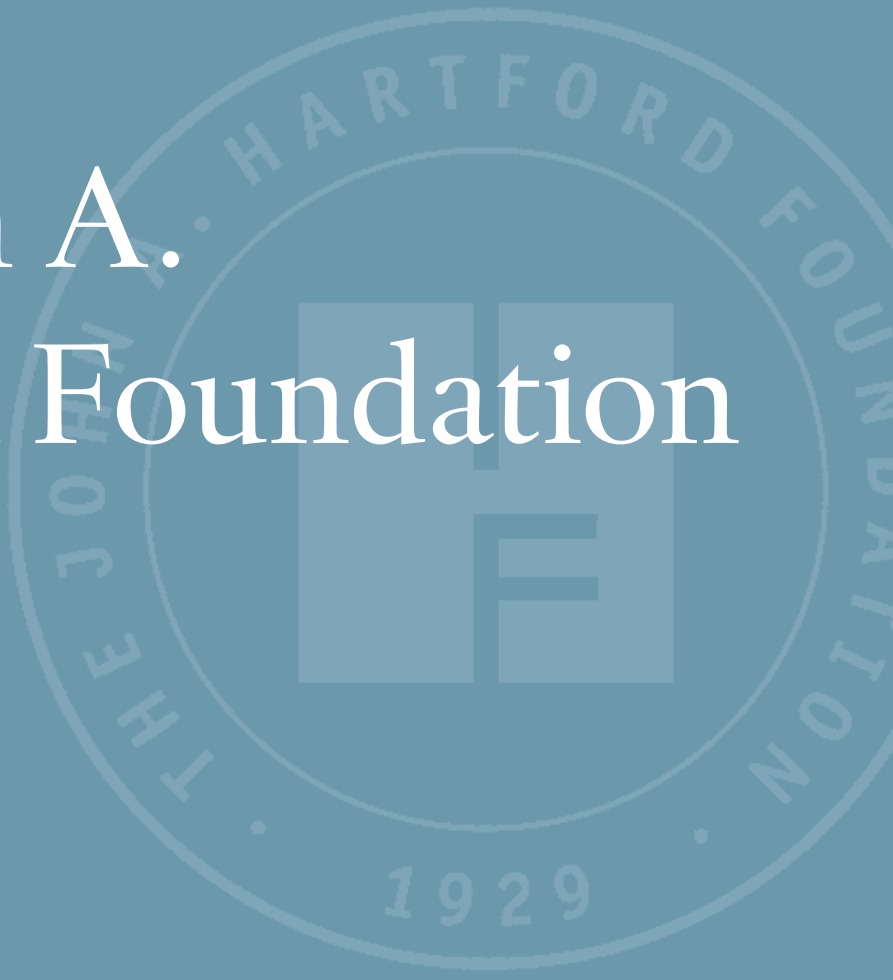
Annual Report 2000

The John A. Hartford Foundation



"IT IS NECESSARY to carve from the whole vast spectrum of human needs one small band that the heart and mind together tell you is the area in which you can make your best contribution."

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


THE JOHN A. HARTFORD FOUNDATION
1929

Contents

The number of Americans over 65 will double to more than 70 million during the next three decades. Providing quality health care for this growing population, and especially for those who are frail, will require a team approach by doctors, nurses, social workers and other health professionals.

Our Annual Report for 2000 highlights the Geriatric Interdisciplinary Team Training (GITT) Program, which is our Foundation's effort to address this need through training. Begun in 1995, eight sites were funded nationwide, each to find a way to provide health professionals with the knowledge and skills necessary to work effectively in teams. As part of this initiative, the Foundation supports a resource center at New York University and a national evaluation conducted by the University of California, Los Angeles.

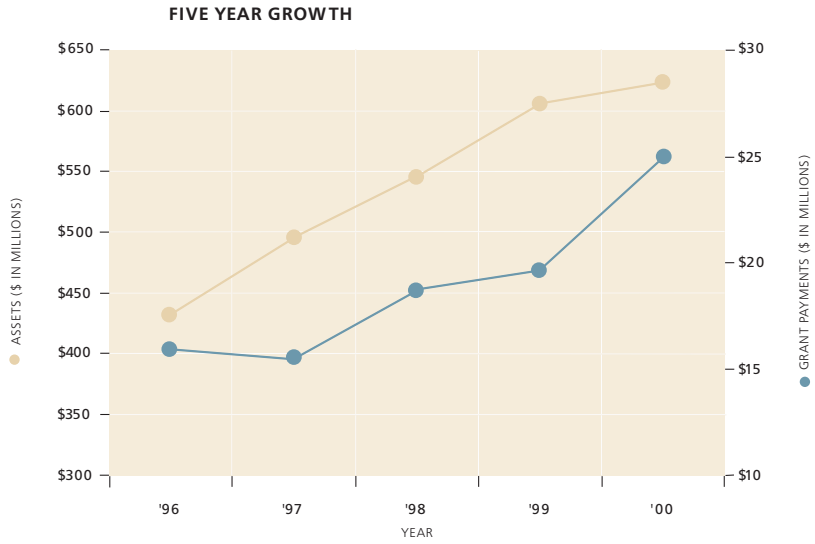
The experience of these model training sites has alerted health professionals to the value of team training for the care of older patients. The efforts described in this Annual Report encouraged the Foundation's Trustees to launch a new "Geriatric Interdisciplinary Teams in Practice Initiative" in 2000.

The Trustees also approved significant grants to expand some of the Foundation's most successful programs. The American Federation for Aging Research will receive funds to continue the Paul B. Beeson Physician Faculty Scholars program, an initiative which seeks to attract the nation's most outstanding physician-scientists to careers in research on aging and the investigation of geriatric clinical care and health services. A five-year grant to the American Geriatrics Society will continue to increase geriatrics expertise in 10 surgical and medical specialties.

The Board also approved a new five-year program to strengthen geriatric nursing. Among the projects funded are five Centers of Geriatric Nursing Excellence; scholarships for doctoral candidates, junior faculty and nurses wishing to pursue joint business and nursing degrees; and a coordinating center at the American Academy of Nursing.

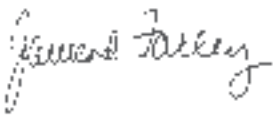
To complement programs in medicine and nursing, the Foundation is supporting three new efforts in social work. The Gerontological Society of America received two grants to support doctoral fellows and expand a faculty scholars program. Our third initiative is to develop aging-rich field training for master's level students. Grants were awarded to six consortia, comprising one or more schools of social work and service agencies. The New York Academy of Medicine is coordinating this effort.

The Foundation again showed positive growth in its total assets, which ended 2000 at $623.6 million. Grant payments totaled $25.1 million for the year. While it appears the U.S. economy is slowing considerably in 2001, we are optimistic that our diversified investment approach will allow the Foundation to continue to expand its grant program. A chart showing the growth of the Foundation's endowment and grant funding for the past five years appears below.



At our Annual Meeting, Nuala Pell and Alexander M. Laughlin stepped down from the Board of Trustees after 20 and 15 years of service, respectively. Their participation and wise counsel have been critical to the growth and success of the Foundation's programs and endowment. Their insights will be missed. At the same time, we are pleased to report that William T. Comfort, Jr., Chairman of Citicorp Venture Capital, has joined the Board of Trustees.

This report would not be complete without thanking my fellow colleagues on the Board and the Foundation's staff for their untiring efforts and dedication. You will read of their accomplishments in this report, but the full extent of their work could not be contained in a single publication. I look forward to another rewarding year at the John A. Hartford Foundation.



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Geriatric Interdisciplinary Team Training: GITT

GERIATRICS: A TEAM DISCIPLINE. First-rate geriatric care is, by definition, team care. That is to say, older patients with complex, chronic conditions require an interdisciplinary team of health professionals to provide a wide range of medical as well as psychosocial support services, to develop a treatment plan, track a patient's progress and coordinate care across clinical settings. It is a complex challenge, too often unmet.

(Background) Houston GITT weekly meeting. (Inset) Houston GITT team with patient, seated, and family member.

Barbara's father, George, age 90, sent home from a Florida hospital after a bout with pneumonia, was not doing well. He complained of being unable to sleep, had trouble walking and his mind was beginning to wander. His wife, age 88, called their local internist, who prescribed a sleeping pill. He also suggested she contact a physical therapist from the hospital to assist her husband in regaining his strength, but when the therapist arrived, George was too groggy to do any exercises. Barbara's mother, overwhelmed, called her daughter, who lived in Pennsylvania, and urged her to come down to Florida to help get her father back on his feet. When Barbara arrived, she was shocked to discover that both of her parents had lost a great deal of weight because they weren't eating properly, and that her father was self-medicating, taking more sleeping pills than prescribed because the initial dosage had not done the trick. Worst of all, the household was deteriorating and no one — neither their primary physician nor anyone from the hospital — seemed to be aware of her parents' failing condition or in charge of coordinating the multiple health care and social services they now required.

Unfortunately, Barbara's parents' situation is increasingly common. And as those who have dealt with the medical needs of an aging parent, spouse, relative or friend well know, a team approach is the best way to address these situations, but it is almost impossible to find. Far too many of us have experienced the confusion and frustration of trying to create a plan and build a network of services that work — not just medically, but practically — for both patient and caregiver. We have spent hours, days, weeks and months consulting with an endless stream of physicians, nurses, therapists, social workers, home care workers, nutritionists, pharmacists and other specialists who, too often, are ignorant of past medical histories, medications or treatment plans and therefore work at cross purposes. Moreover, there is little continuity of care when a loved one is moved — as so often happens — from hospital to rehabilitation center to home to hospital again. Fragmentation of care may result in overlapping or conflicting treatment which is costly and confusing and, worst of all, detrimental to the patient. Without coordination, mishaps ensue.

The aging of America not only poses challenges to a health care system struggling to control costs without sacrificing quality, but to families and friends of frail elderly patients as well. Today, there are close to 35 million Americans over the age of 65, and close to four and one half million over the age of 85. Many older adults can expect to live with three to five chronic diseases and to take from 5 to 10 prescription medications. While only seven percent of over-65 adults are long-term care patients permanently residing in nursing homes, most older adults will use long-term care services at some point in their life. Inevitably, with growing numbers of older Americans living into their eighties and beyond, more and more of us will confront the complex and sometimes devastating consequences of uncoordinated care. And we will wonder if there isn't a better way.

In fact, there is a better way. The value of interdisciplinary geriatric assessment and care delivered by teams is well documented. The benefits include: decreased mortality, increased diagnostic accuracy, improved function, fewer hospitalizations, reductions in length of stay and readmissions, more home discharges, fewer drug prescriptions, and greater satisfaction on the part of patients and caretakers.

Team care is the dominant way geriatrics is practiced. Nonetheless, there are not enough geriatricians to handle today's elderly patients with chronic conditions — let alone tomorrow's estimated 93 million over the next 50 years — and thus, since most older Americans receive their care from other specialists and through poorly structured systems, the majority of ill older Americans do not have the benefits of a team approach. This will only grow worse.

Health professionals not trained to work collaboratively

Paradoxically, even though patients benefit from team care and clinicians are expected to work with each other after their education and training, health professionals' training is not coordinated and they rarely are trained together. To some extent, this is due to regulatory barriers and structures — mandated by accrediting bodies within each discipline — which support curriculum content along strict disciplinary lines and make it difficult to create interdisciplinary education. Because doctors, nurses, social workers, pharmacists, and others do not enjoy the benefits of interdisciplinary education, they have little idea what their colleagues are trained to do. It should come as no surprise, then, that after graduation, most health professionals are ill-prepared for the reality of teamwork.

Foundation's commitment to teams

The Foundation's extensive and long-standing commitment to teams has continued to evolve and grow. Over the past ten years, for example, three major programs have focused on new ways to create and enhance geriatric teams. They include:

1) The Generalist Physician Initiative (GPI) launched in the early 1990s to improve the treatment of elderly patients by integrating nurses, social workers and other health care professionals into primary care medical practices;

2) Geriatric Interdisciplinary Team Training (GITT) launched in mid-1990, to focus on the academic education and training of health professionals in team care;

3) Geriatric Interdisciplinary Teams in Practice launched in 2000 to focus on new approaches to providing team care. (See New Grants Section)

Each Initiative has built on insights gained from the previous one. A key lesson learned from the GPI, for example, was that health care professionals lacked the skills — even if they possessed the will — to work together in teams. A need existed for education and training to teach health professionals how to provide coordinated care over time and across settings, which was why the GITT Initiative was developed. And, in turn, the recently launched Teams in Practice program, which seeks to demonstrate the health benefits and financial impacts of interdisciplinary team care for older adults, builds on key lessons learned from the GITT program, the focus of this year's annual report.

Foundation launches geriatric GITT initiative

In 1995, prompted by insights gained from the GPI — and mindful of its mission to improve the health care of older adults — the Foundation developed the GITT program, to create training models for a range of health professionals in the skills and resources needed for effective team care. Initially targeted were advanced practice nurses, master's level social workers and medical residents (because together, they form the heart of most geriatric teams) from primary care programs. However, once up and running, GITT involved faculty and student trainees in 13 additional disciplines including: audiology, dentistry, ethics/religion, law, management/administration, nutrition, occupational therapy, pharmacy, physical therapy, physician assistants, psychology, public health and speech pathology.

The goals of the five-year $12.9 million GITT program included:

- **creating national training models based on partnerships between "real world" providers of geriatric care and educational institutions that train health professionals;**
- **developing well-tested curriculums for geriatric interdisciplinary team training;**
- **building a cadre of well-trained future professionals in geriatrics and interdisciplinary team skills;**
- **testing staff development training models for practicing health professionals;**
- **helping to improve academic responsiveness to the health care delivery system.**

Mt. Sinai GITT, daily morning meeting.

Planning and Preliminary Implementation

The Project contained multiple components and evolved in distinct phases, beginning with identifying cities or regional areas where strong nurse practitioner programs, physician programs, and social work programs existed in relative proximity to each other. "We called on experts to evaluate and rank programs in these different disciplines," says Kathy Hyer, DrPA, MPP, Co-Principal Investigator of the GITT Resource Center, Director of the Training Academy on Aging at the University of South Florida, and a key player in developing GITT. "The idea was to target institutions with infrastructures large enough to house these programs." Next, says Hyer, "We wanted to create partnerships between 'real world' programs, the ones that were complaining that students weren't coming out with adequate skills relevant to their future work lives, and the actual schools producing these students. So, we identified health service providers — such as On Lok in San Francisco and Rush Presbyterian-St. Luke's Medical Center in Chicago — that were actually providing interdisciplinary care to patients, so that students could watch, train and participate in ongoing team care." Providers were asked to partner with academic institutions and apply for planning grants.

The Foundation invited 30 of these potential education and service health partnerships to apply, and in December 1995 approved one-year planning grants of $100,000 to 13 of the applicants. Funds were used to bring together key individuals from each academic program and each clinical site to begin the process of deciding how to design new team-training learning experiences, how to coordinate schedules of trainees, and how to organize team leaders to interact with one another and faculty in order to successfully implement the three-year GITT program. After careful review — and in an effort to create sites which represented a variety of geographic locations, populations, health professions disciplines, academic and clinical teaching approaches and public/private educational settings — eight projects received three-year GITT Implementation Awards of $750,000. A commitment of $250,000 in local resources was also required.

GITT Sites*

1. Baylor College of Medicine – Houston
2. Great Lakes GITT (a partnership of sites in Detroit and Cleveland)
    a. Henry Ford Health System – Detroit
    b. University Hospitals Health System (Case Western Reserve University) – Cleveland
3. Mount Sinai Medical Center – New York City
4. On Lok – San Francisco
5. Rush-Presbyterian-St. Luke's Medical Center – Chicago
6. University of Colorado Health Sciences Center – Denver
7. University of Minnesota – Minneapolis
8. University of South Florida – Tampa

* *In addition, a partnership of UCLA & Kaiser Permanente's Southern California region, and the University of North Carolina's Telemedicine and Rural Programs, though not officially a part of the GITT Initiative, received funding for GITT-related projects and were invited to interact with other sites and the GITT Resource Center.*

Geriatric Interdisciplinary Team Training Program, National Board of Advisors Meeting, October 23, 2000 at the NYU GITT Resource Center.

GITT Resource Center

A National GITT Resource Center was established. Located in the Division of Nursing of New York University, and directed by Terry Fulmer, PhD, RN, FAAN, Professor of Nursing at NYU, it played a key role in the Initiative: providing project synergy across GITT sites and facilitating the flow of information about GITT to the academic and health services community including how to implement team training. "We are ready to provide people with material that will make it quite easy to do GITT," says Fulmer who, in 1998, with three colleagues, edited *Geriatric Interdisciplinary Team Training*, a major book on the Hartford Initiative.

The Center's ongoing functions included: coordinating technical assistance and data collection; disseminating program information; helping to arrange GITT presentations at national meetings (in the past two years there were about 50); disseminating cross-training products; creating a GITT web site; and supporting cross-site Special Interest Groups in Ethics, Medicine, Nursing and Social Work. These Groups have been exceedingly valuable, creating vital, national networks for participants as well as GITT publications. The Ethics Special Interest Group, for example, created *Ethics Casebook for Geriatric Health Care Teams*, an innovative book, to be published by Johns Hopkins University Press.

The Center (www.gitt.org) is funded for two more years to continue the mission of promoting GITT and disseminating information, including an implementation manual for institutions and organizations seeking to adopt team training.

National Evaluation Process

Drs. David Reuben, Director, Division of Geriatrics, UCLA, and Janet Frank, Assistant Director for Academic Programs for Geriatric Medicine and Gerontology, UCLA, are co-directors of the GITT National Evaluation Study, headquartered at UCLA. The study generated information on GITT sites. The evaluation team Reuben and Frank assembled conducted annual site visits of each project during which they observed and documented the components of each program, including its structure, academic and clinical resources, curriculum content, as well as teaching and training practices. Between 15 and 45 interviews were conducted per visit. These data were integrated with quantitative information which had been generated by each site and fashioned into a national database by the Resource Center at NYU. Now that the analysis is complete, the UCLA Evaluation team is writing a book, tentatively titled *Successful GITTing*, which will describe and analyze the program's structure, process, outcomes and achievements.

GITT SITES: THEME AND VARIATIONS. Close to 2,000 practicing professionals and students received interdisciplinary team training through the GITT Initiative. Among these were 41 percent in medicine, with an average one-month geriatrics exposure during medical residency; 17 percent in nursing, with an average one-semester practicum; 12 percent in social work, with an average one-year placement; and 30 percent in other disciplines. In addition, significant permanent changes within academic curriculums and clinical sites took place in most GITT programs. While every program pursued the same goals, each developed a different program based on the unique strengths of its regional institutions, people and cultures. No two were alike. "I found it fascinating," says national evaluator Dr. Janet Frank, "to see the variety of ways that this program was designed and implemented...there were just so many approaches to getting GITT done." Fundamentally, however, the eight sites developed three model approaches to teaching geriatric interdisciplinary team care, as follows:

The Academic Model drew together geriatric faculty with team experience from schools of medicine, nursing, social work and other disciplines to teach geriatric teaming. Residency rotations or practicums were not generally regarded as "courses," but were part of the overall academic requirement. **Houston GITT, Minnesota GITT and University of South Florida GITT** followed this model.

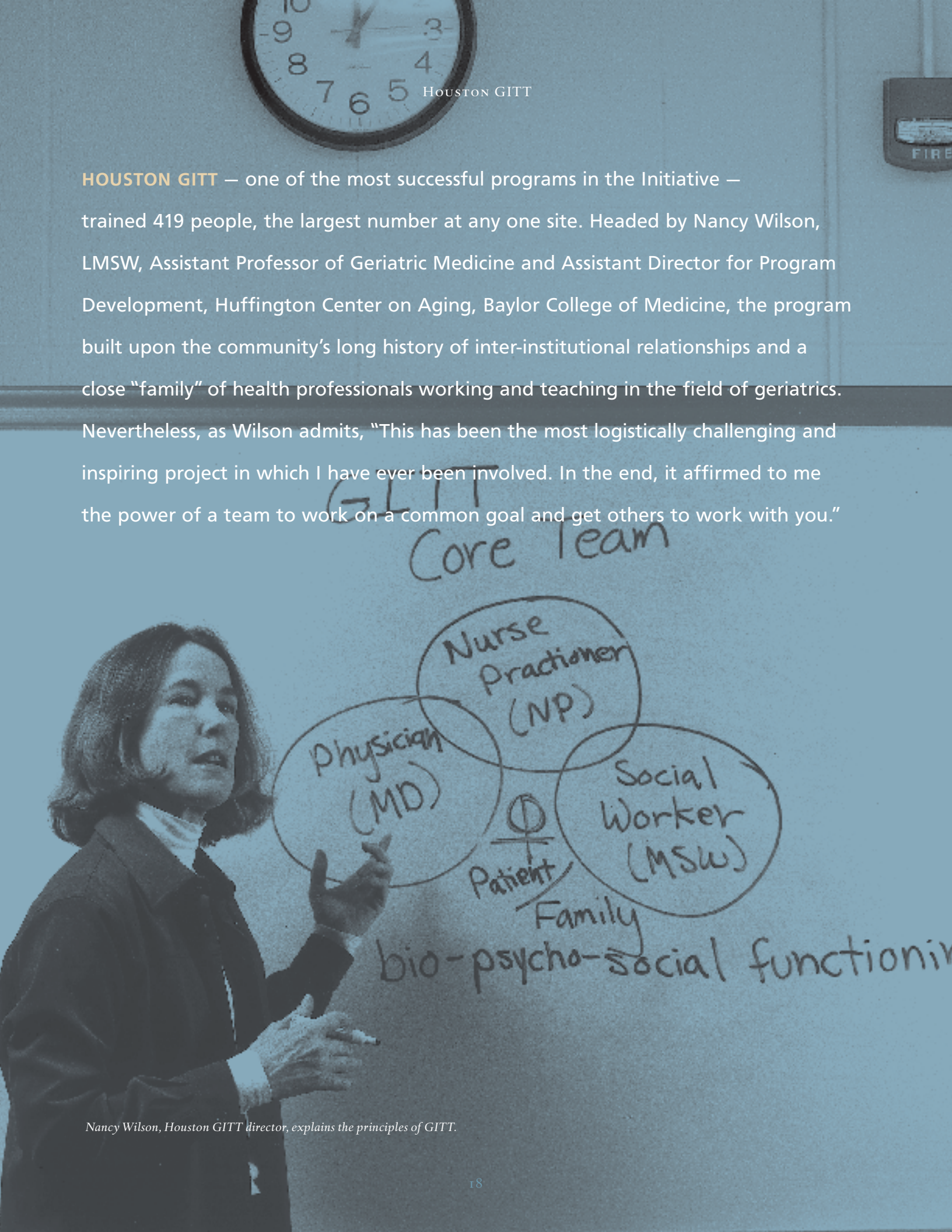
The Clinical Model featured clinical agencies taking the lead in working with trainees placed there. Preceptors with geriatric and team experience from different disciplines were at the sites. In addition to trainees from outside academic programs, students were drawn from people at the agency (nurses, physicians, social workers, and others) or from local institutions, such as a nursing home or hospice care center. Academic and/or continuing education credits were awarded. **On Lok GITT and Great Lakes GITT** exemplified this model.

The Mixed Model incorporated aspects of the Academic and Clinical Models. Faculty with joint appointments, for example, assumed the dual role of educator/clinician to teach GITT. Academic credits might or might not be awarded. **Rush GITT, Mount Sinai GITT and University of Colorado Health Sciences Center GITT** illustrated this model.

Every model and site faced formidable organizational challenges. "It's a complicated program to set up," admits Dr. Kathy Hyer, "with many different barriers to overcome. For example, most schools of nursing, medicine and social work operate on different academic calendars. So, getting faculty from different programs to carve out time together was an enormous task. Then, too, getting students from different schools, at different stages of graduate training, with different course schedules and academic years to work together was another huge hurdle." Highlights of three diverse GITT Projects follow.

(Background) In Houston, physician and social worker meet with patient and family member.

HOUSTON GITT — one of the most successful programs in the Initiative — trained 419 people, the largest number at any one site. Headed by Nancy Wilson, LMSW, Assistant Professor of Geriatric Medicine and Assistant Director for Program Development, Huffington Center on Aging, Baylor College of Medicine, the program built upon the community's long history of inter-institutional relationships and a close "family" of health professionals working and teaching in the field of geriatrics. Nevertheless, as Wilson admits, "This has been the most logistically challenging and inspiring project in which I have ever been involved. In the end, it affirmed to me the power of a team to work on a common goal and get others to work with you."



Nancy Wilson, Houston GITT director, explains the principles of GITT.

Academic and Clinical Partners

Baylor College of Medicine, the lead institution, trained residents in internal medicine, family medicine, psychiatry and physicians assistants; the University of Houston trained master's degree candidates in social work and doctoral-level pharmacists; and the University of Texas at Houston trained advanced practice nurses. Its health service provider partners included: Baylor College of Medicine Geriatric Medicine Associates, the Harris County Hospital District Geriatric Program, Kelsey-Seybold Clinic, MacGregor Medical Associates Senior Care Program, the Houston VAMC Geriatrics and Extended Care and Gero-Psychiatry Units and Hospice at the Texas Medical Center. "The partnerships proved to be incredibly productive and effective," says Wilson, "both in terms of creating new clinical training experiences and also in terms of opportunities for the geriatrics professions to influence care. In particular, by establishing ties with two clinical settings that were major providers for the Medicare population, we had this wonderful opportunity to influence their service model."

Major Changes

The GITT program effected considerable change in the Houston area, including the fulfillment of its basic mandate: forging a faculty-clinician team across three public and private academic institutions, seven academic programs, and six clinical partners at multiple locations. This required, among other things, designing and redesigning courses, lectures and hands-on activities in these disciplines, and building new relationships with major health providers. For example, GITT added or developed: new clinical settings in internal medicine and psychiatry so that residents had an opportunity to train in a managed-care environment for the first time; new sites and curriculum content to the pharmacy and physician assistants programs; a new course within the nurse practitioner program; and team training workshops in which faculty and trainees went through the learning experience together. "While all of this was very exciting," says Wilson, "even more exciting is the fact that all these changes are now permanently a part of these curriculums."

(Above) GITT team members from Baylor Geriatric Medicine Association meet for their Friday morning session.






Innovative core curriculum training materials created

Given the massive challenge of introducing new team-training content across seven disciplines and three institutions, Houston GITT created a core curriculum package, drawing heavily from the knowledge, experience and case studies developed collaboratively by all the sites. Today, these training resources can be adapted and used by institutions and organizations around the country. A major contribution to the national GITT mission, it includes a training video and self-paced learning module in CD-ROM form and print format. "Using core training resources creates some important efficiencies," notes Wilson. "In addition, it's been exciting to see how faculty and the clinicians in this project have utilized the materials for other applications."

(Above) Dr. Robert J. Luchi, Baylor College of Medicine, on a video – part of an innovative package of training materials created by Houston GITT.

An innovative adaptation of GITT skills and materials took place within one of Baylor's four major affiliated hospitals — Harris County Hospital — which works mostly with indigent individuals.

Initially, the GITT initiative supported four interdisciplinary teams at Harris: acute care, skilled nursing, house call, and an outpatient clinic team. "They worked so well," says Carmel Dyer, Associate Professor of Medicine, Baylor College of Medicine, and director of the geriatrics program at Harris County, "that we decided to form a team with our local adult protective service specialists to take care of elderly abused, vulnerable or neglected individuals." The team forged such an outstanding and unique relationship with the state's adult protective services agency that it received national recognition for its effort.

"What we learned from GITT," says Dyer, "was how to deal with conflict, especially when you are working with non-medical people from a state agency with a different code of ethics and regulations." For example, patients often lack the capacity to make a decision. Social workers and physicians often approach the problem from completely different perspectives. "In medicine," says Dyer, "you have to trust your own judgment or else you might make an error. But sometimes somebody else's viewpoint — like a social worker's — takes precedence over yours. And that's something we're not generally trained to do. It's even more difficult when you are dealing with non-medical team members, but our GITT experience gave us the confidence and training to do that."

HOUSTON GITT

CARMEL
DYER
MD, AGSF, FACP

Director of Geriatrics Program
Harris County Hospital District

A vivid example of how "the team" pulled together and saved someone's life took place when, as Dyer recalls, "we were called out to see a 500 pound gentleman who was living in a shack. It was an awful situation. There was no running water, no tiles on the floors, someone would bring him food once or twice a day and there were bugs and roaches everywhere. We went out to visit him and had the idea that he might be psychotic. We talked to the adult protective service specialist and told him he needed to come to the hospital to get a full evaluation. A nurse and social worker went out to talk to the patient, but he refused to leave his home. Adult protective services urged us to go out again but to bring a man this time. So I brought a male nurse's aide and the patient did give us the information we needed to make a clear diagnosis of psychosis. Then we wound up getting a court order to get him to the hospital and within 48 hours, because we had the right diagnosis, he became mentally clear and able to make decisions on his own. And he decided to stay until he was well. So by adult protective services insistence on trying again, and trying to come at the patient from his own viewpoint, I think we did a better job for him than we would have otherwise."

Dyer and her colleagues are continuing to break new ground by adding Law Enforcement and Emergency Medical System personnel to the Hospital's teams, underscoring, yet again, the positive, if unexpected, long-term effect of GITT.

(Above) Dr. Carmel Dyer, who has expanded GITT Teams to include Emergency Medical System and Law Enforcement Personnel, conferring with security officer at Harris County Hospital.

Curriculum Changes in the Nurse Practitioner Program. "One of the reasons I really enjoy gerontology is its interdisciplinary nature," says Vaunette Faye, Director of the Division of Gerontology, head of the Geriatric Nurse Practitioner Program at the University of Texas, and GITT faculty member. A teacher for 18 years, certified as both a geriatric and family nurse practitioner, she built the geriatric nurse practitioner program — from three students 11 years ago to where it is today, with close to 200 master's degree graduates.

"While we have had a growing interdisciplinary community in Houston," observes Faye, "the Hartford Foundation's GITT grant gave us the opportunity to really consolidate and grow those connections as well as grow more inter-disciplinary practice sites in which to train our students."

HOUSTON GITT

VAUNETTE
FAYE
PhD, RN, CS

Director of Gerontological
Nurse Practitioner Program
University of Texas, Houston

Fortuitously, the planning phase of the grant took place just as the School of Nursing was revising its curriculum. "It gave me the opportunity to actually create a new, separate seminar course — with 45 clinical hours — on geriatric inter-disciplinary teams. Students focus on communication, on conflict resolution, on team concepts and issues, look at different teams and work with them. The goal is to help our students either establish a team or fit into an existing team wherever they practice after graduating. It's been a highly successful addition to the curriculum."

The concept of interdisciplinary teams was not new to Faye. "I've been working with other disciplines for a long time. But I did have a transforming type of experience because of my work with GITT. Just as a lot of health professionals don't know that a nurse practitioner can prescribe medication in many states, I don't think I fully appreciated how other disciplines are trained — and the issues around those differences — until the GITT planning team started trying to organize and implement clinical experiences with medical students, social workers, and nurse practitioners. It was such an eye-opening experience for me that we now include information on the education and training of other disciplines in our student training."

(Above left to right) Tom Teasdale, Vaunette Faye and Nancy Wilson, members of the Houston GITT faculty team, review the CD-ROM created for GITT Training.

Graduate of the Nurse Practitioner Program. In 1999, Lillian Flores-Perez graduated from the GITT-enhanced master's degree program designed by Vaunette Faye (see previous page). "I was excited that I was a little bit ahead of the game when I came out of the program. I felt I had this big tool that would help me – and it did."

"The GITT interdisciplinary team was very diverse," says Flores-Perez, "with a social worker, dietician, doctor, the nurse practitioners, plus physical and occupational therapists. And the patients were all indigent, so they not only had medical but social needs. I was able to see how the team problem-solved, made decisions and changed the decisions depending on the patient's needs."

It was while Flores-Perez was observing the interaction of a GITT team that she understood how a nurse-practitioner can utilize both the medical insights of the physician and the social insights of the social worker. Before, those two perspectives often seemed in conflict. "I could see that patients under the age of 80 primarily need medical management. We need to make sure that we control the blood pressure and the diabetes and all those needs so they won't have long-term negative consequences. But then I was able to see that after 80, the primary goal is to make sure that all of their psycho-social needs are cared for. Solely medical management is no longer a priority. So that's when the light bulb went on. And once I learned how this type of team care is crucial for helping the patient, I was able to immediately implement what I'd learned in my current job at Memorial Geriatrics Resource Center where I'm Coordinator of the House Call Program."

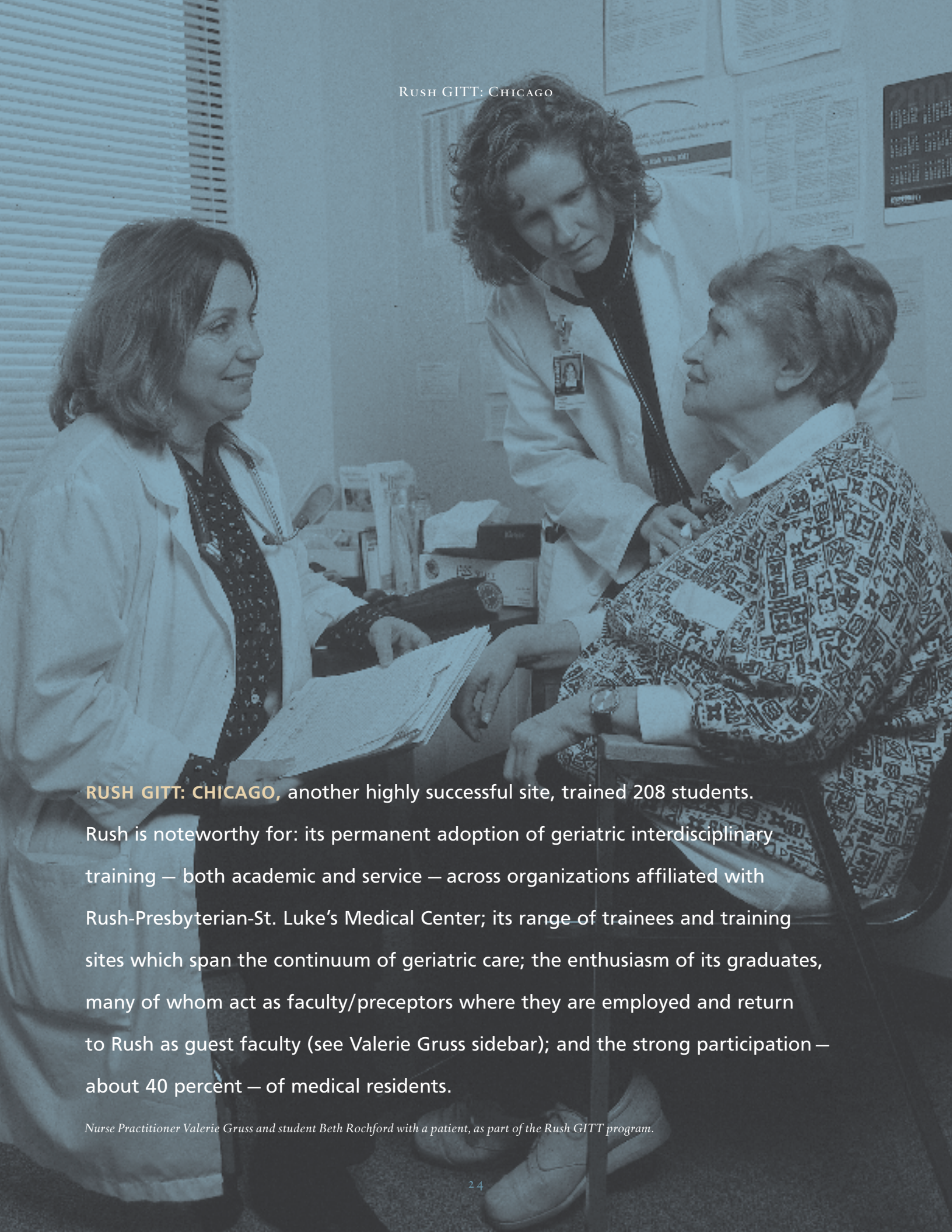
HOUSTON GITT

LILLIAN
FLORES-PEREZ
RN, MSN, NP-C

Graduate of the
Nurse Practitioner Program

Flores-Perez's role is to provide medical management for homebound elderly patients – Medicare or Medicaid – many of whom have dementia and therefore face numerous social as well as medical issues. "I need to make sure they're comfortable, safe and not neglected. My challenges are not as medical as I thought they would be when I was coming out of nursing school." As a direct result of GITT training, she brought in a social worker and a pharmacist to work with the doctor and nurses. "We've been able to accomplish a whole lot," says Flores-Perez.

(Above) Lillian Flores-Perez examines patient at Com For Care Nursing Home in Houston.



RUSH GITT: CHICAGO, another highly successful site, trained 208 students. Rush is noteworthy for: its permanent adoption of geriatric interdisciplinary training — both academic and service — across organizations affiliated with Rush-Presbyterian-St. Luke's Medical Center; its range of trainees and training sites which span the continuum of geriatric care; the enthusiasm of its graduates, many of whom act as faculty/preceptors where they are employed and return to Rush as guest faculty (see Valerie Gruss sidebar); and the strong participation — about 40 percent — of medical residents.

Nurse Practitioner Valerie Gruss and student Beth Rochford with a patient, as part of the Rush GITT program.

The program included three Rush University academic institutions: the Colleges of Medicine, Nursing and Allied Health Sciences; the Loyola University of Chicago Graduate School of Social Work; the Chicago College of Pharmacy; and six clinical sites within the Rush Health System. Twelve disciplines and over 50 faculty participated in the GITT Program: medicine (internal, family practice, physical medicine, rehabilitation and psychiatry), social work, occupational therapy, physical therapy, speech therapy, audiology, health systems management, clinical nutrition, ethics and pastoral care. As in Houston, coordinating the trainees' classroom and clinical schedules was a major challenge.

To solve the problem of different trainee GITT cycles, (physicians did a four-week rotation, for example, while nurse practitioners trained across a quarter) Rush devised three free-standing curriculum modules. This enabled trainees to experience a coherent course, regardless of which module they first used. Modules emphasized four areas: working in teams; working with patients and families; understanding ethical issues in patient care; and understanding health and economic systems. In three years, Rush offered over 20 topics with an interdisciplinary focus, while constantly keeping the program current. For example, it recently added a course on how teams can minimize medical errors and miscommunication, a pressing topic in medicine. Trainees from multiple disciplines met once a week to discuss a practice case, and were assigned to clinical training sites for their practical experience.

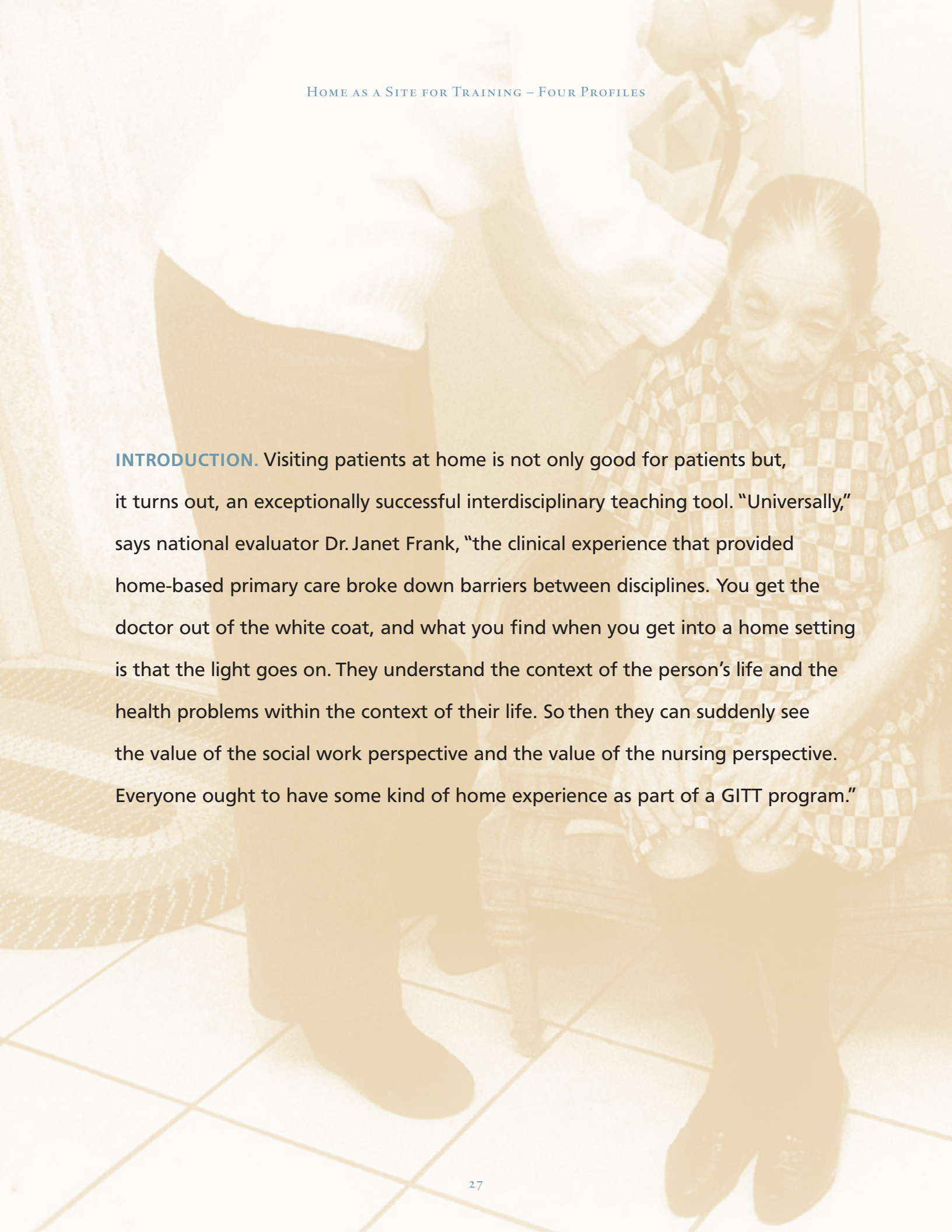
(Above) GITT team members at a clinical site, Pilsen Senior Health Project, located in an inner city Hispanic community in Chicago, reviewing patients scheduled for home visits.

"The Rush system," notes Stan Lapidos, MS, Rush GITT Coordinator, Rush Institute for Healthy Aging, "is based on the practitioner/teacher model, which means that faculty who teach and do research also have their own practice. So we based our education and training on the premise that in order to teach trainees how to function collaboratively, you have to have faculty who provide interdisciplinary care themselves. It's one of the reasons we've been successful and why our project has been integrated into the educational culture of this institution."

From the beginning, Rush committed itself to permanently changing its health care system. "This is not just a demonstration project," says Lapidos. "We believe interdisciplinary teaming is what we should be doing in geriatrics and in health care. Hartford is responsible for having created the opportunity. We take the responsibility and credit for sustaining it and expanding it within our own system. And one of the exciting accomplishments of this project is that we've taken collaborative teams to the patient's home. A lot of our clinical sites are home-based."

Rush-affiliated sites have expanded since the program began. They include a home health care agency, a managed care organization with a network of primary care offices, an assessment and treatment program servicing dementia patients, a family practice clinic serving a low-income Hispanic community, a rehabilitative and skilled nursing facility, and a community hospital. "We are constantly adding and looking for new places to give students opportunities to work together," says Lapidos. "We recognized early on that if we were going to be successful, we had to make sure the needs of this program were complementary to the needs of the clinical practices. We've been able to create a sense of buy-in to the notion of teams by offering trainees who can add value to working with patients. It's of great value, for example, to our hospice program to have medical residents go around and see some of their patients."

(Above) Nurse Practitioner Anna Z. Murphy, GITT team member from Pilsen Senior Health Project, making home visits and examining patients in a Chicago Hispanic community.



INTRODUCTION. Visiting patients at home is not only good for patients but, it turns out, an exceptionally successful interdisciplinary teaching tool. "Universally," says national evaluator Dr. Janet Frank, "the clinical experience that provided home-based primary care broke down barriers between disciplines. You get the doctor out of the white coat, and what you find when you get into a home setting is that the light goes on. They understand the context of the person's life and the health problems within the context of their life. So then they can suddenly see the value of the social work perspective and the value of the nursing perspective. Everyone ought to have some kind of home experience as part of a GITT program."

Steve Rothschild wears a lot of hats. He is co-director of the Rush GITT program, associate professor and geriatrics coordinator of Family Medicine at Rush and clinical director of Pilsen Senior Health Advocates, a family practice clinic whose patients are mostly drawn from Chicago's inner-city Hispanic community. Rothschild is part of the site's home health care team. Coordinated by a nurse practitioner, it also includes two community health workers, trainees in social work and occupational therapy, physicians, pharmacy students and a community liaison member who acts as translator and community advocate. "We go into the home and facilitate solutions to whatever problems are there," says Rothschild. "We had one patient recently discharged from the county hospital who was undocumented and dying. The family wanted the patient to die at home, but lacked Medicaid or Medicare. They didn't know where to begin. Our physician trainee was a traditional, hospital-trained internist who, with help from the team's social worker, spent a lot of time learning what the community resources were for dying patients. Our occupational therapist recommended some adaptive devices to ease the patient's condition. In the end, the team was able to get a successful referral to a hospice that took on the patient without reimbursement. The patient had, in a sense, this positive outcome...which was to die at home peacefully and in comfort." At the same time, the experience transformed the physician. He came away with an improved understanding of how a team can deliver better care than a single practitioner and developed a true apprecia tion of the other disciplines. "I think it does change how people intend to practice," says Rothschild. "It's really a positive result."

RUSH GITT

STEVEN K.
ROTHSCHILD
MD

Director of the Neighborhood Family Practice of Pilsen

(Left to right) Irene Thomas, MD, third year family practice resident at Rush-Illinois Masonic Family Practice and Dr. Steven Rothschild, Clinical Director of Pilsen Senior Health Project, discussing patients to be visited by a GITT team.

Valerie Gruss is an unabashed GITT proselytizer. "Anything that promotes collaboration in health care is great. Wouldn't you want your doctor to be talking to your mother's physical therapist? Wouldn't you want him talking to the pharmacist? Yes, of course, you'd want that, and that's what GITT promotes."

Gruss, a registered nurse for 23 years, spent many of those years in geriatric nursing. She returned to school to get her master's degree and become a geriatric nurse practitioner. In 1998 she graduated from the GITT-Rush program. She currently works with a family practice geriatric physician, and is also halfway into a PhD program.

RUSH GITT

VALERIE
GRUSS
RN, MSN,NP

Associated with Rush Hospital as a home care nurse

Gruss's clinical site during the GITT phase of her training was with the house-call team at Pilsen. "It was a real eye-opener working with other disciplines, actually seeing, hands-on, what they do. Through GITT, I gained insights into their roles, their functions, why they follow certain protocols and where the nurse practitioner fits into the continuity of care." One particular case involving an elderly diabetic with peripheral neuropathy, poor vision and a leg ulcer, who was being cared for by different members of her family, was particularly inspiring. Because of the interdisciplinary team approach, her health improved and she was able to continue living at home. If her case had not been handled by an at-home team, says Gruss, "She would have gone to a clinic, the focus would have been only on her labs and meds, and her multiple problems would not have been addressed."

"Now, in my practice, I have elderly patients with the same sorts of complex problems. I make referrals and coordinate care on a daily basis. This is where my GITT experience has helped me. I am more likely to call for assistance or consult with other disciplines about a patient. This open communication and exchange of expertise fosters a collaborative experience which ultimately benefits the patient."

These days Gruss frequently lectures as a volunteer to new Rush GITT students. "I always tell them, the most important message I have for you is that GITT works.... I'm actually able to implement what I've learned in a clinical practice...and yes, I do practice differently because of GITT."

(Above) Nurse Practitioner Valerie Gruss examines a patient at her Evanston, Illinois office, where she works with a family practice geriatric physician.

As part of Mt. Sinai's GITT program in New York, second year internal medical residents participated in a month-long visiting doctors' program to home-bound patients. Headed up by Jeremy Boal, M.D., Assistant Professor of Medicine and Geriatrics and David Muller, M.D., Assistant Professor of Medicine, and the department of medicine's liaison to GITT, residents made between 40 and 60 home visits and, says Boal, "took on more and more participatory roles as the month went on." In addition to home visits and seminars on interdisciplinary topics, another strong — and unusual — component of the month was a Literature and Medicine discussion group. A weekly reading was assigned — short stories, poems, novels, essays, non-fiction by such masters as Chekhov and Sinclair Lewis — then discussed by residents and faculty. "During that month," says Boal, "we reflected on what it means to be a physician, to act in a professional manner, what are physicians' responsibilities to patients who can't come to an office or pay for services, what is the physician's role as a member of a health care team, and so forth. Second year residents are starting to burn out...and feel very cynical," adds Boal. "They stop enjoying patient encounters. This month-long program reminded them of the reasons they wanted to become doctors in the first place. And the home visits helped them appreciate the skills of fellow health professionals and their patients' lives on a different level."

MT. SINAI GITT

JEREMY
BOAL
MD

Assistant Professor of Medicine and Geriatrics

(Above and background) Dr. Jeremy Boal, a member of the Mt. Sinai GITT program, making home visits with a social worker in a New York City neighborhood.

photos: Bill Gallery

Lisa Davidson, a Mt. Sinai trainee, went through the home-visit program. "When you are seeing someone in your office, you have all the control...but when you do home visits, you really see the problems that people are facing. It's one thing to tell your patient to take your medicine and you need to be on a better diet, but when you see that they're stuck in their apartment and don't have anyone to get their prescription for them or that they are not eating because there is no food in the home, it's a completely different experience. It makes you realize that maybe what we focus on in medicine and the things that are important to us are really not the things that are important to our patients. It has changed the way that I interact with patients. It's more important to find out about them as a person than as a disease. Long-term disease only defines a small part of their life. The team approach worked really well. We talked about issues we are not really trained to pick up on, ethical issues, family support. In fact, one of the things that most impressed me about this program was the amount of enthusiasm from team members, and their ability to find ways to help patients."

"At Mt. Sinai," says Dr. Christine Cassel, GITT director, "we are finding that most of the impact of GITT is with our physician trainees. That's ironic because they were the hardest ones to get to come to seminars. But in the setting where teams are they respond right away. They see the value."

MT. SINAI GITT

LISA
DAVIDSON
MD

Second year medical resident

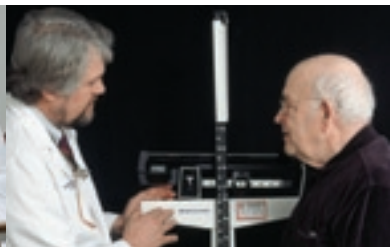
GREAT LAKES GITT (GLGITT) trained 235 individuals in 22 clinical sites in two cities. GLGITT merged two planning grants to the Henry Ford Health System in Detroit, Michigan and the University Hospitals Health System in Cleveland, Ohio to combine the complementary strengths of each city into one program. GLGITT's academic partners included the University Hospitals of Cleveland, Case Western Reserve University and Benjamin Rhodes Institute in Cleveland, and Henry Ford Health System and Wayne State University in Detroit.

Great Lakes GITT team members Dr. Peter Whitehouse and social worker Lauren C. Sample evaluate test results with a patient.

A combined management team from both cities implemented a common training model. Integrating different organizational cultures and care systems from seven academic partners and fifteen clinical partners into one program required, at the outset, a great deal of focus on structure and process. Trained team facilitators were brought in to help provide feedback, support and advice on managing and improving collaborative skills.

In addition to the two-city challenge, GLGITT was notable for: its eight-month training period for all team members, regardless of the discipline, and the innovative use of learning cycles and continuous quality improvement (CQI). (See 'Teams' on page 35.) "Our students walked out with the ability to say 'I can perform in a team to develop and coordinate a plan of care for patients, and I can lead and improve a team and change the system of care for patients,'" says Shirley Moore, PhD, RN, Associate Professor of Nursing at Case Western Reserve University, who co-directed the GLGITT initiative with Nancy Whitelaw. "We decided that those are the types of skills that are needed for today's practitioners."

Specifically, the GLGITT learning process involved an eight-hour introductory workshop focused on the techniques of running a team meeting, followed by nine months in a clinical setting, followed by a final, four-hour workshop for trainees to reflect on what they had learned. Each year a new cycle would start, incorporating new clinical sites and students, led by some of the clinical personnel trained during the previous cycle.



(Above) Team members at Great Lakes GITT clinical site, Fairhill Center for Aging, discuss patients.

The GLGITT model emphasized the development of current health practitioners into preceptors for future health practitioners. Indeed, 151 of those trained were practitioners (physicians, nurses and social workers) who, in turn, trained 84 students in those disciplines. "The value of that approach is that now that the grant money has run out," says Dr. Shirley Moore, "I have an environment that is resource rich in terms of people who can model team behavior. In fact, we have faculty who are placing students with our practitioners in team-care environments."

The GLGITT program took place during a period of dramatic change — due to managed care — in the region's health care system. "Clinics were closed and institutions were downsized," says Moore. "That was a huge challenge for us." Nevertheless, enthusiastic GITT trainees are continuing to integrate team training into courses and selected clinical sites — more in Cleveland than in Detroit, due to the reorganization at the Henry Ford Health Care System. Moreover, the GITT program will be supported by a Web site designed to reinforce the team education of clinical supervisors, instructors and clinicians in the field. "The Web site will be one of the more enduring aspects of the program in terms of showcasing the curriculum and making it accessible to faculty, staff, everyone," says Moore.

(Above) Great Lakes GITT designed an interactive Web site (gitt.cwru.edu) to reinforce the team education and training of clinical supervisors, instructors and clinicians in the field.

There are Teams and then there are 'GITT Teams'. "Learning about 'learning teams' was the single biggest gift that I got from GITT personally," says Evelyn Duffy, instructor of nursing at the Francis P. Bolton School of Nursing at Case Western Reserve and faculty coordinator of nurse practitioner students of the GITT project. Duffy was no stranger to geriatric interdisciplinary teams. She had helped to pioneer them in the Veterns Adminstration system during the early 1980s. Unfortunately, that experience left Duffy with, "a dread of team meetings." Why? Primarily because they were endless. "They would run from two to three hours, at the very least." Duffy's role as both "trainee" and "preceptor" transformed her view of teams.

"In the GITT program," she points out, "the meetings were just one hour long, came with an agenda, with a facilitator, with a time keeper, and with rotating roles. A different team leader each week – sometimes a professional, sometimes a student – really created an egalitarian team." Facilitators provided feedback to the group, asking questions, such as: what can we do better as a team? what can we do better in terms of patient care? At the end of each meeting, team members were given a minute to sum up the most important thing they got from the meeting, the most problematic, and what could be done better next time. This self-evaluation was the continuous quality improvement piece of the process, which helped to make the next team meeting even better. Also, at the end of every learning cycle, all the teams presented their projects as story board presentations so they could share across sites what was happening.

GREAT LAKES GITT

EVELYN
DUFFY
RN, MSN

Trainee and Preceptor

"To see the students integrated into the team was a fantastic experience for them, and really prepared them for where they are now," says Duffy. "Overall," she adds, "if you know you're going to be in and out of a team meeting in an hour, and someone is going to make sure that everything on the agenda gets addressed, and everyone will have time to talk – it makes people want to attend."

(Background) Evelyn Duffy teaching a class at Case Western Reserve University to first-year nursing students.

Before obtaining her master's degree in Occupational Therapy at Rush, Janice Robinson was an occupational therapy assistant at the Rehabilitation Institute of Chicago. "As part of the treatment team in that facility," Robinson recalls, "we had so-called team conferences. They often just consisted of everyone dashing in, communicating in five or ten minutes where the patient was as far as the goals that each of us had individually set, then leaving. But the focus, in GITT training, is really working as a team so all the goals are set by the team, and the team works on those goals. And it emphasized much more communication and ongoing interaction between team members."

RUSH GITT

JANICE
ROBINSON
MS, OTR/L

Occupational Therapy Assistant Program at Greenville Tech, Greenville, South Carolina

After completing her master's degree program at Rush in 1998, Robinson moved back to South Carolina to work in a sub-acute unit of an acute-care hospital. "We started the team from scratch, which was really wonderful because I was able to use all my training from the GITT program to help train this new group in how to work together as a team. I was pleased to see how the sub-acute unit was becoming a nice little family of people — a cohesive group — focused on our patients' care."

Before receiving her GITT training at On Lok, Monika Pettross had participated in interdisciplinary meetings at various hospitals during her clinical rotations. "My impression from those meetings," she recalls, "is that the team expected you to contribute certain pieces of information as a nurse, then your role was over. I was not a contributor to the end plan."

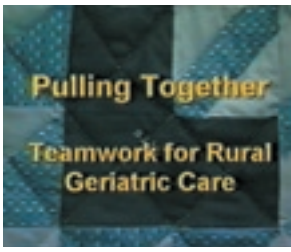
At On Lok, things were different. "I felt that the decisions made were really built on a consensus of people's opinions. You presented your findings, but then there were different options discussed and other disciplines felt comfortable asking — do you need to do another assessment? People understood each other's roles enough to ask those questions. Having had this experience at On Lok, I have a much greater appreciation of the entire patient and how I can best support what other disciplines are doing."

Pettross is now in private care geriatric management. "I'm able to move into a role like this only because of the experience I had at On Lok. I now feel comfortable saying to a client — Let's get a physical therapist in here. Let's get an occupational therapist to do an evaluation. Because I now know how valuable every discipline is and what they can contribute to overall patient care."

ON LOK GITT

MONIKA
PETTROSS
RN, MSN

Private Care Geriatric Manager



Interdisciplinary Care for the Rural Elderly. About 25 percent of the nation's older citizens live in rural communities, and elderly citizens are the fastest growing segment of the rural population. They tend to be poorer, less educated and sicker than their urban counterparts. Yet, typically, there are fewer health professionals to meet their needs.

In 1997, the Hartford Foundation underwrote a collaborative effort between the University of North Carolina at Chapel Hill and Rural Health Group: Fostering Interdisciplinary Approaches to the Care of Rural Elders. Its twin goals were to develop geriatrics knowledge in rural practitioners and students preparing for rural practice, while also developing and testing a training model which promotes interdisciplinary teamwork and community collaboration. "Teamwork is the key to leveraging scarce resources," says Rebecca Hunter, MEd , Project Coordinator, Program on Aging, University of North Carolina at Chapel Hill, School of Medicine.

Because of the long distances between physicians, practitioners and trainees, the project utilized the tools of telemedicine and distance medicine to conduct team training sessions and clinical practice sessions. Real-time video-conferences, for example, alternated with in-person monthly meetings. Also, the project developed a Web-based teaching case in which the trainee goes online, gets to know the patient through video clips, interviews with family members and various practitioners caring for her, then is asked to assess the situation.

"Rural areas are exceptionally underserved and undervalued," says Jan Busby-Whitehead, MD, Project Director. "We feel this program was particularly valuable for rural settings because they so seldom have access to the resources and education that we provided to help them work better as teams."

The two-year project trained 24 general physicians, and produced two training guides, with videos: "Building Teams and Community Relationships" and "Interdisciplinary Approaches to Health and Well Being." The University of North Carolina, building upon the Hartford Project, was awarded a Geriatric Education Center grant from the Bureau of Health Professions to take the best of what it learned and apply that knowledge and training to a larger statewide audience.

(Right) A video with training guide, "Pulling Together, Teamwork for Rural Geriatric Care", was produced by the University of North Carolina Rural GITT.

KEYS TO SUCCESS. It is clear from the GITT Initiative that while there is no one "best way" to implement geriatric interdisciplinary team training, there are key features that must be in place for overall success. Fundamental building blocks include visionary leadership, strong faculty resources, and individuals committed to bringing about change. More specifically, every GITT program needs to:

GITT graduates were invited to participate in a panel discussion at the American Geriatrics Society in Washington D.C. November 15, 2000.

1. Locate "Champions." "To influence academic programs," says Nancy Wilson, "you need to have a 'champion,' someone with authority and influence — like the residency program director or the chairperson in the Nurse Practitioner program in Geriatrics — who can influence what happens in family medicine or social work or within a particular clinical environment."

2. Pick a Skilled Program Manager. There needs to be a skilled and committed individual convening people across disciplines and settings, someone who brings people together, helps them set goals and provides the support and leadership to move efforts forward.

3. Train Faculty and Clinicians First. Make sure that teachers and trainers have themselves received team training and know enough about team principles and skills to thoughtfully incorporate it into their work with students. If those implementing change are themselves good role models, it is easier to get people on board, and more likely that organizational change will be far-reaching.

4. Create a Long-Term Benefit For Clinical Partners and Institutions. Design a program that adds value to those involved, whether it is training clinicians or helping them think through strategies for caring for the elderly. A model that really relates to the aspirations of the organizations — as opposed to getting the money for a grant, doing a great job but then moving on to the next grant — is most likely to be successful.

5. Include a Home-Health Care Setting as part of the Program (see page 27)**.**

6. Provide Booster Doses of GITT. Institutions committed to seeing team training continue should regularly reconvene members of the project to provide fresh infusions of information, training and communication. Teamwork requires ongoing attention to team maintenance.

SIGNIFICANT OUTCOMES. The GITT Initiative, though difficult to implement, fulfilled its complex mission. Among its many achievements, it:

1. **demonstrated the feasibility of introducing and/or increasing interdisciplinary team training into the education and training of health professionals to improve team skills as well as attitudes towards health care teams;**
2. **created a set of training "models" that continue to be used;**
3. **developed curricular models for different disciplines and staff-training models for health professionals;**
4. **created a turn-key implementation manual and training materials, e.g. videos, case studies, manuals, CDs, Web sites;**
5. **developed qualitative measures for evaluating changes in attitudes, knowledge and skills;**
6. **educated a cadre of experts in geriatrics and interdisciplinary team skills ready, willing and able to educate and inspire colleagues throughout the country;**
7. **raised awareness of the regulatory barriers within the health professions which impede interdisciplinary education and training and encouraged new thinking about removing those barriers.**

Nevertheless, despite these successes, the larger question remains: will there be any new adoptions of the GITT models without external funding? This reflects the overall reality that, within the health care system — today struggling to reduce costs and improve efficiencies — there is substantial provider and payer ambivalence towards accepting the expense of high quality geriatric teams, given the absence of much market pressure to promote them. Cognizant of this reality, the Foundation launched a new Initiative, the purpose of which is to test their cost-effectiveness benefits to patients whose care is provided by teams.

Next Step: Geriatric Teams in Practice

In June 2000 the Foundation launched a five-year Initiative, Geriatric Interdisciplinary Teams in Practice, which will continue the GITT mission and momentum in many ways. Its primary focus will be health service provision rather than education. It will support the development and testing of innovative practice models of interdisciplinary team care — such as "virtual teams" that collaborate and coordinate electronically — in order to determine if there are benefits to patients as well as their cost-effectiveness to health care systems and society. Such evidence will not only create exportable models but inform current debates on regulatory and reimbursement policies that determine how health care is delivered. Three grants have already been awarded under this Initiative — to implement and evaluate "The Virtual Integrated Practice Team," to compare and contrast "Health and Organizational Outcomes" of patients receiving an interdisciplinary team approach to other patients in a senior health center, and to implement and evaluate a model of patient-centered team care designed to reduce the problems associated with post-hospital transfers to other health care sites.

Conclusion

Despite the fact that America, for most of its history, has idolized rugged individualists and the culture of individualism, the health community is increasingly recognizing the positive value of interdisciplinary teams to deliver quality health care to patients with complex chronic illnesses. Terry Fulmer, for one, is optimistic. "Every generation is different and our generation values the interdisciplinary process." That is true in the world of business as well as the world of health care, perhaps, in part, because technology has brought complex opportunities which can best be met by skilled interdisciplinary teams. By 2010, over 20 percent of the people in the U.S. will be over 65. To prepare for that demographic challenge, we need to rethink outmoded reimbursement and regulatory policies and, as a nation, embrace the effective, efficient and humane use of team care for our frail elderly and, indeed, for all Americans with chronic diseases who require long-term care.

In 2000, the John A. Hartford Foundation awarded 47 grants under its Aging and Health program totaling $63,045,921.

BUILDING ACADEMIC GERIATRIC NURSING CAPACITY

The John A. Hartford Foundation Academic Geriatric Nursing Capacity Building Initiative, approved by the Foundation's Board of Trustees in March 2000, has three components: support for five Centers of Geriatric Nursing Excellence; awards for pre- and post-doctoral scholars in geriatric nursing; and a coordinating center to support the overall effort. The Centers' concept recognizes the need for a critical mass of gerontological nursing activity in the areas of research, teaching and clinical care in order to produce tomorrow's academic leadership.

Projects funded under the initiative will work in tandem with the Hartford Institute for the Advancement of Gerontological Nursing Practice, which was funded at a level of $5 million for five years in 1996, to strengthen the nation's academic and service capacity. The six projects under the new Initiative are described below.

Centers of Geriatric Nursing Excellence
$6,652,601, Five Years

The Foundation awarded five grants to create Centers of Geriatric Nursing Excellence. Each Center will produce geriatrically-qualified faculty at both pre-and post-doctoral levels and will enhance local and regional activities which will lead to improved care for older adults.

Oregon Health Sciences University
Portland, OR
Patricia G. Archbold, R.N., D.N.Sc.
$1,328,677, Five Years

University of Arkansas for Medical Sciences
Little Rock, AR
Claudia J. Beverly, Ph.D., R.N.
$1,331,250, Five Years

University of California, San Francisco
San Francisco, CA
Jeanie Kayser-Jones, Ph.D., R.N., F.A.A.N.
$1,330,754, Five Years

University of Iowa
Iowa City, IA
Meridean L. Maas, Ph.D., R.N., F.A.A.N.
$1,330,670, Five Years

University of Pennsylvania
Philadelphia, PA
Neville E. Strumpf, Ph.D., R.N.
$1,331,250, Five Years

Nursing Initiative Coordinating Center and Scholar Stipends

American Academy of Nursing
Washington, DC
Claire Fagin, Ph.D., R.N., F.A.A.N.
$8,053,045, Five Years
An award to the American Academy of Nursing (AAN) will provide coordination for the Foundation's initiative to build America's academic geriatric nursing capacity and support 35 doctoral and post-doctoral scholars. Funds for the nursing scholars program will provide two years of support for three cohorts of 10 doctoral and 10 post-doctoral scholars, to be chosen annually. This program also includes scholarships for up to five nursing scholars who wish to pursue advanced study leading to health care management careers. As part of its overall CGNE coordinating effort, the AAN will also sponsor a consensus conference on the geriatric training and preparation of advanced practice nurses and implement a leadership development program.

GERONTOLOGICAL SOCIAL WORK INITIATIVE

Geriatric Social Work Practicum Implementation
$2,854,694, Three Years

These seven grants implement aging-rich practicum field training for master's level social workers which is designed to provide them with the knowledge, skills and attitudes that are at the heart of geriatric social work practice. When members of the National Association of Social Workers were surveyed, 62 percent reported that geriatric knowledge was required in their practice. To meet this need, grants were awarded to six consortia, each composed of at least one master's program in social work and a minimum of five service agencies. These grants will demonstrate the feasibility and effectiveness of new models to train social work students to work effectively with older adults. The infrastructure created will establish each consortium's capacity to produce future cadres of aging-competent social workers.

Using previous Foundation support, each consortium had developed three core capacities that are the basis of creating, implementing and testing training programs focused on the needs of older adults. These core capacities are: geriatric content in its M.S.W. program; a mechanism for the effective collaboration of schools and service agencies; and a rotation model that exposes students to the spectrum of care needed by older Americans.

A seventh grant, to the New York Academy of Medicine, will supplement the Academy's existing program to bring the grantee programs together and extend the development of excellent geriatric practicums. It will also facilitate dissemination to social work educators and professionals.

Practicum Implementation Sites

Hunter College, City University of New York
New York, NY
Rose Dobrof, D.S.W.
Joann Ivry, Ph.D., A.C.S.W.
$325,000, Three Years

Partners in Care Foundation, Inc.
Burbank, CA
W. June Simmons, L.C.S.W.
JoAnn Damron Rodriguez, Ph.D.
$475,000, Three Years

State University of New York, Albany,
Albany, NY
Anne E. Fortune, Ph.D.
$323,640, Three Years

University of California, Berkeley
Berkeley, CA
Barrie Robinson, M.S.S.W.
$475,000, Three Years

University of Houston
Houston, TX
Virginia Cooke Robbins, L.M.S.W., A.C.P.
$325,000, Three Years

University of Michigan
Ann Arbor, MI
Ruth Dunkle, Ph.D.
Lily Jarman-Rhode, M.S.W.
$325,000, Three Years

Coordinating Center

New York Academy of Medicine
New York, NY
Patricia J. Volland, M.S.W., M.B.A.
$606,054, Three Years

Hartford Geriatric Social Work Faculty Program
Gerontological Society of America
Washington, DC
Barbara Berkman, D.S.W.
$5,641,227, Five Years
The Gerontological Society of America (GSA) will use this renewal award to select and support 30 additional Hartford Geriatric Social Work Faculty Scholars. The GSA will use three program components to encourage the Scholars' career development: training in outcomes research and leadership skills; a career development plan with the support of local and national faculty sponsors; and two years of research support to study geriatric outcomes in community-based health practice settings.

This award renews a current grant to the GSA under which 10 Hartford Geriatric Social Work Faculty Scholars were selected and supported. It is a key component of the Hartford Foundation's Social Work Initiative designed to improve the capacity of schools of social work to train the next generation and future generations of social workers to meet the challenges of our aging society. This grant will both advance geriatric social work research and increase the number of educators and role models preparing future generations of social workers to care for the nation's older adults.

Hartford Geriatric Social Work Doctoral Fellows Program
Gerontological Society of America
Washington, DC
James Lubben, D.S.W., M.P.H.
$2,445,146, Five Years
An award to the Gerontological Society of America (GSA) launches the Hartford Geriatric Social Work Doctoral Fellows program. Doctoral social work students will receive financial support for aging-related dissertation work, mentorship and workshops to develop their professional skills and create peer networks.

This project is a key component of the Foundation's Social Work Initiative, which is designed to improve the capacity of schools of social work to train future generations of social workers to meet the challenges of our aging society.

CENTERS OF EXCELLENCE IN GERIATRIC MEDICINE

The Centers of Excellence program was begun in 1988, to meet the urgent demand for physician faculty trained to prepare physicians in the health care needs of older adults. After a brief hiatus, the program was restarted in 1997. At the end of 2000, 20 awards had been made to Centers located around the nation, supported by a coordinating center operated by the American Federation for Aging Research. They have proven successful in increasing the number of academically-oriented physicians trained in geriatrics. In addition, these faculty have strengthened geriatrics in their institutions by obtaining additional funding for research and using a variety of strategies to make the healthcare needs of older adults more prominent.

Renewals
$4,950,000, Three Years

Eleven renewal grants to previously funded centers were awarded. They are designed to increase the number of physician faculty dedicated to geriatrics. Each center will use its grant to meet this goal by providing support for: fellows pursuing advanced training for academic geriatric careers; junior faculty beginning independent academic careers; and efforts to attract faculty from other areas of medicine to geriatric health issues.

Baylor College of Medicine
Houston, TX
Robert J. Luchi, M.D.
$450,000, Three Years

Boston Medical Center
Boston, MA
Rebecca Silliman, M.D., Ph.D.
$450,000, Three Years

Southeast Center of Excellence

A. **Emory University**
Atlanta, GA
Joseph G. Ouslander, M.D.
$450,000, Three Years

B. **University of Alabama at Birmingham**
Birmingham, AL
Richard M. Allman, M.D.
$450,000, Three Years

University of California, San Francisco
San Francisco, CA
C. Seth Landefeld, M.D.
$450,000, Three Years

University of Colorado
Denver, CO
Andrew M. Kramer, M.D.
$450,000, Three Years

University of Hawaii
Honolulu, HI
Patricia L. Blanchette, M.D., M.P.H.
$450,000, Three Years

University of Kansas Medical Center
Kansas City, KS
Stephanie A. Studenski, M.D., M.P.H.
$450,000, Three Years

University of Rochester School of Medicine and Dentistry
Rochester, NY
William J. Hall, M.D.
$450,000, Three Years

University of Texas Health Sciences Center at San Antonio
San Antonio, TX
David V. Espino, M.D.
$450,000, Three Years

Yale University
New Haven, CT
Mary E. Tinetti, M.D.
$450,000, Three Years

New Centers of Excellence

University of Chicago
Chicago, IL
Greg A. Sachs, M.D.
$524,590, Three Years
The University of Chicago will use its grant to enhance development opportunities for junior faculty through a small research grants program and the addition of a research coordinator.

University of Pennsylvania
Philadelphia, PA
Risa J. Lavizzo-Mourey, M.D., M.B.A.
$450,000, Three Years
The University of Pennsylvania's Institute on Aging will enhance its capacity to produce academic geriatrics faculty by developing advanced fellows and/or junior faculty members. Foundation support will provide dedicated research time for fellows or faculty members seeking to acquire additional research skills or carry out research important to their professional development as academic geriatricians.

Enhancing Geriatric Oncology Training
American Society of Clinical Oncology
Alexandria, VA
Charles M. Balch, M.D.
John M. Bennett, M.D.
$2,485,070, Four Years
This grant was awarded to the American Society for Clinical Oncology (ASCO) to implement a model for combined training in geriatrics and oncology at the fellowship and/or junior faculty level. The grant will support a selection of up to seven training centers. Each will receive three years of support to develop leaders in the emerging field of geriatric oncology and to create a sustainable joint research program.

This grant is a continuation of a project begun through a grant to the University of Rochester School of Medicine and Dentistry under which 12 academic health centers collaborated on the development of a training model to enable fellows to gain certifications in both geriatrics and oncology in a three-year training period. ASCO was chosen as the home for the second phase to bring the program increased national visibility.

John A. Hartford/AFAR Fellowship Cohort Expansion
American Federation for Aging Research (AFAR), Inc.
New York, NY
Odette Van der Willik
$881,176, 27 Months
The John A. Hartford/American Federation for Aging Research Geriatric Fellowship Program is designed to foster the development of a new generation of academic geriatricians whose careers will involve exemplary research, teaching and practice. Awardees receive $50,000 to be spent over one or two years on research, travel, and other support. This award will enable expansion of the 2000-2001 JAHF/AFAR Academic Geriatric Fellowship Program to support 15 additional geriatric fellows (bringing the total to 25) beginning their research training.

Second Fellowship Cohort Expansion
American Federation for Aging Research (AFAR), Inc.
New York, NY
Odette Van der Willik
$582,830, 27 Months
This grant starting in July 2001, is targeted to geriatric fellows entering their second year of fellowship training, which is the beginning of their research training. As in previous awards for this purpose, 10 fellows will receive $50,000 to be spent over one or two years on research, advanced training, travel, or other support to attend professional conferences.

Enhancing Geriatrics in Undergraduate Medical Education (Augmentation)
Association of American Medical Colleges
Washington, DC
M. Brownell Anderson
$1,135,323, Two Years
This grant is an augmentation to a current award which supported the AAMC in developing a grants program and issuing a request for proposals to medical schools wishing to enhance the geriatric content of their curriculum. Twenty schools were selected for funding in the first round.

With the new award, the AAMC will select ten additional schools using the same process. The AAMC will provide $100,000 in seed money to each school over a two-year period. The schools are to increase the geriatric content of their curricula and develop new curricular models designed to improve medical students' knowledge and attitudes regarding the care of elders. This grant will bring the total of participating schools to 30.

Increasing Geriatrics Expertise in Surgical and Medical Specialties – Phase III
The American Geriatrics Society, Inc.
New York, NY
David H. Solomon, M.D.
John R. Burton, M.D.
$5,934,618, Four Years
A grant to the American Geriatrics Society (AGS) will continue Foundation support for the third phase of a program to improve the care of older adults by physicians in 10 surgical and medical specialties. The support will allow the AGS, in cooperation with the specialty societies, to continue geriatric curricular and model training development as well as the development of a research agenda for each specialty. It will also create a career development award to address the shortage of researchers focused on the care of older patients.

The specialties involved are: anesthesiology, emergency medicine, general surgery, gynecology, ophthalmology, orthopedic surgery, otolaryngology, physical medicine and rehabilitation, thoracic surgery and urology. Under previous awards, many successes were realized, including the establishment of geriatric special interest groups, special publications of journals dedicated to geriatrics, development of geriatric content for residency training programs and pilot research. The grant for Phase III of the project will institutionalize the previously established mechanisms and create new ways to help prepare surgical and medical specialists to provide enhanced care for older adults.

Paul B. Beeson Physician Faculty Scholars in Aging Research Program
American Federation for Aging Research (AFAR), Inc.
New York, NY
Stephanie Lederman
Odette Van der Willik
$8,427,057, Five Years
An award to the American Federation for Aging Research will support 15 new scholars and extend the Paul B. Beeson Physician Faculty Scholars in Aging Research Program, an initiative supported by several major donors. The Beeson program provides the resources necessary to support the research activities of outstanding junior physician faculty in order to increase the number of physician scientists dedicated to research focused on aging and improving the quality of life of older Americans.

Now in its sixth year of operation, the renewal will significantly increase the number of Beeson Scholars. It will continue to have a major impact on the professional development of the recipients, talented junior physician faculty dedicated to aging research. Past Beeson Scholars have received promotions, enlarged their laboratories, published extensively and received national and international recognition. Future cohorts will benefit from the program's lessons and successes, joining a network of highly talented physician researchers dedicated to improving the health and healthcare of older adults. To date, 62 scholars have received research support as a result of this program.

Training General Internists in Geriatrics:
Planning for Sustained Improvement
Society of General Internal Medicine
Washington, DC
Kurt Kroenke, M.D.
$598,052, One Year
An award to the Society of General Internal Medicine will support the development of a plan to strengthen the geriatric content of training for residents in internal medicine and the geriatric capacity of the general internist faculty who teach them.

This project is an outgrowth of a broader John A. Hartford Foundation strategy designed to improve the geriatric content of internal medicine and its subspecialties, under a grant to the American Geriatrics Society. At an August 1999 "Geriatric Education Retreat" for general internists, consensus rapidly emerged that every general internist should be a competent geriatrician. This grant will create a blueprint to reach that goal. The Society of General Internal Medicine, the primary academic organization of the nation's general internists, will address the lack of adequate geriatric training by assessing major gaps, strategies to meet those needs and gaining buy-in on needed next steps.

Distribution of Geriatrics Educational Materials
American Geriatrics Society, Inc.
New York, NY
Nancy E. Lundebjerg
$693,200, Three Years
This grant will enable the American Geriatrics Society to distribute two educational products, Geriatrics at Your Fingertips and Tools for Geriatric Care to third-year medical students and first-year residents. At the end of three years, 88,000 copies of each will have been distributed.

By distributing these materials at critical periods in the education of physicians, the American Geriatrics Society hopes to preserve and nurture future physicians' interest in the health care of older adults. These resources are convenient guides (a pocket sized book and a laminated fold-out pocket card) to current information on how to treat and assess a wide variety of common geriatric syndromes and conditions such as dementia, depression, falls, incontinence and the special considerations of medical treatments as they apply to older adults.

Improving Functional Health Outcomes in Older People
Agency for Healthcare Research and Quality
Rockville, MD
Arlene S. Bierman M.D., M.S.
$75,000, One Year
This grant, to the Agency for Healthcare Research and Quality (AHRQ), will provide partial support for a meeting to refine and prioritize a research agenda on approaches to improving the independence and quality of life of older people.

This grant will enable AHRQ to commission white papers and convene a meeting with the following three objectives:

- Review the current body of knowledge regarding the functional health outcomes of older people;
- Identify gaps in that knowledge as well as effective clinical interventions; and
- Develop research priorities to inform future initiatives and guide discussion on opportunities for coordination and collaboration between and among federal and private funders.

Attendees at the meeting will include nationally recognized experts in medicine, nursing, social work, social science and health economics together with representatives from the federal government and private foundations.

HOME HOSPITAL NATIONAL DEMONSTRATION AND EVALUATION
$3,106,182, Three Years

Many studies have shown the negative results of hospitalization, and demonstrated the difficulty of preventing post-discharge complications in older adults. Too often, patients are released as "cured" of their original ailment but suffer from newly acquired problems such as delirium, incontinence, immobility, or the aftermath of hospital-acquired infections. Foundation staff approached geriatricians at Johns Hopkins to develop a model for a home-based option in lieu of hospital admission. Three Foundation grants totaling $1,397,314 though 1999 supported this work over the past five years. The last of these awards provided funds to identify sites and develop a comprehensive approach to implementation, evaluation, and eventual dissemination, and led to the four awards described below.

Home Hospital treatment will be implemented and evaluated at three diverse sites over a three-year period. Each site's work is supported by a separate grant and a fourth award was made to Johns Hopkins to serve as the "Home Hospital" coordinating center, providing ongoing technical, evaluative, and data management expertise. The effort involves four phases: 1) site preparation; 2) enrollment and data collection for control group patients, who will receive usual hospital care; 3) enrollment and data collection for intervention patients, whose care will be guided by the appropriate "Home Hospital" protocol; 4) data analysis and dissemination. Data from all sites will be pooled to gain the needed sample size to test the key assumptions of the program. The hypotheses are that "Home Hospital" vs. traditional inpatient care will: 1) be acceptable to patients and providers; 2) result in higher patient satisfaction and comparable clinical outcomes and safety; 3) not increase caregiver burden; and 4) be less costly than traditional care. A further effort will be made to determine the additional potential of "Home Hospital" to prevent delirium. There will also be a qualitative evaluation component, documenting the "Home Hospital" implementation process, which will be necessary for subsequent dissemination efforts.

Implementation Sites

Buffalo General Foundation
Buffalo, NY
Bruce J. Naughton, M.D.
$406,124, Three Years

Fallon Community Health Plan
Worcester, MA
Jeffrey B. Burl, M.D.
$543,032, Three Years

Portland VA Medical Center
Portland, OR
Scott L. Mader, M.D.
$512,447, Three Years

Coordinating Center

Johns Hopkins University School of Hygiene and Public Health
Baltimore, MD
John R. Burton, M.D.
Bruce Leff, M.D.
Donald M. Steinwachs, Ph.D.
$1,644,579, Three Years

GIT IN PRACTICE INITIATIVE
$4,860,212, Four Years

Three grants were made under the Foundation's new "Geriatric Interdisciplinary Teams (GIT) in Practice" initiative, which aims to develop and evaluate approaches to providing team care to improve the health of older adults. It builds on lessons from the Foundation's Geriatric Interdisciplinary Team Training program which focused on developing academic educational models for a range of health professionals regarding the skills and resources necessary for effective team care.

Virtual Integrated Practice: A New Approach to Health Care Teams
Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL
Steven K. Rothschild, M.D.
$1,995,418, Four Years
This award to Rush-Presbyterian-St. Luke's Medical Center will support the implementation and evaluation of its geriatric interdisciplinary team practice model. The Virtual Integrated Practice (VIP) team will integrate health professionals from social work, homecare nursing, nutrition, physical therapy and others into its primary care physicians' offices by using lessons learned in the John A. Hartford Foundation's Geriatric Interdisciplinary Team Training program and will incorporate new care protocols as well as communications and information technologies. The model's impact on cost, clinical and satisfaction outcomes will be evaluated.

A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes
PeaceHealth Oregon Region, Center for Senior Health
Eugene, OR
Ronald D. Stock, M.D.
$1,507,390, Four Years
This grant to PeaceHealth Oregon Region's Center for Senior Health will demonstrate the health benefits and financial impacts of interdisciplinary team care for older adults. Health outcomes and other information will be collected from patients 66 years and older being cared for by Center for Senior Health and compared to the health of patients elsewhere in the PeaceHealth system. Electronic medical records and team care products will facilitate the use of team care in the senior center.

An Interdisciplinary Team Approach to Improving Transitions Across Sites of Geriatric Care
University of Colorado Health Sciences Center
Denver, CO
Eric A. Coleman, M.D., M.P.H.
$1,357,404, Four Years
This grant will enable the University of Colorado Health Sciences Center to implement and evaluate a model of patient-centered team care designed to reduce the difficulty and risk associated with post-hospital transfers to different sites of care. This model recognizes the potential of empowered patients and caregivers to organize and coordinate a care-team as they move through the health system.

Senior Services Program Implementation
Health and Human Services Planning Association, Inc.
West Palm Beach, FL
Kerry A. Rodriguez, J.D.
$1,346,250, Four Years
With support from this grant and contributions of additional partners, the Health and Human Services Planning Association will work to: increase the elder-readiness of the community's health system; facilitate independent living by increasing access to resources; improve the coordination of health care and social services; and test approaches to reduce the need for nursing home care. This grant will begin the implementation of strategies from a prior planning grant.

This grant continues work in Florida under the John A. Hartford Foundation's "Three States Strategy" aimed at improving the elder services capacity of the three states (Florida, New York and California) with the greatest number of older adults.

Expanding the Availability of the Program of All-inclusive Care of Elders (PACE) Model of Care
National PACE Association
Alexandria, VA
Shawn M. Bloom
$549,860, Three Years
A grant to the National PACE Association (NPA) will enable the rapid expansion of the Program for All-Inclusive Care of Elders (PACE) model of care by providing analysis plus technical and marketing assistance to potential new PACE providers. PACE is modeled on On Lok Senior Services care for elders in San Francisco's Chinatown community.

The PACE model was implemented on a limited basis under its previous "demonstration project" status. Over twenty years after On Lok began, the model was given "permanent provider" status within Medicare and rapid expansion of the program was made possible by the Balanced Budget Act of 1997. The lessons of the demonstration sites will inform the new PACE providers. This effort is also funded by the Robert Wood Johnson Foundation.

Improving Depression Care for Elders: Coordinating Center — Supplemental Follow-up
The University of California, Los Angeles
Los Angeles, CA
Jurgen Unutzer, M.D., M.P.H.
$699,831, Five Years
The Foundation is working to overcome barriers to effective depression treatment for elders with an initiative, originally funded in 1998, involving seven demonstration sites and a coordinating center at the University of California, Los Angeles. (Two of the sites are supported by the California HealthCare Foundation.) The enhanced model of care incorporates a depression clinical specialist (i.e., nurse, social worker or psychologist) to work with primary care physicians and their patients.

Supplemental support will extend patient follow-up from one to two years. UCLA will use the funds to better document the impact of the model of enhanced care, and answer questions regarding the appropriate duration of treatment.

National Network for Intergenerational Health:
Organizational Development Plan
University of Maryland
College Park, MD
Sharlene Hirsch
$99,957, One Year
Supported by a previous Foundation grant, the National Network for Intergenerational Health brought together college students and older adults in exercise and other social activities. The University of Maryland, which houses the Network, began a national dissemination effort in 1994 and 29 institutions have completed implementation of the program or are in the final planning stages.

This grant will enable the University of Maryland to develop a plan to establish a self-sustaining permanent organization for the National Network for Intergenerational Health. Support will enable completion of a feasibility study and a business plan to continue this program, which promotes the health of older adults while capturing the benefits of intergenerational exchange.


THE JOHN A. HARTFORD FOUNDATION
1929

On December 31, 2000 the Foundation's assets were $623.6 million, an increase of $16.3 million for the year after cash payments of $30.4 million for grants, expenses and Federal excise tax. Total return on the investments, income plus realized and unrealized capital gains, was 5.1 percent. In 2000 revenues totaled $13.3 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.

The positive growth of the Foundation's assets this year, even after all payout, proved the wisdom of sticking to the fundamentals of investing that have worked over the long term. In addition, prudent diversification of the portfolio by investment style and into alternative asset classes enabled the Foundation to successfully weather a very difficult investment climate in 2000. At the end of the year the Foundation's asset mix was 69 percent equities, 20 percent fixed income, and a combined 11 percent in venture capital, private equity, real estate and event-driven funds, compared with 72, 18 and 10 percent, respectively, at the end of 1999.

As of December 31, 2000, Capital Guardian Trust Company, Sound Shore Management, William Blair & Co., T. Rowe Price Associates, W.P. Stewart & Co., Wasatch Advisors and Pequot Capital Management 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.

In light of the volatile financial markets in 2000 and the uncertainty ahead, the Trustees undertook an asset allocation study and revised their investment policies and objectives to help keep the Foundation on course to meet their long-term goals. The Finance Committee and the Board of Trustees meet regularly with each of the investment managers to review their performance and discuss current investment strategy. J.P. Morgan Chase & Co. is custodian for all the Foundation's securities. A complete listing of investments is available for review at the Foundation offices.

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

Ladies and Gentlemen:

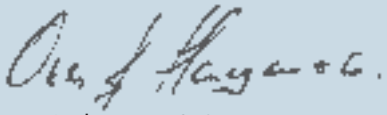
We have audited the balance sheets of The John A. Hartford Foundation, Inc. (a New York not-for-profit corporation) as of December 31, 2000 and 1999 and the related statements of revenues, grants and expenses and changes in net assets and cash flows for the years then ended. These financial statements 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, 2000 and 1999 and its changes in net assets and cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The data contained in pages 65 to 74, 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 7, 2001

The John A. Hartford Foundation, Inc.
Balance Sheets
December 31, 2000 and 1999

Exhibit A

	2000	*1999*
Assets		
Cash in operating accounts	$ 4,926	$ 3,693
Interest and dividends receivable	3,191,919	966,151
Prepayments and deposits	107,310	83,882
Prepaid taxes	90,290	262,978
	3,394,445	1,316,704
Investments, at fair value or adjusted cost (Notes 2 and 3)		
Short-term cash investments	19,362,510	82,410,331
Stocks	425,952,486	429,955,731
Bonds	104,088,770	26,746,000
Investment partnerships	52,837,949	48,738,307
Real estate pooled funds	13,628,720	13,456,383
Total Investments	615,870,435	601,306,752
Office condominium, furniture and equipment (net of accumulated depreciation of $850,453 in 2000 and $510,000 in 1999) (Note 5)	4,325,456	4,652,845
Total Assets	$623,590,336	$607,276,301
Liabilities and Net Assets		
Liabilities:		
Grants payable (Note 2)		
Current	$ 17,633,271	$ 13,525,259
Non-current (Note 7)	45,387,488	18,394,450
Accounts payable	659,517	806,206
Deferred Federal excise tax (Note 2)	1,183,967	1,531,692
Total Liabilities	64,864,243	34,257,607
Net Assets - Unrestricted		
Board designated (Note 2)	9,676,917	5,368,802
Undesignated	549,049,176	567,649,892
Total Net Assets (Exhibit B)	558,726,093	573,018,694
Total Liabilities and Net Assets	$623,590,336	$607,276,301

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

The John A. Hartford Foundation, Inc.
Statements of Revenues, Grants and Expenses and Changes in Net Assets
Years Ended December 31, 2000 and 1999

Exhibit B

	2000	*1999*
Revenues		
Dividends and partnership earnings	$ 5,539,800	$ 5,103,245
Bond interest	6,427,879	5,706,168
Short-term investment earnings	1,290,122	1,659,069
Total Revenues	13,257,801	12,468,482
Grants and Expenses		
Grant expense (less cancellations and refunds of $498,488 in 2000 and $344,227 in 1999)	55,794,904	17,530,337
Foundation-administered projects	336,139	179,829
Grant-related direct expenses	102,562	142,354
Excise and unrelated business income taxes (Note 2)	149,570	219,020
Investment fees	1,889,529	2,174,095
Personnel salaries and benefits (Note 6)	1,729,325	1,667,832
Office and other expenses	858,568	909,581
Depreciation	340,453	338,455
Professional services	84,051	77,531
Total Grants and Expenses	61,285,101	23,239,034
Excess (deficiency) of revenues over grants and expenses	(48,027,300)	(10,770,552)
Net Realized and Change in Unrealized Gains (Note 3)	33,734,699	77,962,469
Increase (Decrease) in Net Assets	(14,292,601)	67,191,917
Net Assets, beginning of year	573,018,694	505,826,777
Net Assets, End of Year (Exhibit A)	$558,726,093	$573,018,694

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
Years Ended December 31, 2000 and 1999

	2000	*1999*
Cash Flows Provided (Used)		
From Operating Activities:		
Interest and dividends received	$ 8,768,667	$ 12,015,589
Cash distributions from partnerships and real estate pooled funds	6,404,258	3,585,923
Grants and Foundation-administered projects paid (net of refunds)	(25,029,993)	(19,824,005)
Expenses and taxes paid	(5,389,685)	(5,959,275)
Net Cash Flows Provided (Used) by Operating Activities	(15,246,753)	(10,181,768)
From Investing Activities:		
Proceeds from sale of investments	321,701,413	292,259,751
Purchases of investments	(369,606,748)	(253,579,332)
Purchases of fixed assets	(122,417)	(12,416)
Net Cash Flows Provided (Used) by Investing Activities	(48,027,752)	38,668,003
Net Increase (Decrease) in Cash and Cash Equivalents	(63,274,505)	28,486,235
Cash and equivalents, beginning of year	82,446,263	53,960,028
Cash and equivalents, end of year	$ 19,171,758	$82,446,263
Reconciliation of Increase in Net Assets to Net Cash Used by Operating Activities		
Increase (Decrease) in Net Assets	$(14,292,601)	$ 67,191,917
Adjustment to reconcile increase in net assets to net cash used by operating activities:		
Depreciation	340,453	338,455
Decrease (increase) in interest and dividends receivable	(2,225,768)	1,017,474
Decrease (increase) in prepayments and deposits	(23,428)	(9,779)
Increase (decrease) in grants payable	31,100,950	(2,113,839)
(Decrease) increase in accounts payable	(39,163)	(78,345)
Net realized and change in unrealized gains	(33,734,699)	(77,962,469)
Other	3,627,503	1,434,818
	$(15,246,753)	$(10,181,768)

The John A. Hartford Foundation, Inc. Exhibit C
Statements of Cash Flows
Years Ended December 31, 2000 and 1999

	2000	*1999*
Supplemental Information:		
Detail of other:		
Investment partnerships and real estate pooled funds:		
Cash distributions	$ 6,404,258	$ 3,585,923
Less: reported income	2,256,562	1,417,905
	4,147,696	2,168,018
Tax expense	149,570	219,020
Less: Taxes paid	669,763	899,758
Excess (tax on realized gains and change in prepaid)	(520,193)	(680,738)
Zero-coupon amortization	—	(52,462)
Total - Other	$ 3,627,503	$ 1,434,818
Composition of Cash and Equivalents:		
Cash in operating accounts	$ 4,926	$ 3,693
Short-term cash investments	19,362,510	82,410,331
Unrealized (gain) loss on forward currency contracts	(195,678)	32,239
	$19,171,758	$82,446,263

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, 2000 and 1999

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 percent or 2 percent rate depending on the amount of qualifying distributions. For 2000 and 1999 the Foundation's rates were 1 percent and 2 percent, respectively.

Investment expenses for 2000 include direct investment fees of $1,889,529 and $114,000 of allocated salaries, legal fees and other office expenses. The 1999 comparative numbers were $2,174,095 and $133,000.

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

The John A. Hartford Foundation, Inc. Exhibit D
Notes to Financial Statements
December 31, 2000 and 1999

The Foundation intends to distribute at least $27,700,000 of undistributed income in grants or qualifying expenditures by December 31, 2001 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 2000 are summarized as follows:

	Cost	*Fair Value*	*Appreciation*
Balance, December 31, 2000	$497,473,732	$615,870,435	$118,396,703
Balance, December 31, 1999	$448,137,539	$601,306,752	$153,169,213
Increase (decrease) in unrealized appreciation during the year, net of decreased deferred Federal excise tax of $347,725			$(34,424,785)
Realized gain, net of provision for excise taxes of $688,480			68,159,484
Net realized and change in unrealized gains			$ 33,734,699

For 1999, the unrealized gain was $54,677,314, net of increased deferred Federal excise tax of $552,296. The realized gain was $23,285,155 net of a provision for Federal excise tax of $475,208.

Receivables and payables on security sales and purchases pending settlement at December 31, 2000 and 1999 were as follows:

	2000	*1999*
Proceeds from sales	$ 1,500,291	$ 82,903
Payables from purchases	(2,450,591)	(332,459)
Net cash pending settlement	$ (950,300)	$ (249,556)

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

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

	2000	*1999*
U.S. Government	$103,669,305	$ 5,188,202
U.S. agency	—	787,915
Corporate	419,465	2,102,467
Commingled fund	—	1,681,411
Foreign denominated	—	16,986,005
	$104,088,770	$26,746,000

The Foundation is a participant in fourteen investment limited partnerships. As of December 31, 2000, $52,913,605 had been invested in these partnerships and future commitments for additional investment aggregated $4,086,395.

The John A. Hartford Foundation, Inc. Exhibit D
Notes to Financial Statements
December 31, 2000 and 1999

In addition, the Foundation was 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. One investment terminated during 2000 and the recorded value of the three remaining investments is $293,721.

Three of the Foundation's investment partnerships permit withdrawals at least once a year. These are valued at their fair value, $26,004,428 (adjusted cost $26,734,224).

Real estate investments included two limited partnerships and five real estate investment trusts. The Foundation had invested $18,010,000 at December 31, 2000 and future commitments for additional investment aggregated $1,990,000.

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, 2000 the Foundation's open foreign currency forward sale and purchase contracts totaled $15,079,665. Total foreign denominated investments at the same date were $35,647,816.

5. Office Condominium, Furniture and Equipment

At December 31, 2000 and 1999 the fixed assets of the Foundation were as follows:

	2000	*1999*
Office condominium	$4,622,812	$4,622,812
Furniture and equipment	553,097	540,033
	5,175,909	5,162,845
Less: Accumulated depreciation	850,453	510,000
Office condominium, furniture and equipment, net	$4,325,456	$4,652,845

6. Pension Plan

The Foundation has a defined contribution retirement plan covering all eligible employees under which the Foundation contributes 14 percent of salary for employees with at least one year of service. Pension expense under the plan for 2000 and 1999 amounted to $153,447 and $145,450, respectively. The Foundation also incurred additional pension costs of approximately $24,000 in 2000 and $30,000 in 1999 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.

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Notes to Financial Statements
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7. Grants Payable

The Foundation estimates that the non-current grants payable as of December 31, 2000 will be disbursed as follows:

2002	$19,283,776
2003	18,640,655
2004	11,384,473
2005	4,990,239
2006	765,262
	55,064,405
Conditional grants and discount to present value	(9,676,917)
	$45,387,488

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 2000 and 1999 was 9.5 percent and 8.5 percent, respectively.

At December 31, 2000, a portion of a grant in the amount of $522,550 was contingent on the grantee raising additional funds. As a result, this amount is 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:

	2000	*1999*
Partnership earnings	$1,456,715	$ 961,748
Realized gains (loss) - net of taxes of $1,098 and $25,009	(108,689)	1,225,393
Unrealized gain (loss) - net of deferred excise tax provision (recovery) of ($10,742) and $4,553	(1,063,449)	450,725
	$ 284,577	$2,637,866

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
AGING & HEALTH PROGRAM				
Academic Geriatrics and Training				
Agency for Healthcare Research and Quality Rockville, MD *Improving Functional Health Outcomes in Older People* Arlene S. Bierman, M.D., M.S.		$ 75,000	$ 60,000	$ 15,000
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.	$ 83,756			83,756
American Academy of Nursing Washington, DC *Nursing Initiative Coordinating Center and Scholar Stipends* Claire Fagin Ph.D., R.N., F.A.A.N		8,053,045	984,900	7,068,145
American Federation for Aging Research, Inc. New York, NY *Fellowship Cohort Expansion* Odette van der Willik		1,464,006	715,930	748,076
American Federation for Aging Research, Inc. New York, NY *Paul B. Beeson Physician Faculty Scholars in Aging Research Program* Stephanie Lederman Odette van der Willik	5,734,495	8,427,057	3,429,258	10,732,294
American Federation for Aging Research, Inc. New York, NY *Centers of Excellence Coordinating Center* Odette van der Willik	2,224,397		368,477	1,855,920
American Federation for Aging Research, Inc. New York, NY *Medical Student Geriatric Scholars* Program Odette van der Willik	934,100		649,345	284,755
American Geriatrics Society, Inc. New York, NY *Increasing Geriatrics Expertise in Surgical and Medical Specialties Phase 3* David H. Solomon, M.D. John R. Burton, M.D.	365,267	5,934,618	300,000	5,999,885
American Geriatrics Society, Inc. New York, NY *Enhancing Geriatric Care Through Practicing Physician Education, Phase II* Sharon Levine, M.D.	1,151,520		508,192	643,328

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
American Geriatrics Society, Inc. New York, NY *Integrating Geriatrics into the Subspecialties of Internal Medicine* William R. Hazzard, M.D.	$ 2,185,937			$ 2,185,937
American Geriatrics Society, Inc. New York, NY *Distribution of Geriatrics Educational Materials* Nancy E. Lundebjerg		$ 693,200	$ 265,400	427,800
American Society of Clinical Oncology Alexandria, VA *Enhancing Geriatric Oncology Training* Charles M. Balch, M.D. John M. Bennett, M.D.		2,485,070	234,163	2,250,907
Association of American Medical Colleges Washington, DC *Enhancing Geriatrics in Undergraduate Medical Education* M. Brownell Anderson	2,327,058	1,135,323	884,678	2,577,703
Baylor College of Medicine Houston, TX *Center of Excellence* Robert J. Luchi, M.D.	125,827	450,000	125,827	450,000
Boston University Medical Center Boston, MA *Center of Excellence* Rebecca A. Silliman, M.D., Ph.D.	131,930	450,000	106,885	475,045
Council on Social Work Education Alexandria, VA *Preparing Gerontology-Competent Social Workers* Joan Levy Zlotnik, Ph.D.	188,743		188,743	
Duke University Durham, NC *Center of Excellence* Harvey Jay Cohen, M.D.	450,000		225,000	225,000
Emory University Atlanta, GA *Southeast Center of Excellence in Geriatric Medicine* Joseph Ouslander, M.D.	202,668	450,000	202,668	450,000
Gerontological Society of America Washington, DC *Hartford Geriatric Social Work Faculty Scholars Program* Barbara Berkman, D.S.W.	1,968,090	5,641,227	1,668,300	5,941,017
Gerontological Society of America Washington, DC *Hartford Geriatric Social Work Doctoral Fellows Program* James Lubben, D.S.W., M.P.H.		2,445,146	172,109	2,273,037

Summary of Active Grants

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
Harvard Medical School Boston, MA *Center of Excellence* Lewis A. Lipsitz, M.D.	$ 450,000		$ 75,000	$ 375,000
Hunter College, City University of New York New York, NY *Geriatric Social Work Practicum Implementation* Rose Dobrof, D.S.W. Joann Ivry, Ph.D.		$ 325,000	150,000	175,000
Institute for Clinical Evaluation Philadelphia, PA *A Credential in Home Care* John J. Norcini, Ph.D.	102,000			102,000
Johns Hopkins University Baltimore, MD *Center of Excellence* John R. Burton, M.D.	450,000		146,884	303,116
Mount Sinai Medical Center New York, NY *Geriatric Interdisciplinary Team Training* Christine K. Cassell, M.D.	125,000		125,000	
Mount Sinai Medical Center New York, NY *Center of Excellence* Christine K. Cassell, M.D.	450,000		150,000	300,000
New York Academy of Medicine New York, NY *Geriatric Social Work Practicum Development: Implementation Coordinating Center* Patricia J. Volland, M.S.W., M.B.A.	214,443	606,054	202,840	617,657
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.	1,203,509		879,317	324,192
New York University New York, NY *Geriatric Interdisciplinary Team Training Program: Resource Center Renewal* Terry T. Fulmer, R.N., Ph.D., F.A.A.N.	975,274		473,501	501,773
Northwestern University Chicago, IL *Center of Excellence* John Clarke, M.D.	67,059		67,059	
Oregon Health Sciences University Portland, OR *Center of Geriatric Nursing Excellence* Patricia G. Archbold, R.N., D.N.Sc.		1,328,677	265,781	1,062,896

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
Partners in Care Foundation, Inc. Burbank, CA *Geriatric Social Work Practicum Implementation* W. June Simmons, L.C.S.W. Joann Damron Rodriguez, Ph.D.		$ 475,000	$ 100,000	$ 375,000
Society of General Internal Medicine Washington, DC *Training General Internists in Geriatrics: Planning for Sustained Improvement* Kurt Kroenke, M.D. C. Seth Landefeld, M.D.		598,052	300,000	298,052
Stanford University Stanford, CA *Enhancing Dissemination of Innovations in Geriatric Education* Georgette Stratos, Ph.D.	$ 779,255		564,383	214,872
State University of New York, Albany Albany, NY *Geriatric Social Work Practicum Implementation* Anne E. Fortune, Ph.D.		323,640	149,972	173,668
University of Alabama at Birmingham Birmingham, AL *Southeast Center of Excellence in Geriatric Medicine* Richard M. Allman, M.D.	137,500	450,000	137,500	450,000
University of Arkansas for Medical Sciences Little Rock, AR *Center of Geriatric Nursing Excellence* Claudia J. Beverly, Ph.D., RN		1,331,250	266,250	1,065,000
University of California, Berkeley Berkeley, CA *Geriatric Social Work Practicum Implementation* Barrie Robinson, M.S.S.W.		475,000	100,000	375,000
University of California, Los Angeles Los Angeles, CA *GITT National Program Evaluation* David B. Reuben, M.D.	398,635		337,701	60,934
University of California, Los Angeles Los Angeles, CA *Center of Excellence Renewal* David B. Reuben, M.D.	450,000		150,000	300,000
University of California, San Francisco San Francisco, CA *Center of Geriatric Nursing Excellence* Jeanie Kayser-Jones, Ph.D., R.N., F.A.A.N.		1,330,754	266,245	1,064,509
University of California, San Francisco San Francisco, CA *Center of Excellence* C. Seth Landefeld, M.D.	271,125	450,000	110,772	610,353

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
University of Chicago Chicago, IL *Center of Excellence* Greg A. Sachs, M.D.		$ 524,590	$ 150,000	$ 374,590
University of Colorado Denver, CO *Center of Excellence* Andrew M. Kramer, M.D.	$ 152,144	450,000	302,144	300,000
University of Hawaii Honolulu, HI *Center of Excellence* Patricia L. Blanchette, M.D., M.P.H.	229,479	450,000	185,845	493,634
University of Houston Houston, TX *Geriatric Social Work Practicum Implementation* Virginia Cooke Robbins, L.M.S.W., A.C.P.		325,000	150,000	175,000
University of Iowa Iowa City, IA *Center of Geriatric Nursing Excellence* Meridean L. Maas, Ph.D., R.N., F.A.A.N.		1,330,670	266,220	1,064,450
University of Kansas Kansas City, KS *Center of Excellence* Stephanie A. Studenski, M.D., M.P.H.	247,024	450,000	393,214	303,810
University of Michigan Ann Arbor, MI *Center of Excellence* Jeffrey B. Halter, M.D.	525,000		225,000	300,000
University of Michigan Ann Arbor, MI *Geriatric Social Work Practicum Implementation* Ruth E. Dunkle, Ph.D. Lily Jarman-Rhode, M.S.W.		325,000	150,000	175,000
University of Pennsylvania Philadelphia, PA *Center of Geriatric Nursing Excellence* Neville E. Strumpf, Ph.D., R.N., F.A.A.N.		1,331,250	266,250	1,065,000
University of Pennsylvania Philadelphia, PA *Center of Excellence* Risa J. Lavizzo-Mourey, M.D., M.B.A.		450,000	149,999	300,001
University of Rochester Rochester, NY *Center of Excellence* William J. Hall, M.D.	63,793	450,000	210,570	303,223
University of Rochester Rochester, NY *A Model for the Development of Combined Oncology-Geriatrics Fellowship Training* John M. Bennett, M.D.	414,426		345,889	68,537

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
University of South Florida Tampa, FL *Geriatric Interdisciplinary Team Training* Eric Pfeiffer, M.D.	9,087		$ 9,087	
University of Texas Health Science Center at San Antonio San Antonio, TX *Center of Excellence* David V. Espino, M.D.	202,939	$ 450,000	349,335	$ 303,604
University of Washington Seattle, WA *Center of Excellence* Itamar B. Abrass, M.D.	700,000		100,000	600,000
Yale University New Haven, CT *Center of Excellence* Mary E. Tinetti, M.D.	202,423	450,000	110,969	541,454
Subtotal	$26,893,903	$52,383,629	$ 19,472,602	$59,804,930
Integrating and Improving Services				
Buffalo General Foundation Buffalo, NY *Home Hospital National Demonstration and Evaluation* Bruce J. Naughton, M.D.		406,124	129,239	276,885
Carle Foundation Hospital Urbana, IL *Evaluation of Geriatric Team Care in Medicare Risk* Cheryl Schraeder, Ph.D., R.N.	$ 350,376			350,376
Duke University Durham, NC *Improving Depression Care for Elders* Linda H. Harpole, M.D.	692,049		296,158	395,891
Fallon Community Health Plan Worcester, MA *Home Hospital National Demonstration and Evaluation* Jeffrey B. Burl, M.D.		543,032	180,813	362,219
Health and Human Services Planning Assocation, Inc. West Palm Beach, FL *Senior Services Program Implementation* Kerry A. Rodriguez, J.D.		1,346,250	181,398	1,164,852
Health and Human Services Planning Assocation, Inc. West Palm Beach, FL *Palm Beach County Senior Services Planning* Kerry A. Rodriguez, J.D.	100,000		100,000	

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
Indiana University Indianapolis, IN *Improving Depression Care for Elders* Christopher M. Callahan, M.D.	$ 761,790		$ 247,138	$ 514,652
Johns Hopkins University Baltimore, MD *Home Hospital National Demonstration and Evaluation: Coordinating Center* John R. Burton, M.D., Bruce Leff, M.D., Donald M. Steinwachs, Ph.D.		$ 1,644,579	429,924	1,214,655
National PACE Association Alexandria, VA *Expanding the Availability of the PACE Model of Care* Shawn M. Bloom		549,860	174,860	375,000
PeaceHealth Oregon Region Eugene, OR *A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes* Ronald D. Stock, M.D.		1,507,390	448,783	1,058,607
Portland VA Medical Center Portland, OR *Home Hospital National Demonstration and Evaluation* Scott L. Mader, M.D.		512,447	144,856	367,591
Rush-Presbyterian-St. Luke's Medical Center Chicago, IL *Virtual Integrated Practice: A New Approach to Health Care Teams* Steven K. Rothschild, M.D.		1,995,418	368,188	1,627,230
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.	39,036			39,036
Spartanburg Regional Medical Center Foundation Spartanburg, SC *Improving Geriatric Care in Rural Healthcare Delivery Systems* R. Bradford Whitney, M.D.	518,064		171,615	346,449
University of California, Los Angeles Los Angeles, CA *Improving Depression Care for Elders Coordinating Center* Jurgen Unutzer, M.D., M.P.H.	1,320,510	699,831	266,929	1,753,412
University of California, Los Angeles Los Angeles, CA *Improving Depression Care for Elders* Jurgen Unutzer, M.D., M.P.H.	705,500		304,034	401,466

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
University of Colorado Health Services Center Denver, CO *An Interdisciplinary Team Approach to Improving Transitions Across Sites of Geriatric Care* Eric A. Coleman, M.D., M.P.H.		$ 1,357,404	$ 272,162	$ 1,085,242
University of Texas Health Science Center at San Antonio San Antonio, TX *Improving Depression Care for Elders* John W. Williams, Jr., M.D.	$ 784,452		330,385	454,067
University of Washington Seattle, WA *Improving Depression Care for Elders* Wayne Katon, M.D.	724,477		274,680	449,797
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.	225,330			225,330
Subtotal	$6,221,584	$ 10,562,335	$ 4,321,162	$ 12,462,757
Aging and Health: Other Grants				
American Federation for Aging Research, Inc. New York, NY *Communications and Dissemination Initiative* Stephanie Lederman	135,740		61,233	74,507
George Washington University Washington, DC *Advancing Aging and Health Policy Understanding: Renewal* Judith Miller Jones	425,000		226,975	198,025
University of Maryland College Park, MD *National Network for Intergenerational Health: Organizational Development Plan* Sharlene Hirsch.		99,957	70,000	29,957
Subtotal	$560,740	$ 99,957	$ 358,208	$ 302,489
Total Aging and Health	$33,676,227	$ 63,045,921	$ 24,151,972	$ 72,570,176
New York Fund				
American Federation for Aging Research, Inc. New York, NY		4,000	4,000	
Bowery Residents' Committee, Inc. New York, NY		10,000	10,000	
Foundation for Health in Aging, Inc. New York, NY		10,000	10,000	
Fund for the City of New York New York, NY		25,000	25,000	

Summary of Active Grants

	Balance Due January 1, 2000	Grants Authorized During Year	Amount Paid During Year	Balance Due December 31, 2000
Help Line New York, NY		$ 10,000	$ 10,000	
Hospital for Special Surgery New York, NY		3,000	3,000	
Independence Care System New York, NY		10,000	10,000	
Medicare Rights Center New York, NY		30,000	10,000	$ 20,000
New York Academy of Medicine New York, NY	$ 20,000	10,000	20,000	10,000
Peekskill Youth Bureau Peekskill, NY		30,000	20,000	10,000
United Hospital Fund New York, NY		12,500	12,500	
Total New York Fund	$ 20,000	$ 154,500	$ 134,500	$ 40,000
Other Grants				
Academy for Health Services Research and Health Policy Washington, DC		2,000	2,000	
The 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	87,500			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*		436,389	436,389	
Total Other Grants	$ 87,500	$ 477,389	$ 477,389	$ 87,500
Grants Refunded or Cancelled	$ 428,481	$ (498,488)	$ (70,007)	
Discount to Present Value	(2,292,499)	(7,384,418)		(9,676,917)
Total (All Grants)	$31,919,709	$55,794,904	$24,693,854	$63,020,759
FOUNDATION-ADMINISTERED PROJECTS				
Geriatric Social Work Initiative Evaluation	614,672		185,789	428,883
To Pursue Selected Activities in the Strategic Plan	203,768	200,000	150,350	253,418
Total	$ 818,440	$ 200,000	$ 336,139	$ 682,301

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

ADDITIONAL ACTIVE GRANTS

Aging and Health: Academic Geriatrics and Training

Baylor College of Medicine
Houston, TX
Geriatric Interdisciplinary Team Training
Nancy Wilson, L.M.S.W.
1996; $750,000; 4 years

Dartmouth Medical School
Hanover, NH
Academic Geriatric Leadership Program: Planning
Paul B. Batalden, M.D.
1999; $102,331; 1 year

Henry Ford Health System
Detroit, MI
Great Lakes Geriatric Interdisciplinary Team Training
Nancy A. Whitelaw, Ph.D.
1996; $718,677; 4 years

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

University Hospitals Health System
Cleveland, OH
Great Lakes Geriatric Interdisciplinary Team Training
Shirley Moore R.N., Ph.D.
1996; $481,323; 4 years

University of Colorado
Denver, CO
Geriatric Interdisciplinary Team Training
Nora Morgenstern, M.D.
Ernestine Kotthoff-Burrell, M.S., R.N., C., A.N.P.
1996; $750,000; 54 months

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 Medicine and Dentistry of New Jersey
Newark, NJ
Expansion of Home Care into Academic Medicine
R. Knight Steel, M.D.
1996; $933,492; 51 months

University of Minnesota
Minneapolis, MN
Geriatric Interdisciplinary Team Training
Robert L. Kane, M.D.
1996; $750,000; 4 years

Aging and Health: Integrating and Improving Services

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

On Lok, Inc.
San Francisco, CA
Integrated Chronic Care Information System
Catherine Eng, M.D.
1996; $1,080,538; 54 months

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


THE JOHN A. HARTFORD FOUNDATION
1929

The John A. Hartford Foundation's overall goal is to increase the nation's capacity to provide effective and affordable care to its rapidly increasing elderly population. In order to maximize the Foundation's impact on the health and well-being of the nation's elders, grants are made in two priority areas:

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

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

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

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

Please do not send correspondence by fax or e-mail. Mail may be sent to:
The John A. Hartford Foundation
55 East 59th Street
New York, NY 10022

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

Credits|Editorial: Eleanor Foa Dienstag Design and Photography: Donald Battershall Design

IMPROVED FOUNDATION WEB SITE PREMIERES. In 2001, the Foundation has updated and expanded its Web site to provide descriptions of current grants, historical information about the Foundation and its initiatives, and links to its grant recipients and aging-related organizations. Information about new grants, as they are made, will be regularly posted to the Web site. The information in this report may also be obtained from www.jhartfound.org.