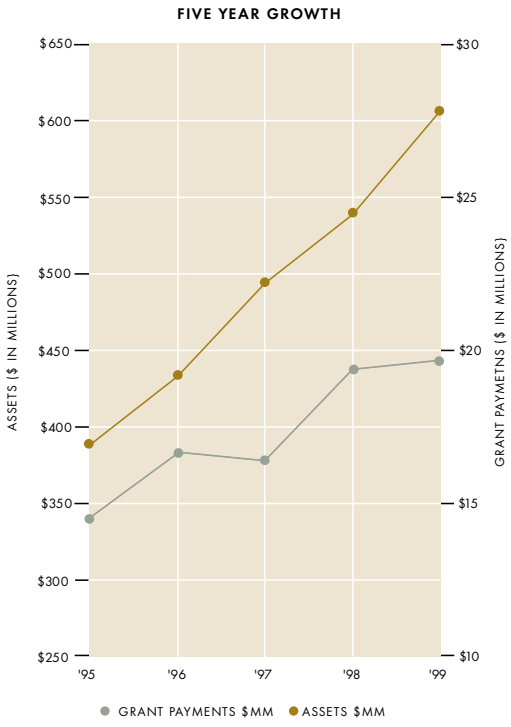
During 1999, the Trustees were proud to extend the GERs and their work with practicing physicians with a new, $2.6 million investment designed to increase the quantity and quality of the geriatrics education medical students receive. The Association of American Medical Colleges (AAMC) will lead this effort, which will provide sub-grants through a competitive process open to the nation's 125 medical schools. Funded institutions will develop new curricular models and other training products and share these innovations with the AAMC, which will in turn disseminate them more broadly.

The Trustees are also pleased to report a significant re-commitment to one of its signature strategies — the Centers of Excellence program, which began in 1988 to address another aspect of the geriatric training challenge — the critical shortage of geriatric faculty in U.S. medical schools.

During 1999, we set aside a total of $3.3 million over three years to continue to fund seven of the program's original Centers — Duke, Harvard, Johns Hopkins, Mount Sinai, UCLA, the University of Michigan and the University of Washington. In addition, we provided $2.0 million over three years to the American Federation for Aging Research to continue its work as a Coordinating Center for the program, which now includes 18 Centers of Excellence.

The Trustees are also proud to report another year of strong growth in the Foundation's assets. Total assets ended the year at $607.3 million, the highest value in a history that had seen the Foundation's endowment decline with the fortunes of the A&P Company. This closing asset value represents growth of $66.4 million for the year after grant payments and administrative expenses of $25.8 million.

Mindful of the lessons learned from the Foundation's history, as 1999 drew to a close the Trustees became concerned by the extreme valuations in certain segments of the equity market and the increasing likelihood of a reversal. Accordingly, actions were taken by the Board to position the Foundation's portfolio less aggressively. At the same time, the Trustees also recognize that the 'new economy' presents opportunities for growth. As the year 2000 begins, we remain confident we can maintain the Foundation's growth so that its grant programs will have an ever-increasing impact. A chart showing the growth in the Foundation's endowment and grant funding over the last five years appears on the right.



At our Annual Meeting, Michael D. Dingman stepped down from the Board of Trustees after two decades of service. His participation and wise counsel on our Finance Committee have been critical to the growth and success of the Foundation's endowment. His insights will be missed. At the same time, we are pleased to report that Christopher T. H. Pell, the former executive director of the Preservation Society of Newport County in Rhode Island and great grand-nephew of the founders, joined the Board of Trustees.

Finally, I would like to once again offer my thanks to all my colleagues on the Board and our staff for their hard work, commitment and accomplishments during this past year. It is a great pleasure to be a part of this superb group, and I look forward to working with them and for the John A. Hartford Foundation in the coming year.

James D. Farley

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(PHOTOGRAPH ON FOLLOWING PAGE)

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ESSAY

Integrating Geriatrics into the Medical Subspecialties and Surgical and Medical Specialties

aging and health

1. Overview and Introduction

AMERICA FACES A SEVERE SHORTAGE OF DOCTORS TRAINED to manage the health care needs of its older citizens. Today, more than 34 million Americans — 12 percent of the population — are over 65 and account for about one third of the nation's $1.1 trillion health care bill. Within the next 50 years, the number will triple to 93 million, an unprecedented demographic age wave. The ramifications of this shortage are financial as well as medical. Caring for older adults, per capita, is currently four times as costly as caring for those under 65. The aging of America will put unprecedented pressure — financial and medical — on our health care system.

Dr. William J. Hall

"By the year 2020, we could have 40 to 50 percent of our health care dollar spent on and by people above the age of 65," says Dr. William J. Hall, Director, Geriatric Programs, University of Rochester. "The demographic change is so unique and so overwhelming — I believe it is the principal health care issue facing America."

Delivering high-quality, cost-effective care to a rapidly aging population poses a formidable challenge. Yet, there are ways to contain those costs. Among them is enriching the geriatric competence of every physician who treats the elderly. "General medicine and geriatrics must unite to improve quality and cost containment," says Dr. Richard W. Besdine, Professor of Medicine, Director of the University of Connecticut Center on Aging, and Travelers Professor of Geriatrics and Gerontology at the University of Connecticut Health Center.

Dr. Richard W. Besdine

Who Cares for the Elderly

Americans over 65 receive their health care in many different settings, under many different forms of insurance — or lack thereof — from many different providers. It is not uncommon, especially for those in their eighties and nineties, to regularly consult with and receive treatment from half a dozen sub-specialists and specialists, in addition to their primary care doctors.

Physicians who provide day-to-day health care to the elderly are, for the most part, either in Internal Medicine and its Subspecialties (endocrinology, cardiology, oncology, rheumatology, nephrology, gastroenterology, immunology, pulmonary-critical care) or such other Specialties as anesthesiology, emergency medicine, general surgery, thoracic surgery, orthopedic surgery, gynecology, ophthalmology, otolaryngology, physical medicine and rehabilitation and urology.

Yet, paradoxically, though the waiting rooms of specialists and subspecialists are increasingly filled with patients over 65, the reality is that these physicians are largely lacking in specific skills relevant to the care, treatment and special needs of the elderly. The reasons are many, chief among them being the deficiency or total absence of gerontology (the study of the aging process) or geriatrics (the medical care of the elderly), at the undergraduate, graduate and post-graduate levels of education in the medical and surgical specialties.

This absence reflects, in part, the values of American society.

"In medicine, as elsewhere," notes Dr. Christine K. Cassel, Professor of Geriatrics and Internal Medicine, and Chair of the Department of Geriatrics and Adult Development at The Mount Sinai Medical Center in New York, "old people and their illnesses are not deemed to be as interesting as those of younger people."

Moreover, observes Dr. Andy Lee, Associate Professor of Ophthalmology, Neurology and Neurosurgery at the University of Iowa Hospitals and Clinics, "We don't even know what we don't know." That is to say, though highly skilled in their disciplines, specialists tend to be profoundly unaware that their lack of geriatric knowledge may be deleterious — even life threatening — to their patients. Many, in fact, consider themselves experts in elder care simply because so many of their patients are over 65. Nothing could be further from the truth.

The Needs of the Elderly and Specialty Medicine

The elderly pose an enormous challenge to the health care system for a variety of reasons, including the combination of — and interplay between — their medical and social needs. "Geriatrics requires a set of knowledge, attitudes and skills that are extremely broad," says Dr. Wendy Levinson, Professor and Chief, Division of General Internal Medicine, University of Chicago Department of Medicine. "They include a lot of concern and attention to issues that doctors have considered outside their domain, such as dealing with caregivers, with where a person is living and how that is affecting the patient."

If there is inadequate attention to support services in the home, or if, as is frequently the case, there is inadequate monitoring of multiple medications, a frail, elderly patient may decline.

"Approximately 19 percent of hospital admissions of older persons are attributable to adverse drug reactions," reports Dr. Kenneth Brummel-Smith, Medical Director, Long Term Care Division, Providence Health System, and Associate Professor of Medicine and Family Medicine, Oregon Health Sciences University. "And each year, drug effects account for a significant number of falls that necessitate operative repair of fractures."

The elderly also tend to have multiple medical problems which, typically, are chronic rather than acute. Yet our health care system, from medical school to Medicare, is built around, rewards and focuses on the care and treatment of acute illnesses and injuries typical of younger patients. As a consequence, we graduate increasing numbers of specialists and subspecialists who are more skilled in "high tech" interventions than in techniques required for dealing with older patients, including such "low-tech" skills as doctor-patient communications.

Dr. Wendy Levinson

"If you listen to doctors talk to their patients as I have," says Dr. Levinson, who has worked extensively in this area, "it's clear they really do not address anything psychological or social."

Geriatricians, of whom there are about 9,000, are trained to look at the whole person and take a multi-disciplinary approach to care. "The essence of geriatrics," says Dr. David Solomon, Professor Emeritus, Medicine/Geriatrics, UCLA School of Medicine, "is the management of complexity." Geriatricians help to prevent common problems in the elderly, including unwanted aggressive treatment, adverse drug events, depression, immobility, dehydration, pressure ulcers, pneumonia, inappropriate bladder catheterization and malnutrition, among others.

Dr. Kenneth Brummel-Smith

Specialists and subspecialists, of whom there are tens of thousands, are largely trained to examine and treat a patient's parts. Today, they function not only as consultants to primary-care physicians, the front-line doctors who treat the elderly, but they frequently assume primary responsibility for the clinical management of their over-65 patients, especially when it comes to cancer patients and/or those with chronic heart or lung disease.

"The advances of medicine are coming so quickly," says Dr. Cassel, "that we are going to need a lot of highly specialized physicians comfortable with caring for older people. There is so much to offer from specialty medicine to improve quality of life for people as they age — but you've got to understand the underlying aging process and the geriatric care issues of multiple co-morbidities in addition to whatever is your specialty area."

"More and more studies are being published which demonstrate that, just as children are not little adults, the elderly, medically and clinically, are very different from younger adults," notes Dr. Solomon.

At present, there is an imbalance between the needs of our aging population and the skills of those who treat them. The compartmentalization of modern medicine has produced world-class specialists and subspecialists, but at the same time, it has created an environment which can be dangerous to the elderly, one in which "successful" procedures may cure the disease but diminish the functional abilities and quality of life of the patient. For example, Dr. John R. Burton, Director of Geriatric Medicine at Johns Hopkins School of Medicine, recently presented to a group of immunologists the case of an 88 year old patient who had, as Burton puts it, "a typical experience for an older person in our highly subspecialty-oriented health care system. This person was a prominent individual and had access to the best. But what happened was fragmentation of care, one prescription compounding another person's prescription, the loss of function and, ultimately, the worst-case outcome."

At best, notes Dr. Solomon, "32 percent of older people leave the hospital at a lower functional state than the one with which they entered." Specialization, absent geriatric input, has further contributed to missed scientific and clinical opportunities to advance and improve older adults' health care.

Geriatrically Enriched Curriculums Needed

Clearly, to best serve the looming tidal wave of older patients, America needs more geriatrically enriched undergraduate and graduate curriculums, more geriatrically competent adult physicians of all types, and more geriatric training programs for practicing specialists and subspecialists who treat older patients for fractures and falls, for pneumonia and glaucoma, for depression and hypertension, for cancer and heart disease.

In short, increasing the quantity and quality of geriatricians, while vitally important, is not enough. "During the last 20 years there has been a major effort to establish the discipline of geriatric medicine and gerontology. While successful, it's not kept up with the demographic imperative," says Dr. Burton. "The next step is to get our colleagues — all of whom deal with older people — to focus on the issue of what is special about the elderly."

Taking The Next Step — Two Hartford Initiatives

In 1994, The John A. Hartford Foundation, in an effort to bridge the present and future gap in geriatric care, launched two major initiatives whose aim is to jump-start the process of broadly disseminating geriatric knowledge, attitudes and skills among specialists and subspecialists. These initiatives represent a combined commitment, over the last five years, of $7.9 million. Their strategies, goals and accomplishments are the focus of this year's Annual Report.

Launching a Paradigm Shift

Imbuing cadres of specialists and subspecialists — those to be educated and those already in practice — with geriatric principles and practices is a daunting task. It will require a major paradigm shift.

Dr. Christine K. Cassel

"Hartford is pushing a boulder uphill," observes Dr. Cassel. "I am aware of that," she adds, "because of all the negative attitudes about aging, the lack of adequate financing, and the general disease orientation of all of our medical schools. They are trying to do something that is really going to require a major culture change, so we shouldn't be surprised if it doesn't happen overnight."

Effecting profound and lasting change is, indeed, a slow process. The Foundation can help launch the process by its sustained commitment to — and ability to leverage — innovative ideas and models. But in the final analysis, only health care providers and their institutions can make it happen, internalizing new values, implementing new plans and transmitting them, in turn, to subsequent generations. It is too early to evaluate the long-term impact of these initiatives. At best, the changes they envision will take decades to roll out. However, we are pleased to share the program's progress to date. There is much good news to report.

2. Initiative I: Integrating Geriatrics into the Subspecialties of Internal Medicine

Internal medicine and family practice are the largest specialties in medicine. General internists and family physicians are, typically, the primary-care physicians of choice for increasing numbers of elderly Americans. However, for several decades, most physicians completing residencies in internal medicine have pursued fellowship training in medical subspecialties. Moreover, a disproportionate share of medicine's "best and brightest" have opted for the high-tech, procedure-intensive subspecialties, such as cardiology and pulmonary-critical care medicine, which are highly rewarded and highly respected. This has resulted in a progressive disassociation between talent — qualitative and quantitative — and need, in terms of health care for the elderly.

In 1994, to increase subspecialists' geriatric competency, the Hartford Foundation provided a grant to the American Geriatrics Society (AGS) to develop and implement a decade-long program to integrate geriatrics into the medical subspecialties. The program has been administered by the Wake Forest University School of Medicine, and directed by Dr. William R. Hazzard, past-president of the AGS and former chairman, Department of Internal Medicine of the Wake Forest University School of Medicine.

Dr. William Hazzard

Initiative's Objectives

The program is designed to encourage and enhance collaborative relationships between geriatrics and each of the subspecialties in order to:

1. Raise awareness among professional leaders to the needs, opportunities and challenges of caring for a rapidly-growing aging population;
2. Capture the interest and support of a committed core group of informed, academic subspecialists in the development of aging research, education, and new systems of care;
3. Attract future subspecialists to the field of aging;
4. Incorporate geriatric content into the training of fellows in each medical subspecialty and gerontologize faculty to provide that training;
5. Augment geriatric content in certifying examinations developed by the subspecialty boards of the American Board of Internal Medicine;
6. Disseminate geriatric content and concepts at regional and national seminars and symposia of subspecialists;
7. Encourage the publication of articles and editorials in leading journals and textbooks;
8. Incorporate more gerontological and geriatric research into the portfolios of relevant government agencies, particularly the National Institutes of Health, and non-governmental agencies, including professional organizations and foundations.

The Geriatric Education Retreat (GER)

The method adopted to effect this vast and profound culture change within the subspecialties of internal medicine is the Geriatric Education Retreat (GER). It is a total immersion approach which brings together groups of 40 to 50 leaders — geriatricians and the "movers-and-shakers" from each subspecialty — to actively participate in an intensive, collaborative five-day learning experience. Each participant brings something different to the GER table. He or she may be the chairman of a department, a training program director, on a review committee, on a subspecialty certification board, or represent a major journal or government agency. Invited participants play an active role as presenters and session leaders, and prepare a written summary of their remarks which are distributed to attendees upon their arrival.

Creating Change Agents and Change Moments

To change systems, one must change leaders, individual by individual. That is why, says Dr. Hazzard, "The GER is a leadership development strategy." The single most important task of each GER is to educate, excite and create a transformative moment — a profound, personal "aha!" — within every subspecialist who attends. "If we can capture the minds and spirit of the leaders of each subspecialty, and get them gerontologized," adds Dr. Hazzard, "then everything proceeds from there."

Planning

Mark Twain said, "It takes three weeks to prepare a good impromptu speech." Similarly, it takes months of careful preparation to create a five-day retreat which "spontaneously" produces its share of "aha's" and measurable results. About one year before each GER, a planning committee is selected, co-led by a geriatrician and a nationally respected academic subspecialist. An intense, one-day planning session takes place, devoted to drawing up the agenda and a list of invitees.

Ingredients for GER Success

The magic ingredients for a successful GER include: capturing five days of a busy person's life; removing that person to a pleasant and fairly remote resort; gathering the "best and brightest" to deliver powerful new ideas through a mix of didactic, Socratic, formal and informal interactions.

"Take one part card-carrying geriatricians, one part subspecialists turned geriatricians, and one part subspecialty leaders who are unconverted, and mix," observes Dr. Hazzard, who has been mixing and matching and presiding over the GERs for four years.

I Never Thought of That Before

A major aim of each GER is to convert the unconverted. As one GER participant wrote, "A good indication of the light bulb going off is the phrase, 'I never thought of that before.' I was pleased to hear it repeated several dozen times throughout the week." According to Dr. Hazzard, "The good news is that the light bulb seems to be going off earlier and earlier."

This may well be due to two factors: (1) with each new GER, the process of "gerontologizing" and "geriatricizing" subspecialists improves; and (2) with the flood tide of elderly patients about to sweep across the health care landscape, physicians are more receptive to the message than in previous years. In short, the timing is right.

GER Agenda

Each GER includes presentations on the following topics:

> Gerontology and geriatric medicine, including geriatric assessment, geriatric syndromes, geriatric pharmacology, team care, system issues, demography, health care organization and financing;

> Gerontologic and geriatric aspects of the subspecialty;

> Development of curricula in geriatrics for the subspeciality, with a view to its specific incorporation into both fellowship training and certifying examinations;

> Developing subspecialty faculty interested in gerontology and geriatrics, specifically, identifying career development paths and funding opportunities;

> Re-educating certified subspecialists, emphasizing continuing medical education (CME), educational materials and mini-fellowships;

> Research opportunities, including collaborative projects involving geriatrics and the subspecialty, such as "Cardiology and the Elderly Patient."

Geriatric Education Retreats (GERs) 1995-2001

To date, there have been eight Geriatric Education Retreats. Held in different venues, each GER is listed, in chronological order.

Endocrinology, Metabolism and Diabetes – Summer 1995 – Orcas Island, Puget Sound, WA. Jeffrey Halter, chair.

Cardiology – Summer 1996 – Banff, Alberta, Canada. Melvin Cheitlin and Michael Rich, co-chairs.

Oncology – Winter 1996 – Las Croabas, Puerto Rico. Harvey Cohen, chair.

Rheumatology, Infectious Diseases, and Immunology – Summer 1997 – Whistler, British Columbia, Canada. Walter Ettinger, chair.

Pulmonary and Critical Care Medicine – Spring 1998 – St. John, U.S. Virgin Islands. Edward Haponik and Leonard Hudson, co-chairs.

Nephrology – Summer 1998 – Jasper Park Lodge, Alberta, Canada. Robert Luke and Laurence Beck, co-chairs.

Gastroenterology – Spring 1999 – St. John, U.S. Virgin Islands. Phillip Toskes, chair.

General Internal Medicine – Summer 1999 – Jasper Park Lodge, Alberta, Canada. Eric Larson and Seth Landefeld, co-chairs.

Upcoming GERs.

Association of Subspecialty Professors (ASP) Leadership Conference, Cabo San Lucas, Spring 2000.

Alliance of Academic Internal Medicine (AAIM), Jasper, Alberta, Canada, Summer 2000.

Neurology and Psychiatry, Winter 2001.

Reverse GER, (Bringing Subspecialty Perspectives to Academic Geriatricians) Summer 2001

Each Geriatric Education Retreat is shaped by a planning meeting, which involves leaders from geriatrics and the discipline which is the retreat's focus, to discuss agenda and invitees. This photograph shows participants in the planning meeting which led to the General Internal Medicine Retreat some ten months later.

Pulmonary-Critical Care GER

"My experience with the Pulmonary-Critical Care GER is that the subspecialists welcomed it," recalls Dr. Cassel. "It was not a hard sales job. The first day there was this steep learning curve. They didn't think they knew it all. Mostly, they said, oh my God, of course you're right. In ICUs, for example, we are seeing more and more elderly patients, and we need to have a better understanding of where the treatment is appropriate and where it isn't, how to study these things, what's the difference physiologically. So they found it very interesting. Also, they liked the idea that there was another NIH Institute to which they could send their grant proposals."

Cassel also noted that the GER is a two-way street. "From the geriatrician's side, we learned a lot, too. Joint research ideas came out of it. People made connections that will endure. I ended up writing an article, 'Geriatrics and Anesthesia,' with an anesthesiologist from Mt. Sinai, for a professional journal, *Anesthesiology Clinics of North America,* edited by one of the critical care people at the GER."

The GER Changed My Career

To Wes Ely, 35, ten years out of medical school, the 1998 Pulmonary-Critical Care GER was a transforming event. "The GER changed my research interests considerably. Before it took place, I was pretty much a garden variety pulmonary-critical care doctor, meaning that I just took care of whatever came through the door. And while I was interested in outcomes research, I had no focus whatsoever on the elderly or those issues. The GER stimulated and lit a fire in me that said, hey, over the next 20 or 30 years, I think I should focus on investigations related to the elderly and how they are handled in the ICU during critical times of illness." Asked to present a project at the GER on mechanical ventilation in the elderly, he subsequently submitted the paper to *The Annals of Internal Medicine,* where it was accepted and published in July 1999.

"As a result of the GER, I'm not only interested in how I can get elderly patients off the ventilator sooner, but how sedatives and analgesics should be delivered to these patients. We are developing methods of tracking delirium which is so common in elderly patients who are mechanically ventilated. These patients are especially difficult to assess because they are intubated. The other topic of principal concern in my studies is the quality of their dying experience when they end up in the ICU. I'm actually doing studies to objectively measure the quality of terminal care in the ICU. There are a lot of things that we have to learn about the right ways to handle patients as they are going through a severe illness.

Dr.Wes Ely is pictured in the Vanderbilt University pulmonary clinic. He has focused his research on older patients in intensive care units since attending a Foundation-supported geriatric education retreat targeted to pulmonary and critical care medicine.

Wes Ely, M.D., M.P.H.
Assistant Professor of Medicine-Allergy,
Pulmonary and Critical Care Medicine,
Co-Medical Director, Lung Transplant Program
Vanderbilt University Medical Center

Seventy-five percent of those people might live, but one quarter or more of them are going to die, and for those people who die, you want them to have a peaceful death. Being in the ICU may be more or less peaceful as a dying experience. Inherently, one may assume that it would be more fraught with invasive procedures, but when end-of-life preferences are discussed in depth, a very peaceful process can actually result from the one-on-one nursing care and family visitation in a controlled environment."

According to Dr. Ely, who found himself to be the most junior person at the Pulmonary GER, it was the opportunity to sit with world-class pulmonary-critical care subspecialists for five days, to share their thoughts and reflect "long and hard about the issues facing us as the aging of America occurs...that really brought the whole subject alive."

If success can be measured, in part, by continuing camaraderie and esprit, then the Pulmonary GER is a model of achievement. "We've remained this tight group. What happened at the end of the GER is that we all thought, 'Let's make this happen, let's learn how it's different for the elderly, how it should be handled differently and let's really make an impact'...I'm not just blowing smoke. It was neat. It was really neat."

GER As Catalyst

Since the Pulmonary GER took place, its participants have, in fact, continued to get together at national meetings dedicated to keeping the "spirit of St. John" alive and to formalizing follow-up plans. They include book publications through the American Thoracic Society and the American College of Chest Physicians, and the development of a research agenda. "When we see one another," says Dr. Ely, "there's a special bond. We recognize that all of us have this unique interest, and that a lot of people are starting to share that interest, but that we had a catalyst. The GER served as a tremendous catalyst to catapult our own ideas and initiatives in the direction of aging and how it relates to pulmonary diseases."

Looking ahead in his field, Dr. Ely hopes he and others will do the appropriate outcomes research to document with data how age affects outcome and how age should be incorporated into patient management. "If you practice evidence-based medicine and enhance decision-making with data — the facts are where the rubber hits the road." Dr. Ely recognizes that integrating geriatrics into his specialty is "at its infancy," but predicts that, "the GERs are going to get phenomenal returns."

The Oncology GER

Another highly-successful model — in many respects the most successful GER of them all — is the Oncology GER. It took place in the winter of 1996, and demonstrates the true power of the Geriatric Education Retreat to transform participants.

Cancer Is A Disease of Aging

Cancer is a disease of aging: 60 percent of new cancer cases occur in Americans 65 and older, and more than 50 percent of cancer deaths occur in those 70 or older. Therefore, with the aging of America, experts are predicting a virtual epidemic of cancer in older patients. Despite this, until recently, there has been little focus on the issue of cancer in the elderly, either in terms of research, training, treatment or clinical trials.

Dr. Harvey Cohen

"A lot happened, directly and indirectly, because of the milieu established at the GER," acknowledges Dr. Harvey Cohen, Director of the Center for the Study of Aging and Human Development, and Chief of the Geriatrics Division, Department of Medicine, Duke University Medical Center, who chaired the retreat. Dr. Cohen, who specialized in hematology and oncology following his original training in internal medicine, has been doing clinical research in the area of older cancer patients since the early 1980s. "Back then," he recalls, "nobody was interested in the subject. It was a big void." Interest had grown, but slowly, which is a key reason he and his colleagues put together an ambitious GER agenda.

Right Time and Right Place

The GER generated high hopes and a "special chemistry" between oncologists and geriatricians from the very beginning. "I think it may partly have been due to its taking place at the right time and place," says Dr. Cohen. Others agree, including Dr. Hall, who sees similarities between the two fields. In addition to the fact that both oncologists and geriatricians are about to be overwhelmed by increasing numbers of patients in their 60s, 70s and 80s, they share similar goals, thinking more in terms of extending "quality of life" than "cures." Also, until recently, all NIH studies excluded anyone over the age of 70. In short, both groups recognize that the need is great, the task broad and the army exceedingly small.

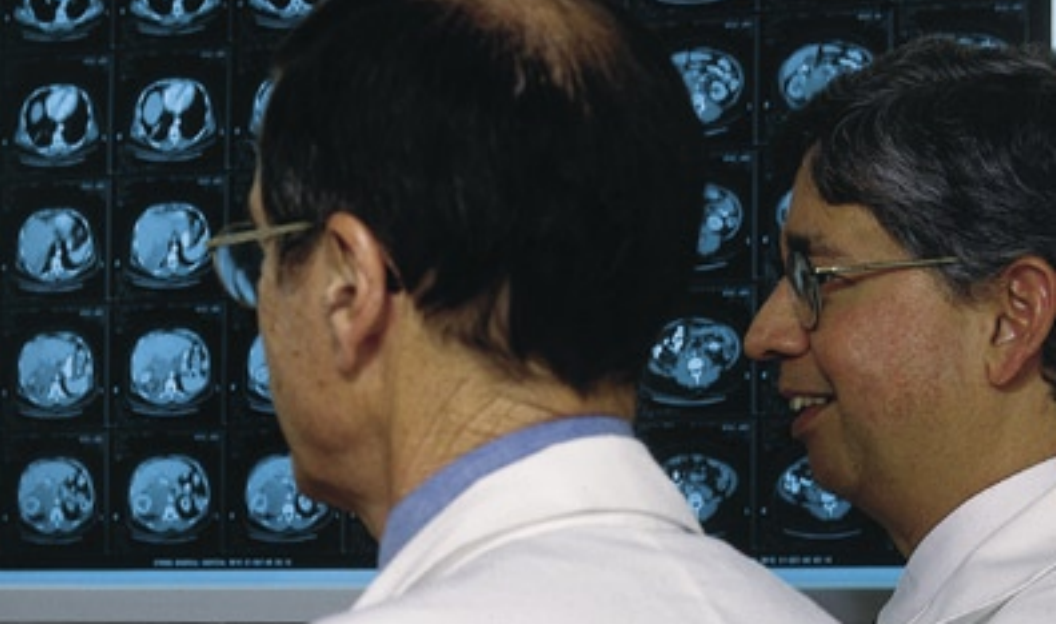
In the photo on the left, Dr. John M. Bennett (extreme left) and Dr. Deepak Sahasrabudhe (right center) discuss test results with patient Louis Falzer (extreme right) at the University of Rochester Cancer Center, as Hematology-Oncology Fellow, Dr. Alex Solky (left center) looks on. In the second photo, Dr. Bennett (left) and Dr. Sahasrabudhe (right) discuss Mr. Falzer's tests with him.

"The enthusiasm generated by the interaction," recalls Dr. John Bennett, Professor of Medicine, Emeritus, The Hematology Medical Oncology Unit, Cancer Center, University of Rochester Medical Center, "demonstrated there was clearly both an educational need and a research need to foster more interaction between geriatrics and oncology." Specifically, it identified the need for increased training for oncologists in geriatrics, as well as the inclusion of more older people in cancer-related clinical trials.

GER Ignites Further Activities

The energy and enthusiasm did not diminish after the GER itself ended. Instead, as hoped, it ignited further activities and actions, including symposia on geriatrics in oncology and hematology in each of the major national meetings of the oncology societies. Dr. Cohen chaired one. Dr. Ludovico Balducci, Professor of Medicine, University of South Florida College of Medicine, who was also a retreat participant, chaired another. Dr. Balducci, also Chief of Oncology at James A. Haley Veteran's Hospital, Tampa, Florida and program leader of the Senior Adult Oncology Program, has focused his research on cancer and the elderly for the last 10 years.

"If you take 100 people between the ages of 70 and 90," he points out, "you may find people who are in excellent health and those who are extremely frail and close to dying. One of the first challenges of geriatric oncology is to try to sort out this diversity. Cancer may behave in a different way biologically in younger and older individuals, which therefore affects how to run clinical studies of cancer treatment in the older person and how to create a reasonable plan for cancer management. And that reconnects to the issue of diversity. In other words, the treatment of the older cancer patient has to be individualized. And how are you going to establish categories of older people based on their function, on their co-morbidity, on their cognition, on their emotional status, on their social support? How can you decide, in short, which patients are most likely to



benefit from treatment, which may be damaged by the treatment, and for which patients treatment may be futile? These are among the critical challenges still to be addressed."

To Dr. Balducci, a key achievement of the GER, in addition to bringing together experienced people in the field of cancer and the elderly to come up with specific plans, was generating interest in studying the issue of cancer and aging among major authorities in the field. They included: outgoing and incoming presidents of The American Society of Clinical Oncology (ASCO); representatives of the National Cancer Institute (NCI); the National Institute of Aging (NIA), the American Cancer Society (ACS), and chairs of the three major cooperative groups which conduct clinical trials.

"The GER has given a tremendous boost to the field," says Dr. Balducci. "Before, we were voices speaking in the desert. Since the retreat, there has been a real concerted effort to get things done."

"We turned a lot of key people on," agrees Dr. Cohen. "I was surprised by how many people got really energized, and I'm gratified by all the activity that has taken place as a result of the retreat."

Oncology-Geriatrics Joint Fellowship Training Model

The idea of a pilot project to develop combined geriatric and oncology training programs — first raised and discussed as an unexpected spin-off from the original GER agenda — has subsequently been nurtured to fruition by Dr. Bennett.

Shortly after the GER, using follow-up funding available through the original AGS award, a meeting was convened of geriatrics and oncology faculty from five academic medical centers which had participated in the retreat (Arkansas, Duke, South Florida, Rochester and Wake Forest) to discuss how to develop and implement a combined training program. Following the meeting, Dr. Bennett led further activities, including the development of a proposal to Hartford to support further efforts.

Oncology GER Outcomes

1. The American Cancer Society devoted a major portion of its October 1997 journal, Cancer, to summarizing the retreat, which drew a great deal of interest and attention. Thirteen papers on Aging and Cancer, originally delivered at the GER, were published, with an introduction by Dr. Hazzard on the overall Hartford Subspecialty Initiative. In addition, articles have appeared in The Journal of Cancer Pharmacology and The Journal of the National Cancer Institute.

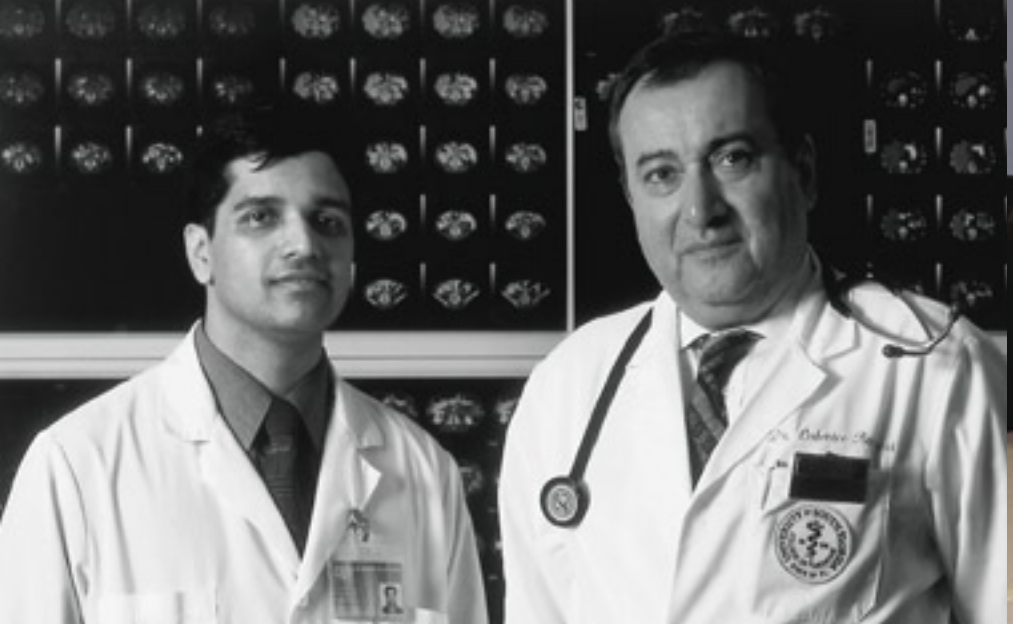
2. In 1997, the President's Cancer Panel, half of whose participants had attended the GER, focused on issues relating to older patients.

3. A joint task force formed between The American Society of Clinical Oncologists (ASCO) and the AGS, was charged to develop a curriculum for Oncology fellows and practicing physicians. ASCO also established an ad-hoc committee on aging, which has led to planning for new educational sessions on geriatrics at the Society's meetings, and support for enriching the geriatric content of the oncology component of the certifying examinations administered by the American Board of Internal Medicine. In fact, every year for the last two years, during the general meeting of the American Society of Clinical Oncology (ASCO), there has been at least one education symposium on cancer and aging. It is now, in fact, a regular topic.

4. Every major cooperative oncology group initiated an aging committee to run clinical trials focused on cancer in the elderly.

5. The National Institute of Aging and the National Cancer Institute have issued a number of Request for Proposals (RFPs) to study the pharmacology of anti-cancer drugs in older people.

6. A project to develop joint fellowship training models in oncology and geriatrics has been launched. (See text, left.)



Dr. Ludovico Balducci (right), at the H. Lee Moffitt Cancer Center and Research Institute, Tampa, Florida, with Hematology-Oncology Fellow, Dr. Santosh Nair (left).

In June 1998, the Hartford Foundation approved a grant of approximately $754,000 (over two and a half years) to coordinate the development and pilot testing of a joint fellowship training model in geriatrics and oncology in diverse settings. The project is co-directed and managed by Dr. Bennett and Dr. William J. Hall, Professor of Medicine and Geriatrics at the University of Rochester School of Medicine and Dentistry.

An additional seven centers (Chicago, Columbia-Cornell, Harvard, Johns Hopkins, Michigan, UCLA and University of Washington) agreed to participate in the planning process. They formed a consortium of the nation's leading geriatrics and oncology training and research programs to carry out the project. They included: Wake Forest, Columbia, Duke, Harvard, Johns Hopkins, the Universities of Arkansas, Chicago, Michigan, Rochester, South Florida, Washington and California, Los Angeles. Twelve fellowship directors from both disciplines, plus representatives from the National Cancer Institute, National Institute on Aging, and the American Board of Internal Medicine, held a successful retreat, whose agenda included:

> developing curriculums and rotations for the training;

> identifying research opportunities and funding for the trainees;

> working with relevant boards to ensure that dual certification will take place for those who complete the program.

The result: a new and highly-promising joint-training proposal, particularly timely because of the recent reduction in the length of geriatric fellowships — from two years to one, after a three-year internal medicine residency. While three years of fellowship training is typical for oncology certification, it can be combined with geriatrics to enable fellows to gain dual certification with no increase in training time beyond that currently required for oncology alone.

Representatives of the American Society of Clinical Oncology (ASCO) meet with joint fellowship training project leaders to plan a two-day Geriatric Oncology Symposium, to be held in conjunction with ASCO's Fall 2000 Educational Conference. Seated (left to right) are: Dr. Joanne E. Mortimer, Professor of Medicine, Washington University School of Medicine, St. Louis, who chairs the Oncology Training Program Committee of ASCO; Michele K. Dinkell and Laura K. Ulepic, Director and Assistant Director, respectively, of the Education and Training Department of ASCO; Dr. William J. Hall and Dr. John M. Bennett, co-directors of the joint training project.

Joint Fellowship Initiative Progress To Date

Seven medical schools have received joint-training model development awards (Harvard, Duke, Rochester, Mt. Sinai and the Universities of S. Florida, Arkansas, and Chicago), and others are in the process of coming aboard. Site visits of funded programs are under way, including a model program led by Dr. Balducci.

An innovative six-year combined Internal Medicine Residency and Medical Oncology geriatric training program has been initiated to attract M.D./Ph.D. candidates. It has recruited its first candidate in Rochester.

The project group is working with the American Board of Internal Medicine to obtain formal listing of this new, combined speciality certification.

The American Society of Clinical Oncology (ASCO), with 12,000 members, plans to jointly sponsor a two-day symposium on Geriatric Oncology in November 2000.

The group is working with the American Cancer Society, which "strongly endorses the geriatric oncology training program," according to Dr. Harmon J. Eyre, its Executive Vice President for Research & Medical Affairs, to persuade the ACS to help fund future fellowship programs and target some of its research grants toward cancer in the elderly.

The project is expected to yield a model for efficient production of geriatric oncologists who will be uniquely positioned to train medical students, residents and fellows in geriatric oncology, and to ensure that cancer research and treatment agendas recognize the special needs of older adults. They will be at the cutting edge of a future generation of research-oriented faculty in a field which will grow in importance as the population ages.

Role of GER: A Good Beginning

"I think we captured the attention and recognition in the oncology community at a modest level," says Dr. Cohen. "It's a good beginning. We also need to start doing more things that will get at the current practicing physician; we need to keep encouraging research, so there is more and more data to bring to treatment decisions about appropriate ways to treat cancer in older people. Without the Hartford Foundation, none of this would have happened. They have absolutely provided the leadership, both intellectually and tangibly. I think we've gotten the right thing to do, but we need to keep plugging at it. You don't just convert people overnight."

Follow-Up Activities

Built into each GER are plans for follow-up activities, programs, and concrete "products." Since the Initiative began, accomplishments big and small have taken place. They include:

1. **Journal articles, editorials and book chapters,** which have appeared in such publications as:
   a. Clinical Infectious Diseases, an official publication of the Infectious Diseases Society of America, devoted a major portion of the publication to 11 papers from the Rheumatology, Infectious Diseases and Immunology GER, plus a detailed report on the mission and strategies of the Hartford Initiative, by guest editors Drs. Kevin P. High and Thomas T. Yoshikawa;
   b. American Journal of Geriatric Cardiology and the Journal of the American Geriatrics Society both published a joint position paper written by the Council on Geriatric Cardiology and the American Geriatrics Society;
   c. Chapters in three major textbooks on diabetes, written by GER participants on aging;
2. **Presentations and symposia at subspecialty society regional and national meetings.** They have taken place at the Annual Meetings of the Association of Professors of Medicine, the American College of Physicians, the American College of Cardiologists, the Annual Meeting of the American Thoracic Society, and four regional diabetes conferences, among others;
3. **Curriculum development and joint fellowship training.** A joint geriatric cardiology curriculum for distribution to all fellowship programs, and a joint Endocrinology/Geriatrics fellowship program at the University of Michigan have been developed;
4. **Research agendas to be forwarded to the NIH, to industry, to non-profit organizations, foundations and professional associations.** For example, a gastroenterology-geriatrics task force within the American Gastroenterology Association is now focusing on clinical and basic research, training and curriculum needs. In addition, the American Heart Association is examining existing databases relevant to geriatric cardiology to assess the current state of knowledge and identify areas where additional research is needed. It is doing so principally through sponsorship of a conference on "Existing Databases in Geriatric Cardiovascular Disease and Stroke;"
5. **Formal endorsements and support from a variety of organizations.** These include, among others, the American College of Physicians, and the Residency Review Committee of Internal Medicine;
6. **Assessing the progress of each attendee, 6 to 12 months later, in achieving GER goals.** Over 65 percent of Cardiology GER participants, for example, reported that they had been increasingly involved in geriatric cardiology initiatives since the retreat.

Common GER Themes

Common themes and follow-up activities have emerged from every retreat.

Most importantly, each GER has identified issues and opportunities for leadership relevant to the broad task of caring for elderly and aging patients, of which participants would have remained unaware, had they not attended.

Each GER has generated recognition of specific research needs within its subspecialty for projects focused on clinical and scientific aspects of aging.

Each GER has developed tactics and strategies to disseminate and promulgate geriatric issues.

Each GER has recognized the need for individuals equally adept in geriatrics as well as a particular subspecialty.

Each GER has also recognized the need for geriatrics-oriented national research networks and registries for specific areas of research, such as geriatric oncology.

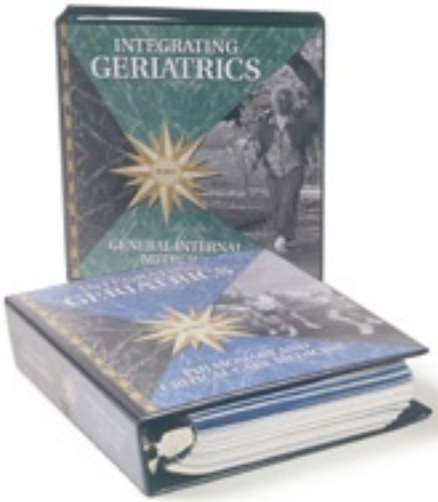
Looking Ahead

The subspecialty effort continues to gain momentum and take on a life of its own within each discipline. Lessons learned in one subspecialty — whether in curriculum development, joint training programs, clinical and research agendas, case-based teaching modules — can be applied to other subspecialties.

GER participants recognize that this is the beginning of a long process of cross-fertilization, and are encouraged by the enthusiasm and energy already engendered. "A big part of these meetings is bringing people together, helping to build liaisons and partnerships," says Dr. Hazzard.

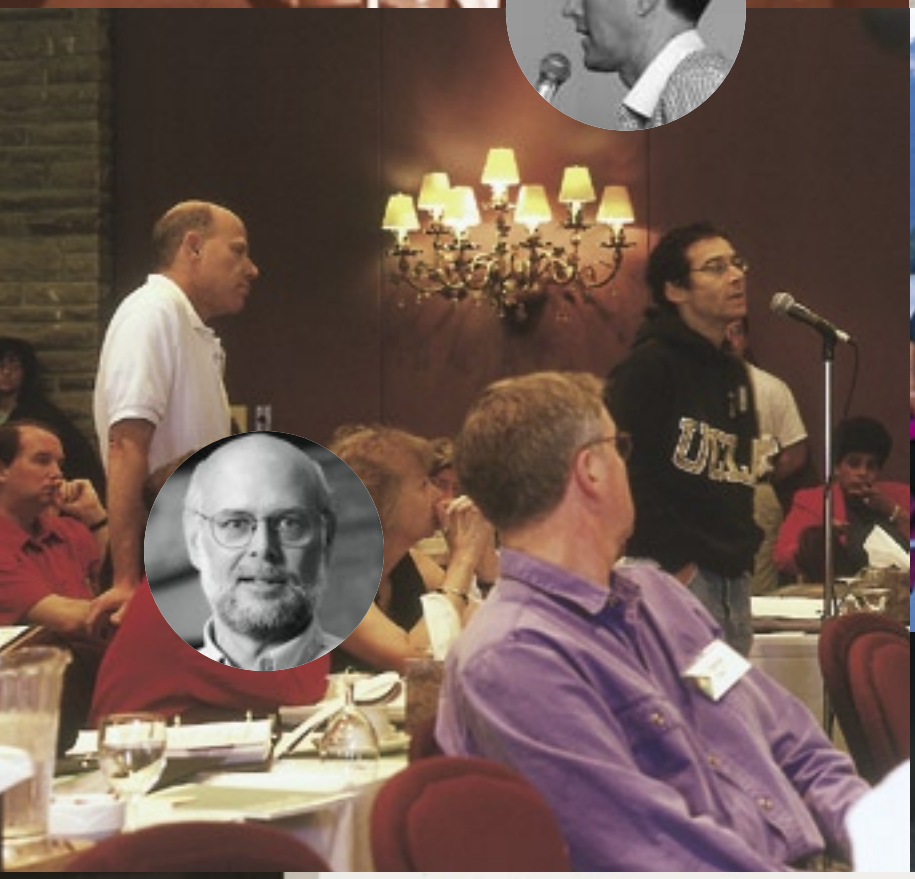
His assessment of the progress to date is both optimistic and realistic. "The overall results have been amazing. However, I think we are on our own ten yard line. We've still got 90 percent of the way to go."

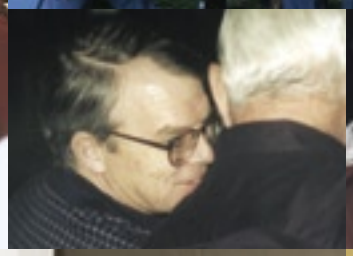
In the final analysis, lasting change can only derive from and be championed by individual leaders in Internal Medicine and its subspecialties. Once an oncologist or cardiologist sees the light, and progresses from saying, "I don't need geriatrics to take care of my older patients," to its opposite; once that physician further grasps the enormous scientific and clinical opportunities within the field, as well as the burgeoning numbers of older people who will soon be seeking treatment, then the personal process of transformation is complete. Eventually, over time, the "geriatricized" or "gerontologized" subspecialist who has internalized the message will create a growing cadre of converts who, in turn, will proselytize and transform the subspecialty's total culture and practice. Prompted, prodded and inspired by the Hartford Initiative, each will carry forward the spirit and message of geriatrics to colleagues past, present and future.



General Internal Medicine GER

The Geriatric Education Retreat (GER) focusing on the relationship between Geriatrics and General Internal Medicine took place in Jasper, Alberta, Canada, August 7th-12th, 1999. The GER included topics such as demography, health promotion/disease prevention, geriatric assessment, geriatric syndromes, interdisciplinary teamcare, physician:patient communication, health system and service organization, ethical issues, etc. Formal and informal discussions throughout the week covered the academic research, physician training, patient care, and financing aspects of these issues.






Clinical Domains
GIM
Geriatrics
•Long term care
•Home-based care
•Team-based care
•Geriatric syndromes
•Multiple co-morbidities
•Frailty

3. Initiative II: Increasing Geriatrics Expertise in the Surgical and Medical Specialties

EACH OF THE SURGICAL AND MEDICAL SPECIALTIES has its own attitudes, practices, customs, curriculums, professional organizations, certifying boards, etc. Given the enormity of the task of increasing geriatrics knowledge, training and practice in these wholly separate and diverse cultures, the strategy chosen to achieve success is a bottom-up, infiltration process rather than a top-down immersion one.

In 1994, the Hartford Foundation formally launched the Specialists Initiative, which is administered by the American Geriatrics Society (AGS). It is co-directed by Dr. David H. Solomon, Professor Emeritus of Medicine/Geriatrics, UCLA School of Medicine, and Dr. John R. Burton, Director of the Division of Geriatric Medicine and Gerontology and Mason F. Lord Professor at the Johns Hopkins University School of Medicine.[1] AGS staff coordinate meetings, provide information and program support for participants, and publish quarterly newsletters about Hartford-supported initiatives.

Five specialties were selected to participate in the first phase of the project — emergency medicine, general surgery, gynecology, orthopedic surgery and urology — with the following goals:

- to improve the amount and quality of geriatric education received by residents in these specialties;
- to identify and support specialty faculty in promoting geriatric training and research within their own professional disciplines; and
- to assist professional certifying bodies and professional societies in improving their members' ability to care for older patients.

1. They succeeded Dr. Dennis W. Jahnigen, Goodstein Professor of Geriatric Medicine, Director of the Center on Aging at the University of Colorado Health Sciences Center, and past president of the American Geriatrics Society, who died on July 5, 1998.

Changing the Paradigm Within Professional Societies

The most influential organizations within each specialty are its professional societies. Therefore, the number one objective of the initiative is to find new ways to focus the attention of the major professional societies on geriatric issues within each specialty, or as Dr. Solomon puts it, "Changing the paradigm within the professional societies."

Each society is, in effect, an educational institution. That is why, for example, one is called the American College of Obstetrics and Gynecology, another, the American College of Surgeons. It is where new programs are disseminated to institutions around the country. It is where, at annual meetings, intense education takes place. It is where new ideas have the biggest impact.

The initiative provides project support to national organizations in each target specialty to develop and disseminate curriculum and training materials, organize educational symposia and geriatric interest groups, sponsor resident/fellow research or senior investigator awards, and review their boards' certifying examinations for content relevant to older adults. It supports liaison activities between the AGS and other leaders in organized medicine, including the Association of American Medical Colleges, American Medical Association and National Board of Medical Examiners.

In 1997, the Foundation extended its support to reach specialists in anesthesiology, ophthalmology, otolaryngology, physical medicine & rehabilitation, thoracic surgery and other specialties. In addition, to enhance the project's reach and effectiveness, other program features were added. They included:

> developing a core geriatrics curriculum;

> providing coordinated consultation and outreach programs to assist with residency training on the national and local levels;

> providing faculty leadership and curriculum development;

> holding an annual interdisciplinary leadership conference.

The New Frontier of Geriatrics

Dr. Solomon who, in the late 1970s, helped to pioneer the acceptance of geriatrics as a specialty and, with others, "plotted to get geriatrics on the educational map," is now personally convinced that increasing geriatric expertise in the specialties is not just important, "It is the new frontier of geriatrics."

Dr. David H. Solomon

"The diseases that accumulate in older people — in an exponential incidence curve — require treatment by a variety of specialists. And the more aging-associated diseases patients have," he adds, "the more specialists they are going to come in contact with. Technology has advanced so much in the surgical and procedural specialties that a great many more people at advancing ages are eligible for surgery and other interventions."

Over 40 percent of acute-care hospital beds, for example, are occupied by those over 65. And in 1996, the last year for which figures were available, 23 percent of those over the age of 65 were having an operative procedure.

Dr. John R. Burton

"In the 1970s, when I was in training and Chief Resident in Medicine at Hopkins," says Dr. Burton, "the average age of the patients I took care of was 52, and they stayed in the hospital 14.5 days. Now, the average age is 73 and they are in the hospital for about four days. In fact, 70 percent of admissions into the medical center are people 65 and over, and the median age is 78. It's a whole different paradigm." While geriatrics is now recognized as a legitimate discipline, "We can't meet the needs," says Dr. Burton, "because we simply don't have enough people."

Surgical Specialties

The absence of geriatric knowledge in the surgical specialties is particularly worrisome to Dr. Solomon. "We have to recognize that disasters occur to older people more often in hospitalization and surgery than they do in ordinary, continuing out-patient care. The fact is that we geriatricians do very little good for our patients who — elderly and vulnerable — are admitted to surgery. The pre-operative work is done by or under the direction of a surgeon. The operation and post-operative care is carried out, for the most part, with no geriatrician around. We are trying to encourage the development of jointly administered care for older people post-operatively and, in general, within the hospital."

Dr. Burton heads up a hip-fracture service at Johns Hopkins which pioneered jointly-administered care. "It's an example of geriatrics and orthopedists coming together focused on a specific and common problem of older people, improving care and providing an excellent education in the process, so that orthopedic residents who never thought about aging, now think, 'We've got to get this person out of bed, we've got to get this catheter out and get them up.' That never happened before."

Such jointly administered care is particularly advanced in the surgical specialty of orthopedics, where hip-fracture services are, according to Dr. Solomon, "springing up all over."

Interdisciplinary Leadership Conferences

Dr. Kenneth Koval, Chief of the Fracture Service at the Hospital for Joint Diseases in New York, and Director of the Geriatric Hip Fracture Program, is an active participant in the Initiative through its Interdisciplinary Leadership Conferences. These annual Conferences play a major role in raising the awareness of leaders within the professional societies and, thus, launching the process that brings about meaningful change. They are attended by a representative from each specialty's professional society and from a national medical organization such as the AMA, by geriatricians and by AGS staff, who organize and provide ongoing support to members.

There have been three Leadership Conferences to date. "It gives us an opportunity," says Dr. Solomon, "to have leaders interact with each other, to exchange ideas, generate enthusiasm and increase their commitment. There's no substitute for bringing specialists together along with key geriatric leaders."

Orthopedics and Geriatrics

When Dr. Koval attended the first Leadership Conference, he was already involved in researching and working with the elderly. He trained at the Hospital for Joint Diseases, then did a trauma fellowship at the University of South Florida, where he dealt with healthy, active young trauma victims. When he came back to New York and tried to use the same skills and techniques, he discovered they were not working as well in the elderly.

"I learned to modify my techniques, and also decided to focus my research on the elderly. The more you write, the more you learn, and the more interesting it gets."

Dr. Koval also discovered that although orthopedics in large part deals with geriatric patients, to most of his colleagues, "Older people are not sexy. Doctors come out of trauma fellowships more interested in treating the difficult trauma cases or an injury nobody else can fix. Every resident thinks he or she knows how to fix hip fractures, which are common injuries in the elderly." However, buoyed by the Leadership Conference, where everyone was focused on "pushing forth knowledge to educate their peers," he began to see that he could "make a national impact in patient care issues," and that it was important to raise the awareness level of his professional society to geriatric issues.[1]

Dr. Koval tries to convey to colleagues at professional meetings and to students in training that the challenge is not just fixing the bone, but dealing with the whole person. "When I lecture young residents, I tell them that I've taken the most common fracture, the hip fracture, and spent my career to date trying to improve the outcomes. That involves not just orthopedics but the social-economic-functional outcomes."

The message is getting through, especially at the national level. "There has been a real change in the last five years. More and more people are interested in treating the elderly. More funds are becoming available to do research. And the American Academy of Orthopaedic Surgery (AAOS) has taken a leadership role."

In 1995, Dr. Kenneth Brummel-Smith made it clear to the AAOS Board that many orthopedic surgeons are not familiar with issues related to caring for older patients. The AAOS launched an ongoing partnership with the AGS and the Hartford Foundation to increase geriatrics knowledge among orthopedic surgeons.

1. Dr. Koval also participated in the GER on Rheumatology, Immunology and Infectious Diseases — an example of synergy between Hartford's geriatric initiatives.

Dr. Kenneth Koval is shown with Laura Landon, R.N., a nurse manager at the Hospital for Joint Diseases in New York City. He has helped to put orthopedic surgery "way ahead" of other surgical specialties in addressing the special needs of older adults.

Kenneth Koval, M.D.
Chief of Fracture Service
Hospital for Joint Diseases
Orthopedic Department
New York University

AAOS Activities

As a direct result of the Initiative, the AAOS has improved and increased the amounts of educational material directed toward the elderly. It formed a Task Force On Future Directions in Orthopedic Aspects of Aging to review AAOS' efforts with respect to health policy, practice, research and education. A Special Interest Group on Geriatrics of the AAOS is also up and running. At the 1998, 1999 and 2000 AAOS Annual Meetings, symposia and instructional courses have proliferated. They have covered such topics as: Osteoporosis and the Orthopedic Surgeon; Fracture Movement in the Elderly (moderated by Dr. Koval); and The Graying Of America and its Impact on the Orthopedic Practice. Most importantly, in 1998, the AAOS published a geriatrics curriculum, "Caring for the Aging Patient," in the *Archives of the AAOS*. This case-based learning tool is available online at the Academy's web site. "The meetings are proactive," says Koval, "and we are including test questions on training examinations, as well. Overall, orthopedics is way ahead of the other surgical specialties."

Professional Societies Progress

"When we started out, none of the societies had a committee on aging," observes Dr. Solomon. "Now, six of the major societies do — and in most of the others we are on the right path but not quite there yet." This is good news because it means that each of these societies has, at a minimum, held a major symposium on aging at annual meetings — attended by thousands — and/or published professional journals devoted exclusively to aging issues.

Professional societies, like most organizations, respond to individual leadership, enthusiasm and commitment. Ophthalmology is a good example. "The American Academy of Ophthalmology has formed a committee on aging, planned a symposium at its national meeting, developed two kinds of curriculum materials and established contacts with their Residency Review Committee and Board in a very short time," notes Dr. Solomon. "The reason is Andy Lee. He applied for one of the project's Outreach Grants and received it. He happens to be a firebrand with tremendous energy and great enthusiasm." In fact, as we will see, receiving one of the Initiative's Faculty Development and Residency Training Outreach Grants catalyzed Dr. Lee's interest in and dedication to geriatric issues.

Ophthalmology and Geriatrics

Andy Lee: From Acting Locally to Thinking More Globally

"Ophthalmology has been a geriatric-based subspecialty all along, although we have not traditionally recognized it as such," says Dr. Lee, who went to medical school at the University of Virginia, was a resident in ophthalmology at Baylor in Houston, then did his neuro-ophthalmology fellowship and post-doctoral training in neurology at Johns Hopkins. He has been on the faculty at Baylor since 1994. "A large portion of the population we serve is in the geriatric age range and most of the eye diseases that we encounter — cataracts, glaucoma, diabetic retinopathy and age-related macular degeneration — are geriatric diseases."

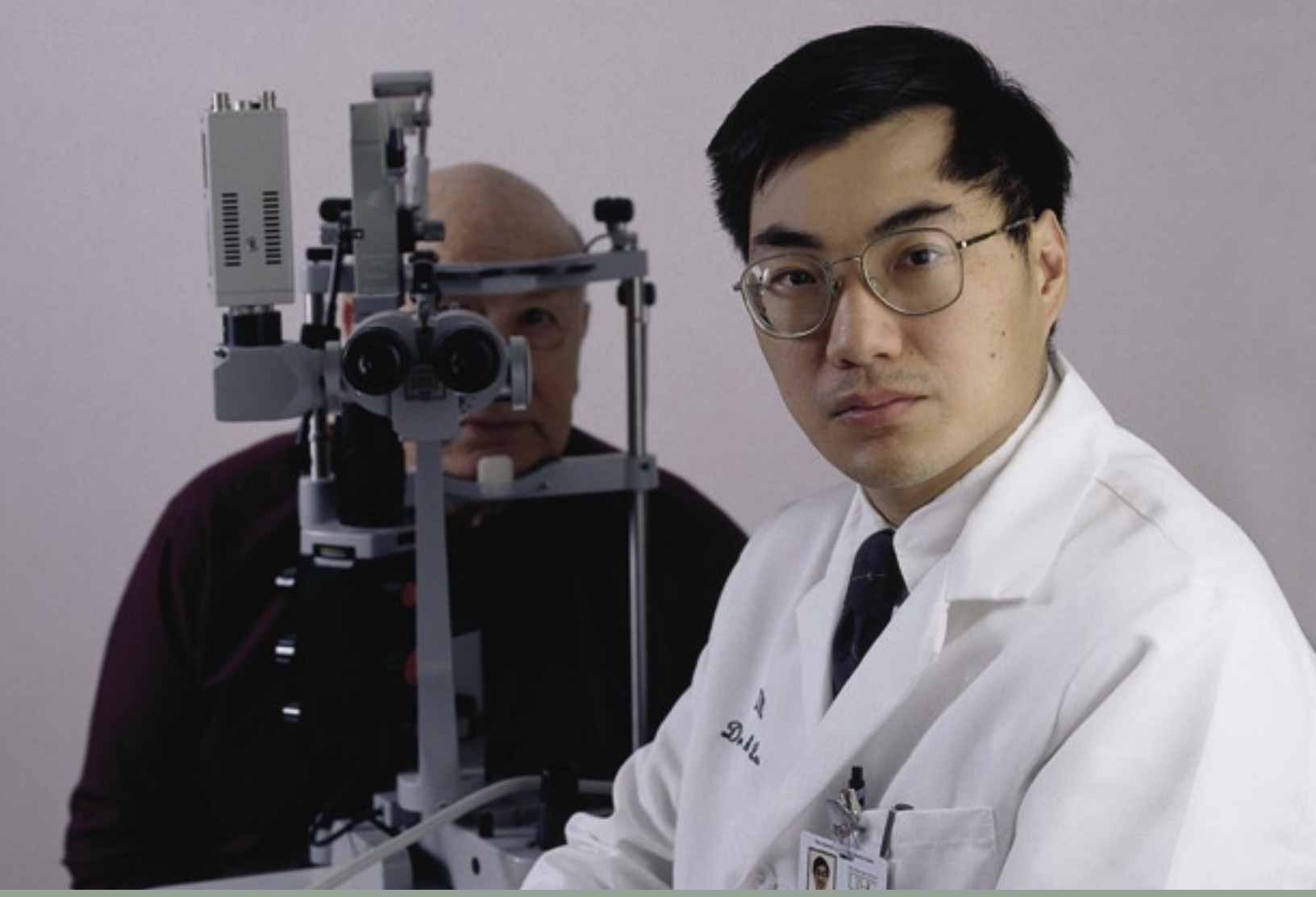
Yet, geriatrics has never been incorporated into the medical training of an ophthalmologist. The thinking within the specialty has been, according to Dr. Lee, that many eye specialists have the attitude that, "I have tons of elderly patients, why do I need someone to tell me about the elderly? We get lulled into a false sense of security."

However, as an ophthalmologist also doing neurology and neurosurgery, Dr. Lee began to increasingly realize that there was not much communication between these disciplines when it came to older patients, and that geriatric patients were not just older adults. "The functional impact of visual impairment is different in the elderly patient."

Dr. Lee applied for the Residency Training Grant when he was Associate Professor of Ophthalmology, Neurology and Neurosurgery at Baylor, and Adjunct Associate Professor of Ophthalmology and Neurosurgery at the Anderson Center in Houston.[1] As Training Program Director at Baylor, he wanted to "impact young doctors by integrating our curriculum with the geriatric curriculum." When he became a key clinical faculty member at Baylor's Huffington Center on Aging and saw the dearth of information for ophthalmology residents, it became clear to him that more needed to be done. "We needed to build on the pilot program here and increase geriatrics expertise through our national organization. It was an easy transition from acting locally to thinking more globally."

Dr. Lee joined the Initiative's interdisciplinary leadership team and participates in its annual meetings. "The chance to interact with others, to see what they've done so I don't have to relearn or reinvent the wheel, all of that has been very helpful to me." Energized by the grant and the leadership conferences, Dr. Lee is devoting more and more of his time to geriatric issues and moving into a national leadership position.

1. Dr. Lee moved in February 2000 to the University of Iowa.



Dr. Andrew G. Lee is shown with a patient in the University of Iowa eye clinic. He is a member of the interdisciplinary leadership team of the Foundation project focused on increasing the geriatric content of surgical and medical specialties.

Andrew G. Lee, M.D.
Neuro-ophthalmology
Associate Professor of-Ophthalmology,
Neurology and Neurosurgery
University of Iowa Hospitals and Clinics

He submitted a list of prospective authors and topics to the editor of the *Archives of Ophthalmology,* who has now agreed to devote a special issue to geriatrics for ophthalmologists. He serves on the American Academy of Ophthalmology's (AAO) Education Committee and has also persuaded the AAO to create a task force on aging, which he volunteered to chair. The committee's goal is to accomplish at the national level what he and others have accomplished at the grass-roots level, specifically, "to impact curriculum in our national training and credentialing organizations." Those organizations include: the Residency Review Committee which determines the standards by which residents are trained; the American Board of Ophthalmology, which determines board certification for practicing ophthalmologists; the Ophthalmology Knowledge and Assessment Program, the service testing organization for residents; and the American Academy of Ophthalmology, which provides Continuing Medical Education credits and holds annual meetings where information on geriatrics can be disseminated.

Obviously, it is a long and complex process.

Academy Is Expanding Its Horizons

The Academy is already expanding its horizons. In the curriculum area, a slide-script series, "Eye Care of the Elderly," is being developed and offered to Academy members, along with "Geriatrics At Your Fingertips," developed by the AGS Education Committee. At its upcoming national annual meeting in Dallas, typically attended by 14,000 to 16,000 ophthalmologists, the Academy is sponsoring a symposium entitled "Caring For the Needs of the Aging Ophthalmology Patient." Half the speakers will be geriatricians and half will be ophthalmologists. The papers delivered at the symposium will then be published in a key journal.

Dr. Lee's future goals for the Academy are clear. "I hope that by this time next year we will have transformed the task force into a standing committee on aging. Also, that we will have curriculum content for all ophthalmology residents in training, for our in-service examination, and that we will have an annual symposium devoted to aging issues."

Though impatient and eager to move faster toward the goal of increasing geriatrics expertise across the board, Dr. Lee is "excited and pleased" by the progress to date. "Once the American Academy took note of what we were doing and got behind it, people began to listen." The Academy is providing resources — staff, personnel, access to information and access to other committee members — that Dr. Lee did not have before it became involved.

"I think that if my project could serve as a model for other specialties, it would be for the goal of raising awareness so that the national organizations take it upon themselves and make it their project. That's what's happened in ophthalmology. From that perspective, you could count ophthalmology a success, and the cost was minimal."

Still Much To Be Done

Dr. Lee recognizes that there is still much to be done. "We're just on the ground floor. I think everybody intellectually recognizes that the baby boomers are aging, but I don't think that most doctors realize what the impact is going to be in their specialty. I hope this symposium at the annual meeting will not just increase awareness, but give ophthalmologists the opportunity to ask the questions that we haven't even thought about yet."

In terms of research, Dr. Lee would like to see more research dollars targeted to age-related macular degeneration, cataracts and glaucoma. And clinically, he would like to make sure that every practicing ophthalmologist knows that "Elderly patients are not just older adults. Obviously, you want to have the greatest good for the most number of people. But if we can convince even one ophthalmologist to be more aware and prevent even one fall or at least increase awareness of the impact of visual acuity on activities of daily living and functional outcomes in the elderly, then I think that would be a success."

Investing in Dr. Lee is "doubly gratifying," says Dr. Solomon. "When you find someone like that, you are not only getting a lot of action in a short time, but you know you are 'geriatricising' one of the future leaders in ophthalmology. We are trying to do that in every specialty."

Residency Training Outreach Program

The Faculty Development and Residency Training Outreach Program is designed to encourage graduate medical programs to integrate geriatrics into their curriculums, and create more Andy Lees. The grants provided are flexible, so that each institution can tailor its award according to its needs. That might include supporting additional training in geriatrics for key faculty members, purchasing curricular materials or developing case-based instructional materials. Today, there are 23 residency program directors in 20 institutions from 10 specialties participating in the Program, fueling projects to increase geriatrics education. They are: anesthesiology, emergency medicine, general surgery, gynecology, ophthalmology, orthopedic surgery, otolaryngology, physical medicine and rehabilitation, thoracic surgery and urology.

Integrating Curriculum Changes Into The Specialties

"More and more specialists understand that health care today is geriatric care," says Dr. Burton. "By developing, testing and field-trying curriculum changes in selected institutions," he adds, "and by getting geriatric medicine folks to connect to specialists in their own institutions — to create, for example, a geriatric curriculum in general surgery — the Initiative is accelerating the process of change."

Grants from the Hartford Foundation have supported a variety of curriculum changes across the specialties. They include the following:

- The Society for Academic Emergency Medicine has disseminated a geriatrics curriculum which is being taught at a variety of workshops and educational symposia and may soon be integrated into basic texts;
- Members of the East Carolina University Curriculum Project, co-directed by Dr. Walter J. Pories, Professor of Surgery and Biochemistry, and Sherralyn S. Cox, Ph.D., Associate Professor of Surgery, updated the new surgical resident curriculum with geriatrics information and presented it to the Association of Program Directors in Surgery (APDS). In 1999, the APDS, in turn, distributed the new curriculum to residency programs and is considering further dissemination via the Internet and a CD-ROM;
- The American College of Obstetrics and Gynecology completed and disseminated *Basic Geriatric Care Objectives for Residency Training in Obstetrics and Gynecology* to all Residency Program directors and all Ob-Gyn residents;
- The American Urological Association's Guidelines for Residency Training, for the first time in its history, will feature a separate section on geriatric urology.

Dr. Diane M. Hartmann (front), Assistant Professor of Obstetrics and Gynecology, University of Rochester, is shown here overseeing resident, Dr. Tracey Thomas-Doyle (rear), who is with an elderly patient. She is working with the Foundation project to enhance the geriatric content of surgical and medical specialties.

Thoracic Surgery Curriculum

As head of thoracic surgery at the University of Michigan Medical Center, and immediate past president of the Thoracic Surgery Directors' Association (TSDA), an organization composed of the 90 Thoracic Surgery Residency Program Directors in the United States, Dr. Mark Orringer has been "thinking about curriculum issues for the past eight years." He became interested in the Initiative's Residency Training Outreach Program as a way to incorporate geriatrics into the curriculum, and received an outreach grant in 1998.

The Management of Our Elderly Patients Can Be Improved

The incident that sparked Dr. Orringer's interest in geriatrics and personal "aha" is worth recounting.

"A few years ago," Dr. Orringer recalls, "I operated on the 80-plus year old father of a colleague. He had problems with his esophagus. The operative time was short, and the procedure went well. But after surgery, the patient was confused and put in restraints 'to protect him.' While restrained, he aspirated and ultimately died of pneumonia. Retrospectively, we missed the mark badly," says Dr. Orringer. "There's not a thoracic surgeon who hasn't mismanaged delirium, because we have not been trained to recognize it and respond with appropriate measures."

In 1998, Dr. Orringer "charged the TSDA to incorporate a unit on the elderly at the residency level." He and Dr. Jeffrey B. Halter, Professor of Internal Medicine, Chief, Division of Geriatric Medicine, Director, Geriatric Center, University of Michigan, and past president of the AGS, subsequently developed material which addresses the very issues which precipitated such a negative spiral in his elderly patient: How do you evaluate dementia and delirium? What is the difference between the two? What is the effect of aging on the pre-operative and post-operative patient? Why is it important to get elderly patients up and moving rather than into restraints? He hopes the paper will soon become a standard part of a thoracic surgeon's residency curriculum.

Dr. Mark Orringer is shown with a post-surgical patient. He has challenged the Thoracic Surgery Directors Association, which is composed of the leaders of that specialty's training programs, to increase the extent to which geriatrics issues are addressed during their residents' training.

Mark Orringer, M.D.
John Alexander Distinguished
Professor and Head
Section of General Thoracic Surgery
University of Michigan Medical Center

"We need to develop patient scenarios, clinical scenarios, living case studies for our practicing physicians," says Dr. Orringer, clearly fired up on the subject and willing to take a leadership role. For example, as head of outreach of another professional organization, the Society of Thoracic Surgeons, he recently led a postgraduate session on the elderly. More importantly, he is developing curriculum software — an interactive CD-ROM — with his outreach grant funds. "The potential for recognizing the importance of principles of geriatrics in our thoracic surgery patients would not even exist without the Hartford Foundation," says Dr. Orringer. "They are really pivotal in this. I recognize that it is a slow, slow process, but we may truly be opening the door to an important body of knowledge which we have simply been missing in our educational process as surgeons."

Long-Term Vision and Commitment

Dr. Burton acknowledges that getting specialty leaders committed to infiltrating their boards and annual meetings is a slow process. "It takes long-term vision and commitment. However, a sustained effort over time is really what it will require to change things, to create a groundswell."

Dr. Solomon concurs. "If we look back to when this program began, and look at the ten specialties we're dealing with, it's clear that the initiators of this program, Dennis Jahnigen and Patricia Connelly, started from zero. There was nothing going on, it was a barren wasteland, which was very reminiscent of where we were in geriatric medicine in the late 1970s. We've been through this before and we know that it takes a long time. Fortunately, the Hartford Foundation understands and accepts that."

4. Conclusion

THE GOAL OF INTEGRATING GERIATRICS into the medical subspecialties and relevant specialties — driven by the financial and medical implications of an unprecedented baby-boom juggernaut — is not a choice, but an imperative.

If the short-term strategies of each Hartford/AGS Initiative are radically different, their long-term goals are not. Whether through an intensive immersion process or through infiltrating and influencing professional medical societies, whether through top-down or bottom-up leadership, the aim is to improve the quantity and quality of geriatric education for subspecialists and specialists alike, and thus improve the quality of care for older Americans.

Both strategies require energized, committed individuals willing to lead the process of change. Both strategies require professional societies and accrediting organizations willing to take ownership of the idea that geriatric knowledge is essential to the research and practice of quality medicine in the 21st Century. Both strategies require that the "best and brightest" fill the leadership roles initially supported by the Foundation and its AGS colleagues.

As we enter the new millenium, we are heartened by the many changes — personal, organizational, governmental — we have already witnessed over the past half decade. We are proud of the Foundation's role in jump-starting the process of change within the subspecialties and specialties. We are confident that, in time, the seeds planted by these two Initiatives will take root and become the accepted practice of tomorrow. We look forward to that transformation, so urgently needed, in the health care environment, and to all the benefits — to patients, physicians and basic science — it will bring.

In ten years, the baby boomers will be 65 and eligible for Medicare. We have met the future, and it is us.

1999 Grant Descriptions

To meet the ongoing health care needs of today's – and tomorrow's – elders, the Foundation awarded in 1999, 24 grants and amendments under its Aging and Health program totaling $17,090,935.

Centers of Excellence Program

In 1988, the Foundation initiated its first Centers of Excellence (CoE) program to address the critical shortage of geriatric faculty in U.S. medical schools. The program was reinstituted in 1997, and renewed in 1999, the purpose unchanged: to increase production of faculty knowledgeable in geriatrics and aging through support for institutions which combine robust scientific and clinical resources in geriatrics with a demonstrated capacity to attract excellent trainees. While each institution retains many of its fellows in its own geriatric faculty positions, there are clear signs that medical centers across the nation have attracted increasing numbers of CoE program alumni. Common activities across CoE sites under this grant include training stipends for research-intensive geriatric fellows and research and/or pilot project support for junior faculty, both within and outside of geriatrics. Other objectives, which vary across the sites, include the development of enhanced educational capacity for geriatric faculty whose careers emphasize clinical teaching, and the development of infrastructure to facilitate research activities of geriatric fellows and faculty. Additional funds to the University of Washington are directed at enhancing geriatric capacity of faculty who teach at remote locations under the WAMI program, which reaches Washington, Alaska, Montana and Idaho.

Award: $3,300,000
Duration: Three years

The CoE program also provides for a coordinating center under an award to the American Federation for Aging Research.

Duke University
Durham, NC
Harvey J. Cohen, M.D.
$450,000
Three years

Harvard Medical School
Boston, MA
Lewis A. Lipsitz, M.D.
$450,000
Three years

Johns Hopkins University
Baltimore, MD
John R. Burton, M.D.
$450,000
Three years

Mount Sinai Medical Center
New York, NY
Rosanne M. Leipzig, M.D., Ph.D.
$450,000
Three years

University of California,
Los Angeles, CA
David B. Reuben, M.D.
$450,000
Three years

University of Michigan
Ann Arbor, MI
Jeffrey B. Halter, M.D.
$450,000
Three years

University of Washington
Itamar B. Abrass, M.D.
Seattle, WA
$600,000
Three years

American Federation for Aging Research (AFAR), Inc.
New York, NY
Odette van der Willik
Stephanie Lederman

Centers of Excellence Coordinating Center

The goal of the Centers of Excellence (CoE) effort has been to address the critical shortage of geriatric faculty members in American medical schools and to strengthen training in geriatrics for physicians. The Centers of Excellence program is a central component of the Foundation's strategic plan to increase academic geriatrics capacity throughout the country. By identifying and funding CoEs in geriatrics around the country, more institutional attention will be brought to the field and faculty will be able to develop in the leaders that geriatrics needs. The CoE coordinating center activities of the American Federation for Aging Research include systematization across the seven previously-funded and 11 new CoEs, as well as the seven CoE Designation Award sites. AFAR coordinates meetings for trainees, prepares and circulates newsletters, maintains a web site on behalf of the program, and conducts periodic evaluations of current and previous trainees' career development. In addition, it administers a research fellows program for up to three cohorts of researchers.

Award: $2,032,939
Duration: Four years

American Academy of Family Physicians Foundation
Kansas City, MO
Gregg A. Warshaw, M.D.

Improving Geriatric Medicine Education in Community Hospital Family Practice Residency Programs: Building on Success

As part of its Geriatrics in Residency Training Initiative, the Foundation made an award to the American Academy of Family Physicians Foundation (AAFPF) to work with family medicine residency programs, based mostly in small community hospitals. The grant enabled the AAFPF to deliver on-site consultation with family medicine experts in geriatrics, as well as to provide training workshops for residency faculty charged with teaching geriatrics. This renewal grant supports AAFPF's continued efforts to improve the quality of geriatrics training in family medicine residency programs. In addition to the two original approaches, a new effort to work with the Association of Family Practice Residency Directors to develop consensus on geriatrics training issues will be added.

Award: $324,533
Duration: 27 months

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

Integrating Geriatrics into the Subspecialties of Internal Medicine

This project grew out of a recommendation of the 1993 Institute of Medicine (IOM) report that there be increased attention to geriatrics in the training provided to relevant subspecialists in internal medicine because they are so vital to effective care of older adults. To date, awards totaling some $3.4 million have contributed to the development of geriatric education retreats (GERs) for nine subspecialties of internal medicine (endocrinology, cardiology, oncology, arthritis/rheumatology, infectious disease, immunology, pulmonary and critical care medicine, gastroenterology and nephrology) and follow-up activities. A retreat focused on general internal medicine, whose members engage in primary care service and training programs, health services research and epidemiology, took place in the summer 1999 and funds previously awarded also covered a winter 2000 meeting. This renewal will strengthen and extend the work needed to more firmly and fully integrate geriatrics into relevant medical subspecialties and address additional disciplines. The proposed project provides funding to extend the GER concept to psychiatry and neurology (which share a specialty certifying board) and to significantly enhance follow-up within each medical subspecialty.

Award: $2,185,937
Duration: Two years

Association of American Medical Colleges
Washington, DC
M. Brownell Anderson

Enhancing Geriatrics in Undergraduate Medical Education

The Association of American Medical Colleges has received Foundation support to operate a competitive grants program to help medical schools improve the geriatrics education they provide their students. Through this grant, the Association will fund the development of new educational approaches, evaluate their impact on student knowledge and attitudes, and disseminate successful ideas to all U.S. medical schools. A request for proposals to the deans of the 125 medical schools in the United States will ask that the schools describe how they would use two-year awards of up to $100,000 to significantly increase the quality and quantity of geriatrics education throughout the medical school curriculum. Funded sites will be required to share curricular models and training products with the Association for the use of other schools and eventual dissemination of successful models. The program will be evaluated through several methods including quarterly progress reports, an implementation timetable, a curriculum evaluation process and a site visit to each of the funded schools.

The Association will use multiple approaches to disseminate and support the adoption of the successful innovations developed in this project. Included in these methods: electronic mailing lists; a newsletter, *The Reporter;* professional media relations; annual meetings; a major workshop and the annual special issue of the AAMC journal, *Academic Medicine.*

Award: $2,628,870
Duration: Four years

Dartmouth Medical School
Hanover, NH
Paul B. Batalden, M.D.

Academic Geriatric Leadership Program: Planning Phase

In order to respond to the shortage of academic geriatric leaders, Dartmouth Medical School was invited by the Foundation to create a leadership development program. This six-month planning project is the first step in a potential 10-year program targeted to recently appointed leaders of academic geriatric programs. The plan will incorporate established learning programs for medical leaders, and will be supplemented with short courses constructed around four areas relevant to all academic geriatric leadership: research, education and training, design/redesign of care, and service improvement.

Award: $102,331
Duration: Six months

Foundation-Administered Grant

Geriatric Social Work Initiative Evaluation

The Foundation's Geriatric Social Work Initiative was designed to address three of the most pressing factors limiting the training of geriatrically-knowledgeable social workers: lack of geriatric faculty, lack of aging-rich clinical training sites, and lack of curriculums and standards which reflect competencies in aging services. Through a contract with Westat, a Maryland-based, consulting firm, in collaboration with Boston University, will evaluate the Initiative and provide feedback to the Foundation and its social work grantees to increase the program's short-and long-term impact. Evaluative components include the documentation of current geriatric social work education, identification of the degree to which the Initiative's component parts are being implemented effectively and whether they are working synergistically to have impact beyond the sum of the individual grants. Evaluation methods will include mail and follow-up telephone surveys to social work faculty, directors and deans, and students in selected undergraduate and graduate education programs in the U.S.

An expert panel will provide input about changes which are emerging in geriatric social work programs. In addition, a labor market study of the field of social work will be conducted under this award.

Award: $614,672
Duration: Two years

Gerontological Society of America
Washington, DC
Barbara Berkman, Ph.D.

Hartford Geriatric Social Work Faculty Scholars Program

A major factor limiting student interest in pursuing geriatric social work careers is the shortage of dedicated faculty members available as mentors and teachers. This project, administered by the Gerontological Society of America, will identify and develop outstanding junior social work faculty members committed to teaching, research and leadership in geriatric social work, and capable of advancing the field in the new millenium. Up to 10 faculty members will receive support as Hartford Geriatric Social Work Faculty Scholars. Their potential for leadership careers will be fortified by three program components: 1) an integrated, two-year faculty development institute, designed to strengthen critical skills that predict success, such as education, outcomes research and leadership; 2) a defined faculty advancement plan with local mentors committed to the Scholars' ongoing professional development at their own institutions; and 3) two years of support for a research project in a community-based practice setting on social work roles in improving geriatric outcomes.

Award: $2,304,856
Duration: Three years

The Institute for Clinical Evaluation
Philadelphia, PA
John J. Norcini, Ph.D.

A Credential in Home Care

The Institute for Clinical Evaluation (ICE), whose mission is to improve the quality of health care available to the public, is a non-profit educational organization established by the American Board of Internal Medicine Foundation. Through this award, ICE will develop and implement an evaluation process to credential physicians in home care. Between 1988 and 1996, spending by Medicare for home care benefits increased from about $2 billion to $17 billion, averaging 31 percent annually. In June 1996, when the Foundation approved a national effort to expand home care into academic medicine, it was estimated that fewer than one in twenty U.S. medical schools required their students to do at least five home visits, and nearly half did not devote even a single curricular hour to it. Although home care is expanding rapidly, there are few formal skills assessment programs in this arena. ICE certificates are designed to function as a credential for clinical practice, documenting a clinician's ability to deliver specific types of care in a competent and safe fashion.

Award: $204,000
Duration: 33 months

New York Academy of Medicine
New York, NY
Patricia Volland, M.S.W, M.B.A.

Geriatric Social Work Practicum Site Development Program

This project addresses the shortage of sites available to train future social work professionals to meet the needs of the country's older adults. Up to 11 schools with master's programs in social work, each in collaboration with at least five clinical sites, will receive planning grants under this program. Each awardee will develop designs for practicum experiences that are representative of the continuum of aging services. The plans will be considered for as many as five implementation awards after the first year. The New York Academy of Medicine will serve as the coordinating center by providing technical assistance and support to each grantee, fostering cross-site communication, building a database of resources, developing evaluation criteria, and facilitating dissemination to social work educators and professionals.

Award: $1,011,093
Duration: Three years

New York University
New York, NY
Terry R. Fulmer, Ph.D., R.N., FAAN

Geriatric Interdisciplinary Team Training Program: Resource Center

The Foundation's Geriatric Interdisciplinary Team Training (GITT) initiative addresses the need to train multiple health professionals to work as a team in providing comprehensive health care for elders. The GITT Resource Center (originally funded in 1995) is housed at New York University's Division of Nursing. The Center has greatly enhanced the success of the initiative by facilitating and supporting activities of the nine GITT training sites. This project renewal continues the Resource Center's activities for the remaining period of Foundation-supported training at the sites. It is intended to maximize the impact of the GITT initiative by pursuing three interrelated tasks. First, it will capture the lessons of GITT through the evaluation of student outcomes. Second, it will use those lessons and the educational materials developed by GITT sites to produce refined models and materials adapted to the needs of a variety of potential educational institutions. Third, it will disseminate the lessons and tools of GITT and provide technical assistance to institutions wishing to implement GITT models through a series of professional papers, a web site with up-to-date information and training materials from the project, and conference presentations.

Award: $1,341,520
Duration: Three years

University of Rochester School of Medicine and Dentistry
Rochester, NY
John M. Bennett, M.D.
William J. Hall, M.D.

A Model for the Development of Combined Oncology-Geriatrics Fellowship Training

The University of Rochester School of Medicine and Dentistry was awarded an augmentation of its Foundation grant to fund a subcontract with the American Society of Clinical Oncology to plan and implement a special symposium on the essentials of geriatric oncology in conjunction with its Fall 2000 Educational Conference. The symposium will cover such topics as demographics and cancer epidemiology; physiology of aging; cancer development in relation to age; treatment issues in older adults regarding chemotherapy, radiation, surgery, and psychosocial factors; and rehabilitation and palliative care. Presentations will form the basis of a curriculum on geriatric oncology which will be distributed by the Society.

Award: $77,000
Duration: 18 months

Health and Human Services Planning Association
West Palm Beach, FL
W. Cecil Bennett

Palm Beach County Senior Services Planning

Based on the Foundation's strategic planning objective of seeking ways to improve health care for elders in the three states with the greatest number of older adults (California, Florida, and New York), this project represents the Foundation's initial effort. Florida Governor Jeb Bush is committed to "Golden Choices," a program to enable elders to live independently with dignity. This concept involves diversion of elders from nursing home placement, which would require preventive services and elimination of waiting lists for community-based resources. In order to achieve success, substantial state and local cooperation, including economic commitments from local stakeholders, is necessary. Foundation support to strengthen the next steps in the local planning process in Palm Beach County (recognizing the parallel state-level effort) could enhance the county's service system and make it a statewide and national model for older adult services. This grant provides partial funding for a one-year planning effort intended to identify broad options for overall system redesign and recommend one or two pilot demonstrations. Comprehensive information on Palm Beach County's older adult population, continuous community input and feedback, and identification of local resources to complement state and federal funding streams will be featured.

Award: $181,500
Duration: One year

University of Wisconsin, Madison
Madison, WI
Mark A. Sager, M.D.

Improving the Quality of Care and the Retention of Direct Care Workers in Community Based Long-Term Care

The University of Wisconsin project is intended to demonstrate ways to reduce turnover among nursing assistants and aides and thus overcome a major barrier to improving quality in long-term care. In response to their observations and subsequent investigation of the long-term care industry, the University of Wisconsin developed a Worker Education, Training and Assistance (WETA) program, which is designed to improve nurse's aide retention and job satisfaction, and patient and family satisfaction and perceptions about quality of long-term care. This award is to implement and evaluate the WETA program, which involves a series of educational and worker recognition programs, together with modest salary increases and other benefits. The project will focus on the residential care and home care industries. The project's evaluation plan includes a before and after comparison o staff turnover rates, a variety of worker and client satisfaction, and qualitative observational data.

Award: $309,616
Duration: Three years

American Federation for Aging Research (AFAR), Inc.
New York, NY
Stephanie Lederman

Communications and Dissemination Initiative

In late 1998, the JAHF undertook a communications audit of its programs and outreach mechanisms. The primary findings were that grant recipients feel they lack the expertise or capacity to speak outside of their own community about their work and that the Foundation itself should create a strong, consistent message about its priorities. A series of potential activities were identified to connect each program's networks, generate new knowledge about what practices and health services work best for older Americans, and begin to share that information both across the medical community and to larger audiences. These activities will aid grantees in learning to communicate the importance of their work to larger audiences, as well as to disseminate information to other parties which could benefit from it. This project will also increase Foundation staff capacity in communications and outreach to key audiences, and respond to media inquiries.

Award: $201,740
Duration: Three years

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

Advancing Aging and Health Policy Understanding

The National Health Policy Forum's work to provide high-quality, balanced information to Congressional staff and federal agency decision-makers is an important counter-weight to the interests of industry lobbyists and political ideologues. Given the ever-changing health care environment, the Foundation's strategic planning objective of ensuring that key stakeholders and the general public have more accurate and timely information about aging and health issues is particularly important. The Foundation's current project with the National Health Policy Forum has served this educational purpose over the last two years. Through the renewal of this grant, the National Health Policy Forum will continue to produce high-quality, non-partisan, informational briefing sessions for staff of Congress, the Department of Health and Human Services and other regulatory agencies on topics related to aging and health, support the Private Markets Technical Advisory Group and develop an educational workshop on the impact of provisions of the Balanced Budget Act of 1997.

Award: $625,000
Duration: Two years

Grantmakers in Aging
Dayton, OH
Carol A. Farquhar

Grantmakers in Aging 2000 Annual Meeting

Grantmakers in Aging (GIA) is the only national professional organization of grantmakers active in the field of aging. Its mission is to promote and strengthen grantmaking for an aging society.

GIA plans include continued outreach, membership support and an organizational development plan to be created by the executive director. Hartford will lead a coalition of funding partners to organize and execute the October 2000 annual meeting to be held in New York City. A series of committees will be created with local funder leadership to develop the component parts of the meeting. Funds will be used to support the costs for the meeting planner, speakers' honoraria and travel expenses, as well as to subsidize attendee costs.

Award: $60,000
Duration: 18 months

Grantmakers in Health
Washington, DC
Lauren LeRoy, Ph.D.

Support for Annual Meeting in 2000 ("Spanning the Generations") and Related Activities

Grantmakers in Health (GIH) is an educational organization serving trustees and staff of foundations and corporate giving programs working in the health field. It works to build the knowledge, skills and effectiveness of the grantmaking community, as well as to foster communication among and between grantmakers. GIH provides an array of services designed to help grantmakers anticipate and respond to today's complex and rapidly changing health care environment. These include providing technical assistance and consultation to grantmakers on both programmatic and operational issues; brokering professional relationships; convening, publishing, educating and training. GIH's funding partners each make a contribution to support the organization's core activities and additionally, several funding partners make supplemental contributions for special meetings. The award will support a portion of the expenses of the "Spanning the Generations" 2000 annual meeting, and related programming. Hartford contributions and input will enhance the meeting's aging-related quality and content. Its expected audience of over 250 grantmakers will benefit from this additional factual and strategic information.

Award: $100,000
Duration: Ten months

The People-to-People Health Foundation, Inc. (Project HOPE)
Washington, DC
John K. Iglehart

Health Affairs Thematic Issue on Medications

Medications are a major factor affecting both the health and functional status of older adults and their financial well being. The prescription drug benefit added as a component of Medicare Catastrophic Coverage legislation in 1987 was never implemented. Since then, both the therapeutic potential and the cost of medications have continued to escalate. Prescription drug coverage is rapidly eroding and the portion of older adults with no drug insurance at all (currently approximately one third of the Medicare population) will increase dramatically in the future. Several legislative proposals are in various stages of development, giving the Foundation an unusual opportunity to help to bring information and clarity to the debate. To address the knowledge deficit, the Foundation awarded this grant to the People-to-People Health Foundation to support the publication of a special thematic issue of *Health Affairs* dedicated to prescription drugs, Medicare and managed care. Through this issue, papers by authoritative experts in the field will be commissioned, currently available information on prescription drugs will be dramatically expanded, and the work of Foundation-supported researchers will be represented.

Award: $100,000
Duration: One year

1999 JAHF/Financial Reports

FINANCIAL SUMMARY

On December 31, 1999 the Foundation's assets were $607.3 million, an increase of $65.6 million for the year after cash payments of $25.8 million for grants, expenses and Federal excise tax. Total return on the investments, income plus realized and unrealized capital gains, was 17.9 percent. In 1998 revenues totaled $12.5 million, a yield of approximately 2.1 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.

In 1999 the Foundation again benefited from its previous investments in the technology sector as the stocks of the "new economy" continued to soar to record levels. International diversification also improved the Foundation's performance as many foreign developed and emerging markets outperformed the US. To continue to prudently and selectively diversify the portfolio, in 1999 the Foundation made commitments to one new private equity fund and one new real estate fund. At the end of 1999, the Foundation's asset mix was 72 percent equities, 18 percent fixed income, and a combined 10 percent in venture capital, private equity, real estate and event-driven funds, compared with 63, 27 and 10 percent, respectively, at the end of 1998. Worried about the historically very high valuations in certain sectors of the equity market, the Foundation took steps near year-end that will position its investments less aggressively in 2000.

As of December 31, 1999, Capital Guardian Trust Company, Sound Shore Management, William Blair & Co., Pequot Capital Management, T. Rowe Price Associates and W.P. Stewart & Co. manage the Foundation's investments. 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, Angelo, Gordon & Co. and Heitman/JMB Advisory Corporation. Event-driven investment managers are Halcyon/Alan B. Slifka Management 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.

INDEPENDENT AUDITORS' REPORT

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

Ladies and Gentlemen:

We have audited the balance sheets of The John A. Hartford Foundation, Inc. (a New York not-for-profit corporation) as of December 31, 1999 and 1998 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, 1999 and 1998 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 67 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
New York, New York
March 3, 2000

The John A. Hartford Foundation, Inc.
Exhibit A
Balance Sheets
December 31, 1999 and 1998

	1999	1998
Assets		
Cash in operating accounts	$ 3,693	$ 6,397
Interest and dividends receivable	966,151	1,983,625
Prepayments and deposits	83,882	74,103
Prepaid taxes	262,978	58,804
	1,316,704	2,122,929
Investments, at fair value or adjusted cost (Notes 2 and 3)		
Short-term cash investments	82,410,331	53,690,882
Stocks	429,955,731	339,371,341
Long-term bonds	26,746,000	90,848,986
Investment partnerships	48,738,307	40,754,517
Real estate pooled funds	13,456,383	9,958,088
Total Investments	601,306,752	534,623,814
Office condominium, furniture and equipment (net of accumulated depreciation of $510,000 in 1999 and $171,544 in 1998)(Note 5)	4,652,845	4,975,530
Total Assets	$607,276,301	$541,722,273
Liabilities and Net Assets		
Liabilities:		
Grants payable (Note 2)		
Current	$ 13,525,259	$ 15,967,626
Non-current (Note 7)	18,394,450	18,065,922
Accounts payable	806,206	882,552
Deferred Federal excise tax (Note 2)	1,531,692	979,396
Total Liabilities	34,257,607	35,895,496
Net Assets - Unrestricted		
Board designated (Note 2)	5,368,802	2,368,756
Undesignated	567,649,892	503,458,021
Total Net Assets (Exhibit B)	573,018,694	505,826,777
Total Liabilities and Net Assets	$607,276,301	$541,722,273

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
December 31, 1999 and 1998

	1999	1998
Revenues		
Dividends and partnership earnings	$ 5,103,245	$ 5,209,677
Long-term bond interest	5,706,168	5,757,160
Short-term investment earnings	1,659,069	2,314,934
Total Revenues	12,468,482	13,281,771
Grants and Expenses		
Grant expense (less cancellations and refunds of $344,227 in 1999 and $880,506 in 1998)	17,530,337	13,636,590
Foundation-administered projects	179,829	264,446
Grant-related direct expenses	142,354	112,836
Excise and unrelated business income taxes (Note 2)	219,020	159,013
Investment fees	2,174,095	2,502,165
Personnel salaries and benefits (Note 6)	1,667,832	1,522,155
Office and other expenses	909,581	868,952
Depreciation	338,455	284,167
Professional services	77,531	91,869
Total Grants and Expenses	23,239,034	19,442,193
Excess (deficiency) of revenues over grants and expenses	(10,770,552)	(6,160,422)
Net Realized and Change in Unrealized Gains (Note 3)	77,962,469	55,578,576
Increase in Net Assets	67,191,917	49,418,154
Net Assets, beginning of year	505,826,777	456,408,623
Net Assets, End of Year (Exhibit A)	$573,018,694	$505,826,777

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

The John A. Hartford Foundation, Inc.
Exhibit C
Statements of Cash Flows
December 31, 1999 and 1998

	1999	1998
Cash Flows Provided (Used)		
From Operating Activities:		
Interest and dividends received	$ 12,015,589	$ 11,773,812
Cash distributions from partnerships and real estate pooled funds	3,585,923	4,638,720
Grants and Foundation-administered projects paid (net of refunds)	(19,824,005)	(19,107,226)
Expenses and taxes paid	(5,959,275)	(5,977,135)
Net Cash Flows Provided (Used) by Operating Activities	(10,181,768)	(8,671,829)
From Investing Activities:		
Proceeds from sale of investments	292,259,751	224,868,913
Purchases of investments	(253,579,332)	(215,250,140)
Sale (purchase) of fixed assets - net	(12,416)	142,927
Net Cash Flows Provided by Investing Activities	38,668,003	9,761,700
Net Increase in Cash and Cash Equivalents	28,486,235	1,089,871
Cash and equivalents, beginning of year	53,960,028	52,870,157
Cash and equivalents, end of year	$ 82,446,263	$ 53,960,028
Reconciliation of Increase in Net Assets to Net Cash Used by Operating Activities		
Increase in Net Assets	$ 67,191,917	$ 49,418,154
Adjustment to reconcile increase in net assets to net cash used by operating activities:		
Depreciation	338,455	284,167
Decrease (increase)in interest and dividends receivable	1,017,474	(235,166)
Decrease (increase) in prepayments and deposits	(9,779)	74
Increase (decrease) in grants payable	(2,113,839)	(5,203,750)
(Decrease) increase in accounts payable	(78,345)	(172,547)
Net realized and change in unrealized gains	(77,962,469)	(55,578,576)
Other	1,434,818	2,815,815
	$ (10,181,768)	$ (8,671,829)

The John A. Hartford Foundation, Inc.
Exhibit C
Statements of Cash Flows
December 31, 1999 and 1998

	1999	1998
Supplemental Information:		
Detail of other:		
Investment partnerships and real estate pooled funds:		
Cash distributions	$ 3,585,923	$ 4,638,720
Less: reported income	1,417,905	1,211,963
	2,168,018	3,426,757
Tax expense	219,020	159,013
Less: Taxes paid	899,758	709,125
Excess (tax on realized gains and change in prepaid)	(680,738)	(550,112)
Zero-coupon amortization	(52,462)	(60,830)
Total - Other	$ 1,434,818	$ 2,815,815
Composition of Cash and Equivalents:		
Cash in operating accounts	$ 3,693	$ 6,397
Short-term cash investments	82,410,331	53,690,882
Unrealized loss on forward currency contracts	32,239	262,749
	$82,446,263	$53,960,028

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

The John A. Hartford Foundation, Inc.
Exhibit D
Notes to Financial Statements
December 31, 1999 and 1998

1. Purpose of Foundation

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

2. Summary of Significant Accounting Policies

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

The preparation of financial statements in conformity with 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.

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.

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. Also recorded as designated net assets are conditional grants for which the conditions have not been satisfied.

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

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 1999 and 1998 the Foundation's rates were 2% and 1%, respectively.

Investment expenses for 1999 include direct investment fees of $2,174,095 and $133,000 of allocated salaries, legal fees and other office expenses. The 1998 comparative numbers were $2,502,165 and $131,000.

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

The Foundation intends to distribute at least $26,200,000 of undistributed income in grants or qualifying expenditures by December 31, 2000 to comply with Internal Revenue Service regulations.

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

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

3. Investments

The net gains in 1999 is summarized as follows:

	Cost	Fair Value	Appreciation
Balance, December 31, 1999	$448,137,539	$601,306,752	$153,169,213
Balance, December 31, 1998	$436,684,211	$534,623,814	$97,939,603
Increase in unrealized appreciation during the year, net of increased deferred Federal excise tax of $552,296			$ 54,677,314
Realized gain, net of provision for excise taxes of $475,208			23,285,155
Net realized and change in unrealized gains			$77,962,469

For 1998, the unrealized gain was $3,805,701, net of increased deferred Federal excise tax of $38,441. The realized gain was $51,189,134 net of a provision for Federal excise tax of $517,062. In 1998, the Foundation also recorded a gain of $583,741 on the sale of its office condominium.

Receivables and payables on security sales and purchases pending settlement at December 31, 1999 and 1998 were as follows:

	1999	1998
Proceeds from sales	$ 82,903	$ 689,949
Payables from purchases	(332,459)	(690,275)
Net cash pending settlement	$ (249,556)	$ (326)

The net amount has 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:

	1999	1998
U.S. Government	$ 5,188,202	$ 13,643,506
U.S. agency	787,915	8,659,787
Corporate 2,102,467	51,576,224	
Commingled fund	1,681,411	1,962,258
Foreign denominated	16,986,005	15,007,211
	$26,746,000	$90,848,986

The Foundation is a participant in thirteen investment limited partnerships. As of December 31, 1999, $44,638,354 had been invested in these partnerships and future commitments for additional investment aggregated $7,361,646.

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 $375,927.

Two of the Foundation's investment partnerships permit withdrawals at least once a year. These are valued at their fair value, $19,600,170 (adjusted cost $19,687,408).

Real estate investments included two limited partnerships and five real estate investment trusts. The Foundation had invested $16,650,000 at December 31, 1999 and future commitments for additional investment aggregated $3,350,000.

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, 1999 the Foundation's open foreign currency forward sale and purchase contracts totaled $4,541,460. Total foreign denominated investments at the same date were $66,917,939.

5. Office Condominium, Furniture and Equipment

At December 31, 1999 and 1998 the fixed assets of the Foundation were as follows:

	1999	1998
Office condominium	$ 4,622,812	$ 4,611,026
Furniture and equipment	540,033	536,048
	5,162,845	5,147,074
Less: Accumulated depreciation	510,000	171,544
Office condominium, furniture and equipment, net	$4,652,845	$4,975,530

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 1999 and 1998 amounted to $145,450 and $110,698, respectively. The Foundation also incurred additional pension costs of approximately $30,000 in 1999 and $35,000 in 1998 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, 1999 will be disbursed as follows:

2001	$ 12,896,319
2002	6,147,430
2003	1,643,200
	20,686,949
Discount to present value	2,292,499
	$18,394,450

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 1999 and 1998 was 8.5% and 7.75%, respectively.

At December 31, 1999, there were four grants totaling $3,076,303 that were contingent on all four proceeding in tandem. One grantee had not accepted the grant. As a result, these grants are shown as part of board designated net assets.

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:

	1999	1998
Partnership earnings	$ 961,748	$ 924,616
Realized gains - net of taxes of $25,009 and $3,727	1,225,393	369,030
Unrealized gain (loss) - net of deferred excise tax provision (recovery) of $4,553 and ($6,591)	450,725	(652,548)
	$2,637,866	$ 641,098

SUMMARY OF ACTIVE GRANTS

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Aging and Health				
Academic Geriatrics and Training				
American Academy of Family Physicians Foundation Leawood, KS *Improving Geriatric Medicine Education in Community Hospital Family Practice Residency Programs: Building on Success* Gregg A. Warshaw, M.D.		$ 324,533	$ 240,777	$ 83,756
American Federation for Aging Research (AFAR), Inc. New York, NY *Paul Beeson Physician Faculty Scholars in Aging Research Program* Stephanie Lederman Odette van der Willik	$ 8,605,732		2,871,237	5,734,495
American Federation for Aging Research (AFAR), Inc. New York, NY *Medical Student Geriatric Scholars Program* Odette van der Willik	1,579,296		645,196	934,100
American Federation for Aging Research (AFAR), Inc. New York, NY *Centers of Excellence Coordinating Center* Stephanie Lederman Odette van der Willik	768,477	2,032,939	577,019	2,224,397
American Geriatrics Society, Inc. New York, NY *Integrating Geriatrics into the Subspecialties of Internal Medicine* William R. Hazzard, M.D.	1,067,826	2,185,937	1,067,826	2,185,937
American Geriatrics Society, Inc. New York, NY *Increasing Geriatrics Expertise in Non-Primary Care Specialties* David H. Solomon, M.D. John R. Burton, M.D.	736,480		371,213	365,267
American Geriatrics Society, Inc. New York, NY *Enhancing Geriatric Knowledge of Practicing Physicians through Continuing Medical Education, Phase II* Patricia P. Barry, M.D., M.P.H.	1,531,520		380,000	1,151,520

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Association of American Medical Colleges Washington, DC *Enhancing Geriatrics in Undergraduate Medical Education* M. Brownell Anderson		$ 2,628,870	$ 301,812	$ 2,327,058
Baylor College of Medicine Houston, TX *Geriatric Interdisciplinary Team Training* Nancy Wilson, LMSW	$ 130,678		130,678	
Baylor College of Medicine Houston, TX *Center of Excellence* Robert J. Luchi, M.D.	350,000		224,173	125,827
Boston University Boston, MA *Center of Excellence* Patricia P. Barry, M.D., M.P.H.	352,101		220,171	131,930
Council on Social Work Education Alexandria, VA *Preparing Gerontology-Competent Social Workers* Joan Levy Zlotnik, Ph.D.	432,925		244,182	188,743
Dartmouth Medical School Hanover, NH *Academic Geriatric Leadership Program: Planning Phase* Paul B. Batalden, M.D.		102,331	102,331	
Duke University Durham, NC *Center of Excellence* Harvey Jay Cohen, M.D.	75,000	450,000	75,000	450,000
Emory University Atlanta, GA *Southeast Center of Excellence in Geriatric Medicine* Joseph G. Ouslander, M.D.	275,000		72,332	202,668
Gerontological Society of America Washington, DC *Hartford Geriatric Social Work Faculty Scholars Program* Barbara Berkman, Ph.D.		2,304,856	336,766	1,968,090
Harvard Medical School Boston, MA *Center of Excellence* Lewis A. Lipsitz, M.D.	150,000	450,000	150,000	450,000

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Henry Ford Health System Detroit, MI *Great Lakes Geriatric Interdisciplinary Team Training* Nancy A. Whitelaw, Ph.D.	$ 229,390		$ 229,390	
Institute for Clinical Evaluation Philadelphia, PA *A Credential in Home Care* John J. Norcini, Ph.D.		$ 204,000	102,000	$ 102,000
Johns Hopkins University Baltimore, MD *Center of Excellence* John R. Burton, M.D.	153,116	450,000	153,116	450,000
Mount Sinai Medical Center New York, NY *Geriatric Interdisciplinary Team Training* Christine K. Cassel, M.D.	125,000			125,000
Mount Sinai Medical Center New York, NY *Center of Excellence* Roseanne M. Leipzig, M.D., Ph.D.	150,303	450,000	150,303	450,000
New York Academy of Medicine New York, NY *Geriatric Social Work Practicum Site Development Program* Patricia J. Volland, M.S.W., M.B.A.		1,011,093	796,650	214,443
New York University New York, NY *Geriatric Interdisciplinary Team Training Program: Resource Center* Terry T. Fulmer, R.N., Ph.D., F.A.A.N.	142,895	1,341,520	509,141	975,274
New York University New York, NY *The John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing Practice* Mathy D. Mezey, R.N., Ed.D., F.A.A.N.	2,649,660		1,446,151	1,203,509
Northwestern University Chicago, IL *Center of Excellence* Janice B. Schwartz, M.D.	437,500		77,535	359,965
On Lok, Inc. San Francisco, CA *Geriatric Interdisciplinary Team Training* Jennie Chin Hansen, R.N., M.S.	125,468		125,468	

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Rush-Presbyterian-St. Luke's Medical Chicago, IL *Geriatric Interdisciplinary Team Training* Denis A. Evans, M.D.	$ 250,000		$ 250,000	
Stanford University Stanford, CA *Enhancing Dissemination of Innovations in Geriatric Education* Georgette Stratos, Ph.D.	948,397		169,142	$ 779,255
University Hospitals Health System Cleveland, OH *Great Lakes Geriatric Interdisciplinary Team Training* Shirley M. Moore, R.N., Ph.D.	153,176		153,176	
University of Alabama at Birmingham Birmingham, AL *Southeast Center of Excellence in Geriatric Medicine* Richard M. Allman, M.D.	275,000		137,500	137,500
University of California, Los Angeles Los Angeles, CA *GITT National Program Evaluation* David B. Reuben, M.D. Janet C. Frank, Dr.P.H.	516,846		118,211	398,635
University of California, Los Angeles Los Angeles, CA *Center of Excellence* David B. Reuben, M.D.	75,000	$ 450,000	75,000	450,000
University of California, San Francisco San Francisco, CA *Center of Excellence* C. Seth Landefeld, M.D.	385,370		114,245	271,125
University of Colorado Denver, CO *Geriatric Interdisciplinary Team Training* Nora Morgenstern, M.D. Ernestine Kotthoff-Burrell, R.N., C., A.N.P.	125,000		125,000	
University of Colorado Denver, CO *Center of Excellence* Andrew M. Kramer, M.D.	328,141		175,997	152,144
University of Hawaii Honolulu, HI *Center of Excellence* Patricia L. Blanchette, M.D., M.P.H.	363,662		134,183	229,479

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
University of Kansas Kansas City, KS *Center of Excellence* Stephanie A. Studenski, M.D., M.P.H.	$ 380,702		$ 133,678	$ 247,024
University of Medicine and Dentistry of New Jersey Newark, NJ *Expansion of Home Care into Academic Medicine* R. Knight Steel, M.D.	198,352		198,352	
University of Michigan Ann Arbor, MI *Center of Excellence* Jeffrey B. Halter, M.D.	75,000	$ 450,000		525,000
University of Minnesota Minneapolis, MN *Geriatric Interdisciplinary Team Training* Robert L. Kane, M.D.	262,125		262,125	
University of Rochester Rochester, NY *Center of Excellence* William J. Hall, M.D.	269,670		205,877	63,793
University of Rochester Rochester, NY *A Model for the Development of Combined Oncology-Geriatrics Fellowship Training* John M. Bennett, M.D. William J. Hall, M.D.	563,649	77,000	226,223	414,426
University of South Florida Foundation, Inc. Tampa, FL *Geriatric Interdisciplinary Team Training* Eric Pfeiffer, M.D.	250,000		240,913	9,087
University of Texas, San Antonio San Antonio, TX *Center of Excellence* David V. Espino, M.D. Michael S. Katz, M.D.	350,469		147,530	202,939
University of Washington Seattle, WA *Center of Excellence* Itamar B. Abrass, M.D.	100,000	600,000		700,000
Yale University New Haven, CT *Center of Excellence* Mary E. Tinetti, M.D.	400,000		197,577	202,423
Subtotal	$26,338,926	$15,513,079	$ 14,665,196	$ 27,186,809

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Integrating and Improving Services				
Carle Foundation Hospital Urbana, IL *Evaluation of Geriatric Team Care in Medicare Risk* Cheryl Schraeder, R.N., Ph.D.	$ 551,485		$ 201,109	$ 350,376
Duke University Durham, NC *Improving Depression Care for Elders* Linda H. Harpole, M.D. Eugene Z. Oddone, M.D.	947,509		255,460	692,049
Health and Human Services Planning Association, Inc. West Palm Beach, FL *Palm Beach County Senior Services Planning* W. Cecil Bennett		$ 181,500	81,500	100,000
Indiana University Indianapolis, IN *Improving Depression Care for Elders* Christopher M. Callahan, M.D.	1,035,641		273,851	761,790
On Lok, Inc. San Francisco, CA *Integrated Chronic Care Information System* Catherine Eng, M.D.	135,575			135,575
Seattle Institute for Biomedical and Clinical Research Seattle, WA *Client Outcomes in Community Residential Settings in the State of Washington* Susan C. Hedrick, Ph.D.	273,726		234,690	39,036
Spartanburg Regional Medical Center Foundation Spartanburg, SC *Improving Geriatric Care in Rural Healthcare Delivery Systems* R. Bradford Whitney, Jr., M.D.	794,942		276,878	518,064
University of California, Los Angeles Los Angeles, CA *Improving Depression Care for Elders Coordinating Center* Jürgen Unützer, M.D., M.P.H.	1,813,227		492,717	1,320,510
University of California, Los Angeles Los Angeles, CA *Improving Depression Care for Elders* Jürgen Unützer, M.D., M.P.H.	1,022,629		317,129	705,500

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
University of Texas Health Science Center at San Antonio San Antonio, TX *Improving Depression Care for Elders* John W. Williams, Jr., M.D.	$ 1,070,977		$ 286,525	$ 784,452
University of Washington Seattle, WA *Improving Depression Care for Elders* Wayne Katon, M.D. Elizabeth Lin, M.D.	1,048,935		324,458	724,477
University of Wisconsin-Madison Madison, WI *Improving the Quality of Care and the Retention of Direct Care Workers in Community Based Long-Term Care* Mark A. Sager, M.D.		$ 309,616	84,286	225,330
Subtotal	$ 8,694,646	$ 491,116	$ 2,828,603	$ 6,357,159
Aging and Health — Other				
American Federation for Aging Research (AFAR), Inc. New York, NY *Communications and Dissemination Initiative* Stephanie Lederman		201,740	66,000	135,740
Brandeis University Waltham, MA *National Policy and Resource Center on Women and Aging* Phyllis H. Mutschler, Ph.D.	177,592		177,592	
Cold Spring Harbor Laboratory Cold Spring Harbor, NY *The Biology of Long-Term Memory* Timothy P. Tully, Ph.D.	158,853		158,853	
George Washington University Washington, DC *Advancing Aging and Health Policy Understanding* Judith Miller Jones	116,474	625,000	316,474	425,000
Grantmakers in Aging Dayton, OH *Campaign to engage grantmakers across the country in funding projects in aging* Carol A. Farquhar	28,025		28,025	
Grantmakers in Aging Dayton, OH *Grantmakers in Aging 2000 Annual Meeting* Carol A. Farquhar		60,000	60,000	

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
Grantmakers in Health Washington, DC *Support for Annual Meeting in 2000 ("Spanning the Generations") and Related Activities* Lauren LeRoy, Ph.D.		$ 100,000	$ 100,000	
People-to-People Health Foundation, Inc. Bethesda, MD *Health Affairs Thematic Issue on Medications* John K. Iglehart		100,000	100,000	
University of Maryland College Park, MD *Expanding the National Network for Intergenerational Health* Daniel Leviton, Ph.D.	$ 133,785		133,785	
Subtotal	$ 614,729	$ 1,086,740	$ 1,140,729	$ 560,740
Total Aging and Health	$35,648,301	$17,090,935	$18,634,528	$ 34,104,708
Health Care Cost and Quality				
Institute for Health Policy Solutions Washington, DC *Health Plan Purchasing Cooperative Resource Center* Richard E. Curtis	109,550		109,550	
National Business Coalition on Health, Inc. Washington, DC *Expanding and Strengthening the Community Health Reform Movement* Gregg O. Lehman, Ph.D.	63,721		63,721	
Total Health Care Cost and Quality	173,271		173,271	
New York Fund				
American Cancer Society (Illinois) Evanston, IL		500	500	
Boys' Club of New York New York, NY		25,000	25,000	
Childrens Oncology Services of Southern Arizona Tucson, AZ		500	500	
Community Service Society of New York New York, NY		25,000	25,000	
Hospital for Special Surgery New York, NY		3,000	3,000	

	Balance Due January 1, 1999	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 1999
International Rescue Committee, Inc. New York, NY		$ 5,000	$ 5,000	
New York Academy of Medicine New York, NY		40,000	20,000	$ 20,000
New York Presbyterian Hospital New York, NY		5,000	5,000	
Presbyterian Senior Services New York, NY		500	500	
United Hospital Fund New York, NY		2,500	2,500	
Total New York Fund		107,000	87,000	20,000
Other Grants				
Association for Health Services Research Washington, DC		2,000	2,000	
Foundation Center New York, NY		10,000	10,000	
Grantmakers in Aging Dayton, OH		5,000	5,000	
Grantmakers in Health Washington, DC		10,000	10,000	
National Foundation for Facial Reconstruction New York, NY	$ 262,500		175,000	87,500
New York Regional Association of Grantmakers New York, NY		9,000	9,000	
RAND Corporation Santa Monica, CA		5,000	5,000	
Matching Grants*		559,372	559,372	
Total Other	$ 262,500	$ 600,372	$ 775,372	$ 87,500
Grants Refunded or Cancelled	$ 318,232	($344,227)	($25,995)	
Discount to Present Value	($2,368,756)	$ 76,257		($2,292,499)
Total (All Grants)	$34,033,548	$17,530,337	$ 19,644,176	$ 31,919,709
Foundation-Administered Projects				
Geriatric Social Work Initiative Evaluation		614,672		614,672
To Pursue Selected Activities in the Strategic Plan	183,597	200,000	179,829	203,768
Total	$ 183,597	$ 814,672	$ 179,829	$ 818,440

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

Aging and Health

Academic Geriatrics and Training

Bowman Gray School of Medicine
Winston-Salem, NC
Center of Excellence Designation Award
William R. Hazzard, M.D.
1997; $10,000; 2 years

Case Western Reserve University
Cleveland, OH
Center of Excellence Designation Award
Jerome Kowal, M.D.
1997; $10,000; 2 years

Kaiser Foundation Hospitals
Los Angeles, CA
Training of Trainers in Interdisciplinary Team Training
Richard Della Penna, M.D.
1997; $490,426; 3 years

St. Louis University
St. Louis, MO
Center of Excellence Designation Award
John Morley, M.B.Ch.
1997; $10,000; 2 years

Stanford University
Palo Alto, CA
Center of Excellence Designation Award
Peter Pompei, M.D.
1997; $10,000; 2 years

University of Arkansas for Medical Sciences
Little Rock, AR
Center of Excellence Designation Award
David A. Lipshitz, M.D.
1997; $10,000; 2 years

University of Connecticut Center on Aging
Farmington, CT
Center of Excellence Designation Award
Richard W. Besdine, M.D.
1997; $10,000; 2 years

University of North Carolina at Chapel Hill
Chapel Hill, NC
Fostering Interdisciplinary Approaches to the Care of the Rural Elderly
Jan Busby-Whitehead, M.D.
1997; $598,000; 32 months

University of Pennsylvania
Philadelphia, PA
Center of Excellence Designation Award
Risa Lavizzo-Mourey, M.D.
1997; $10,000; 2 years

Integrating and Improving Services

Arizona State University
Tempe, AZ
Enhancing Generalist Physician Program Impact
Frank G. Williams, Ph.D.
1996; $1,201,439; 3 years

Dartmouth Medical School
Hanover, NH
Replication of Community Centers of Excellence in Aging
John H. Wasson, M.D.
1996; $273,882; 3 years

Dartmouth Medical School
Hanover, NH
A Program to Improve Treatment of Depression in the Elderly
James E. Barrett, M.D.
1995; $2,000,000; 5 years

Institute for Advanced Studies in Aging and Geriatric Medicine
Washington, DC
Planning A National Geriatrics Research Cooperative
William B. Ershler, M.D.
1998; $56,810; 1 year

Johns Hopkins Bayview Medical Center, Inc.
Baltimore, MD
Johns Hopkins Home Hospital
John R. Burton, M.D.
1999; $94,050; 1 year

Aging and Health: Other

Mount Sinai School of Medicine
New York, NY
Geriatric Medications Information for Practicing Physicians
Rosanne M. Leipzig, M.D.
1998; $33,000; 2 years

Museum of Science
Boston, MA
Traveling Exhibition on Aging
Steven L. Solomon
1998; $50,000; 2 years

Vanderbilt University School of Medicine
Nashville, TN
Improving Pharmacotherapy In Home Health Patients
Wayne A. Ray, Ph.D.
1994; $1,272,459; 5 years

Application Procedures

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. The letter should summarize the purpose and activities of the proposal and the qualifications of the applicant and institution, and provide an estimated budget and time frame for the period.

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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Or through our web site:
http://www.jhartfound.org

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

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